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Accelerated Action for the Health of Adolescents (AA-HA!)

A manual to facilitate the process of developing national adolescent health strategies and plans

The Partnership for Maternal, Newborn & Child Health

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ABBREVIATIONS & ACRONYMS

Abbreviation	Full text
AA-HA!	Global Accelerated Action for the Health of Adolescents
ADH	Adolescent Health
AHSBA	Adolescent Health Services Barrier Assessment
AIDS	Acquired Immunodeficiency Syndrome
APPLY AA-HA!	Approach, Prevention, Priority Setting, Leadership, Yields
CAH	Child and Adolescent Health
HIV	Human Immunodeficiency Virus
H6	Partnership of UNAIDS, UNFPA, UNICEF, UN Women, WHO, World Bank
MCA	Maternal, Newborn, Child and Adolescent Health Department
MCH	Maternal and Child Health
mhGAP	Mental Health Gap Action Program
NCDs	Non-communicable Diseases
OHT	One Health Costing Tool
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
SDGs	Sustainable Development Goals
SRH	Sexual Reproductive Health
STIs	Sexually Transmitted Infections
TB	Tuberculosis
TWG	Technical Working Group
UN Women	The United Nations Entity for Gender Equality and the Empowerment of Women
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
WB	World Bank
WHO	World Health Organization

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INTRODUCTION

Why Accelerated Action for the Health of Adolescents (AA-HA!)?

For years, the unique health issues associated with adolescence have been little understood or, in some cases, ignored. But that has now changed. Adolescent health and development was made an integral part of the Global Strategy for Women's, Children's and Adolescents' Health (2016–2030), and is at the heart of Global Accelerated Action for the Health of Adolescents (AA-HA!): guidance to support country implementation, which reflects the coming of age of adolescent health within global public health (1). The guidance, launched in 2017 by WHO in collaboration with WHO's other partners in the H6 Partnership and UNESCO, shows that investments in adolescent health bring a triple dividend of benefits for adolescents now, for their future adult lives, and for the next generation. The guidance aims to assist governments in deciding what they plan to do – and how they plan to do it – as they respond to the health needs of adolescents in their countries, in line with the seven overarching messages of the AA-HA! which are encapsulated by the acronym: APPLY AA-HA! Together (Figure 1)

As emphasised in the AA-HA! overarching messages, there is no ideal, one-size-fits-all package of adolescent health interventions that will meet the needs of every country, because the nature, scale and impact of adolescent health needs differ between countries. In addition, all governments face resource constraints and must make difficult choices to ensure their adolescent health resources are used most effectively. The AA-HA! guidance therefore provides direction for governments on how to evaluate their country's adolescent health needs before developing their adolescent health programmes, strategies and plans. This involves six key steps: needs assessment, landscape analysis, setting priorities, programming,

Figure 1: Apply AA-HA! Together: The overarching messages of the AA-HA!

developing a framework for the monitoring and evaluation of the programme, costing.

AA-HA! also emphasizes the need for a multisectoral response and whole-of-government approach to address broader determinants of adolescent health. The health sector cannot successfully act alone and other sectors need to normalize attention to adolescents' needs in all aspects of their work.

Why comprehensive multisectoral adolescent health strategies and plans?

The majority of adolescent health issues are preventable and multiple risk behaviours, such as tobacco use, unhealthy diets, physical inactivity and harmful use of alcohol, which impact long-term health, are modifiable. It is very important and effective to address multiple interrelated health outcomes and associated behaviours through integrated policies and programmes that respond to adolescents' multiple needs and developmental stages, tackling a full spectrum of adolescent health issues from mental health, nutrition, SRH and HIV to injuries prevention. Moreover, to achieve the Sustainable Development Goal (SDG) targets, not only does the health sector need to address adolescent health in a comprehensive manner, but other sectors must also normalize attention to adolescents' needs in all aspects of their work. While the health sector may lead the overall response to health, addressing broad determinants of adolescent health and wellbeing requires multi-sectoral action.

Since the launch of the Global AA-HA! Guidance in May 2017, WHO, UNESCO and other UN agencies from the H6 Partnership have been working closely with countries to support them in updating and developing comprehensive adolescent health strategies and plans. Through AA-HA! regional and national workshops, country teams examine their needs and priorities with technical support from well-trained experts.

In 2017-2018, five intercountry workshops took place with the aim to provide technical support for implementation of the Global AA-HA! Guidance in regions and countries. Teams from 66 countries in the regions of the Anglophone, Lusophone and Francophone Africa, Anglophone and Lusophone Americas and the Eastern Mediterranean region were trained in how to apply the AA-HA! guidance for national priority-setting, programming, and monitoring & evaluation. Several AA-HA! early adopter countries, including Bahrain, Barbados, Belize, Botswana, Gabon, Guyana, Haiti, Saudi Arabia, Somalia, St. Vincent and Grenadines, Sudan, Rwanda, UAE undertook a systematic process of needs assessment, landscape analysis, national prioritization and programming for adolescent health to inform their national adolescent health strategies and plans. To assist similar processes in the second wave of AA-HA! early adopter countries, this manual summarizes the process of using the AA-HA! guidance to facilitate the development of national adolescent health strategies and plans.

About this manual

The purpose of this manual is to assist countries in planning, organizing and facilitating the process of developing national comprehensive multisectoral adolescent health strategies and plans aligned with the AA-HA! guidance. The manual describes an approach that was tested in several countries but is not intended to be prescriptive as processes should be adapted to suit the needs of the country or programmes where the approach is being used. For example, the first national AA-HA! workshop in Sudan was held over 3 days, while in Haiti it was held over 4 days. In addition, the team in Haiti organized sub-regional orientation workshops with district authorities prior the national workshop. More examples of such variations are provided in this manual.

The manual is intended for professionals responsible for planning and developing adolescent health programmes in countries, such as national and subnational programme managers in charge of adolescent health or working in areas relevant to it, and national and international trainers, consultants and professionals supporting national governments in developing their adolescent health strategies and plans.

Contents of this manual

The manual outlines the main steps in the process of developing a national adolescent health strategy and plan (Figure 2).

In many countries the process described in this manual was applied to incorporate the adolescent health component in the integrated Reproductive, Maternal, Newborn and Child Health (RMNCAH) strategy. Therefore, the terms "national adolescent health strategy and plan" are used to encompass the "adolescent health component in the integrated RMNCAH strategy" or other forms of incorporating an adolescent health component into existing strategies and plans. The process can be applied to update an existing strategy or plan – e.g. during the midterm review – or to develop a new one.

Figure 2: Sequence of workshops and in-country activities to develop national adolescent health strategies and plans

STEP 1

Planning the process for developing a national adolescent health strategy and plan

- secure political commitment
- engage key stakeholders and establish the Technical Working Group
- get an initial AA-HA! orientation via AA-HA! webinars
- identify funding
- identify needs for technical assitance

STEP 2

Preparing a background document on the status of adolescent health and policy response for the first national AA-HA! workshop

STEP 3

Workshop to train members of the Technical Working Group

STEP 4

First national AA-HA! workshop

STEP 5

Finalization of the national adolescent health strategy, and its Implementation Plan including a Monitoring & Evaluation Framework

STEP 6

Costing the Implementation Plan

To support planning at various stages of the process, the manual typically includes the following type of material to guide members of the Technical Working Group (TWG) :

Concept note for the workshop/Overview of the activity

Standard (generic) draft agenda for the workshop

Detailed outline for each session

Handouts for facilitators

Handouts to be distributed to participants

Tips for facilitators

Terms of reference to undertake the work

Reference to the relevant content from the AA-HA! guidance

Examples from countries, Case studies

Complementarity to the AA-HA! and other resources

This manual complements the **AA-HA! guidance** and is intended to be used in connection with the latter. Therefore, the manual does not repeat the contents of the AA-HA! guidance, but it does makes clear reference to the relevant sections of the guidance document as appropriate.

The Technical guidance for prioritizing adolescent health (UNFPA 2017) enables country stakeholders to conduct a systematic situation assessment that will help them prioritize adolescent health within their national policy processes. For each key step – needs assessment, landscape analysis, prioritization – it describes the rationale, scope, key stakeholders to be involved, and provides practical examples from countries describing how it was undertaken in various settings. The AA-HA! manual to facilitate the process of developing national adolescent health strategies and plans draws on these key steps, and provides further granularity on how to organize the process and plan the logistics required, such as contracting work and conducting consensus building workshops.

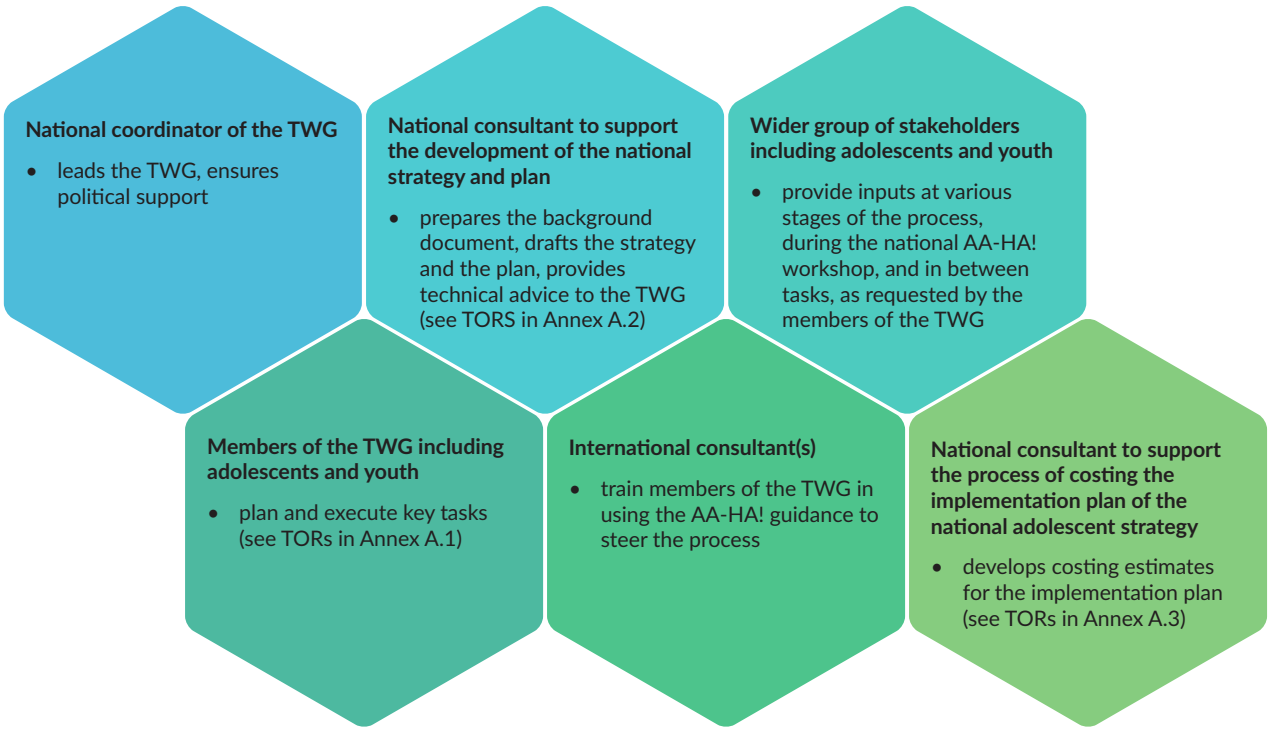
The Handbook for Conducting an Adolescent Health Services Barriers Assessment (AHSBA) (WHO 2019) with a Focus on Disadvantaged Adolescents, outlines how governments at national and subnational levels can assess health service equity and barriers to identify which adolescents are being left behind in their countries, provinces, municipalities and districts, and why. The handbook complements the needs assessment and landscape analysis that are described in the AA-HA! guidance and in this manual, to indemnify specific barriers which prevent disadvantaged adolescents from accessing effective health services.

PLANNING THE PROCESS FOR DEVELOPING A NATIONAL ADOLESCENT HEALTH STRATEGY AND PLAN

Leadership for adolescent health within the Ministry of Health, and in each of the key sectors across government, is an essential condition for successful programming. The complexity of adolescence, and the large number of professional disciplines and agencies across sectors that need to be involved, call for strong coordination. Therefore, at the outset, a national coordinator for the process of developing a national adolescent health strategy and plan needs to be appointed. While often this role is assigned to a focal-point in the Ministry of Health, it might be the case that the lead is taken by a focal-point in another ministry (e.g. ministry of education, ministry of youth and sport). However, it is important that the mandate for coordination is assigned by the highest level of the national government in order to command collaboration between different arms of government, working closely with communities, civil society, young people and the private sector.

The national coordinator will provide political leadership, guide members of the TWG as well as the broader community of stakeholders that contribute to the process. The figure below (Figure 3) shows the overall configuration of key roles and groups of stakeholders involved in the process.

Figure 3: Key roles and groups of stakeholders involved in the process of developing the national adolescent health strategy



OVERVIEW OF THE PLANNING PROCESS

OBJECTIVE

- Secure high-level political support.
- Establish a Technical Working Group to oversee and steer the process
- Get an initial AA-HA! orientation via webinars (see Overview of AA-HA! webinars).
- Engage key stakeholders from relevant sectors of the government, academic institutions, civil society organizations, adolescents and youth and other partners.
- Identify the funding necessary to develop the national adolescent health strategy and plan.
- Identify the needs for technical assistance, and make the necessary arrangements to secure it.

METHODS

- Individual and group meetings
- Presentations
- Use of case-studies from application of AA-HA! guidance in other countries

EXPECTED OUTCOMES

- High-level political support secured.
- Technical Working Group formally established, with clear terms of reference (See Annex A.1), and representation of adolescents and young people.
- Technical Working Group orientated in the AA-HA! process via webinars.
- Buy-in and commitment to the whole process from key stakeholders including representation from key sectors: health, financing, education, social protection, youth and sports, roads and transport, telecommunications, housing and urban planning, energy, water and sanitation, environment, criminal justice.
- Funding to develop the strategy identified.
- National consultant(s) to facilitate the process contracted (see TORs in Annex A.2).
- Activities where external technical assistance is required, if any, identified, and support secured from the relevant agencies.

- AA-HA! summary http://apps.who.int/iris/bitstream/10665/255418/1/WHO-FWC-MCA-17.05-eng.pdf?ua=1
- AA-HA ! guidance, main document, section 1: 1. AA-HA! – A never-before moment for adolescent health
- AA-HA! webinars
- AA-HA! case-studies

MATERIALS

In addition to the AA-HA! guidance, the following advocacy materials might be useful in sensitizing key stakeholders on the need to invest in adolescent health and development:

- World Health Organization. A standards-driven approach to improve the quality of health-care services for adolescents. Policy brief. Geneva: World Health Organization 2015. WHO/FWC/MCA/15.06 http://apps.who.int/iris/bitstream/10665/184035/1/WHO_FWC_MCA_15.06_eng.pdf?ua=1
- World Health Organization. Building an adolescent competent workforce. Policy brief. Geneva: World Health Organization 2015. WHO/FWC/MCA/15.05 http://www.who.int/maternal_child_adolescent/documents/adolescent-competent-workforce/en/
- Global Strategy for Women's, Children's and Adolescents' Health (2016-2030) https://www.who.int/life-course/partners/global-strategy/globalstrategyreport2016-2030-lowres.pdf
- Adolescent Health – the Missing Population in Universal Health Coverage. Background Paper. Plan International et al. 2019 (in print)

- In Sudan, the national adolescent health strategy (ADH) was developed under the leadership of the Directorate of maternal and child health. High-level political support was secured from His Excellency the Federal Minister of Health, and the Undersecretary of Health who was in communication with undersecretaries of related sectors, who in turn supported their delegates to participate in the process of developing the ADH strategy. A TWG was created including staff from child and adolescent health, expanded programme of immunization, reproductive and maternal health and nutrition programmes, non-communicable diseases, UNFPA, UNICEF, WHO and three representatives from academia. The consultation process was initiated through letters issued by the Undersecretary of the Federal Ministry of Health inviting partners to share information and engage in the subsequent consultations. Although the TWG did not include youth, or stakeholders from other sectors, the need to involve them was fully realized after the first national AA-HA! workshop. Members of the TWG reached out to individual contacts in the Ministry of the Interior, Social Development, General Education, Ministry of Youth and Sport, State Ministries of Health during the preparation of the needs assessment draft document, and they participated in the subsequent steps. Youth were also involved via a series of focus group discussions. See the case study in Annex C.2.

OVERVIEW OF AA-HA! WEBINARS

OBJECTIVE

- Provide an e-learning opportunity to orient users on how to use the AA-HA! documents to develop national adolescent health strategies and plans
- In resource constrained setting, provide an alternative to a face-to-face workshop to train the members of the TWG in using the AA-HA! guidance

METHODS

- Six webinar sessions, 60 min each, pre-recorded and accessible online

HOW TO ACCESS WEBINAR MATERIALS

- The webinar sessions can be accessed from the WHO website

STEP 2

PREPARING A BACKGROUND DOCUMENT ON THE STATUS OF ADOLESCENT HEALTH AND POLICY RESPONSE FOR THE FIRST NATIONAL AA-HA! WORKSHOP

In this step, the national consultant, with the support of the TWG will conduct a needs assessment and landscape analysis and summarize the findings in a background document. This background document will be used as a basis for discussions during the workshop to train members of the TWG, and during the first national AA-HA! workshop.

OVERVIEW OF THE BACKGROUND DOCUMENT

OBJECTIVE

- Take stock of the adolescent health situation in the country (mortality, morbidity, risk factors and social determinants), considering the status as well as trends and inequities in exposure to risk factors, burdens and health-service access, to inform the development of the strategy's priorities (needs assessment).
- Map existing adolescent health programmes and initiatives, policies, legislation, capacity and resources within the country (landscape analysis).

METHODS

- Desk review of data sources (e.g. Health Information Management System (HIMS), Global Health Observatory data, Demographic and Household Surveys (DHS), Multiple Indicator Cluster Surveys (MICS), Global School-Based Student Health Survey (GSHS), The World Mental Health Survey Initiative, Global Youth Tobacco Survey (GYTS), national disease surveillance records, national vital statistics, educational records, reports from key ministries featuring adolescents, reports from research studies, research from projects working with vulnerable groups or in fragile settings etc.).
- Desk review of policy documents (legal and policy framework, programmes' and project's descriptions, projects' evaluations, etc.).
- Interviews with key stakeholders from the health and other sectors, UN agencies (UNAIDs, UNESCO, UNFPA, UNICEF, WHO, UN Women).
- Focus group discussions with adolescents and youth.
- When documentation on specific areas or programmes (e.g. mental health) are not available in the country, it is suggested that separate mapping exercises for existing programmes are conducted.
- It is suggested that data are presented disaggregated by age (10-14 years and 15-19 years) and sex, as well as by geographic locations to show disparities.

EXPECTED OUTCOMES

- Identified conditions that have the greatest impact on adolescent health and development in the country, both in terms of the impact during adolescence and risk or protective factors for their future health, by age, sex and part of the country, and among those who are most vulnerable.
- Existing interventions, programmes, legislation, policies, projects, and capacity and resources within the country mapped against key health conditions, and gaps identified, and priorities recommended.

- AA-HA! guidance main document; section 4.1: needs assessment; section 4.2: landscape analysis; section 2: disease and injury burdens, and risk factors; section 3: evidence-based interventions
- AA-HA! Annex 2: this annex provides additional information about risk factors and their determinants for unintentional injury, violence, sexual and reproductive health, including HIV, communicable diseases, non-communicable diseases and malnutrition, mental health, substance use and self-harm. It is recommended to consult this section in preparing the background document to make sure that important risk factors are not missed.

MATERIALS

In addition to the AA-HA! guidance, the following materials might be useful in planning and conducting the needs assessment and landscape analysis:

- EWEC. Technical guidance for prioritizing adolescent health. New York: UNFPA; 2017
- WHO (2019). Handbook for Conducting an Adolescent Health Services Barriers Assessment (AHSBA) with a Focus on Disadvantaged Adolescents.

PROPOSED OUTLINE OF THE BACKGROUND DOCUMENT

1) Background.
2) Disease and injury burdens, risk factors and their social determinants for:
   - Unintentional injury
   - Violence
   - Sexual and reproductive health, including HIV
   - Communicable diseases
   - Non-communicable diseases and malnutrition
   - Mental health, substance use and self-harm
   - Particular burdens in humanitarian or fragile settings within the country (if applicable)
3) Barriers for adolescents to access services, and inequalities between subgroups of adolescents.
4) Landscape analysis. For each priority health area, reflect the following:
   - existing interventions, programmes, legislation, policies and projects that address adolescent health and development, as well as the results and outcomes of these initiatives and their alignment with the evidence base in what works;
   - what is being done by the government, NGOs and civil society organizations to address inequities and respond to social, economic and other determinants of adolescents' health problems;
   - stakeholders and organizations involved in these programmes and activities at the national and subnational level, and what each is doing and planning to do in the near future;
   - how youth are involved in these initiatives;
   - existing and potential sources of financing.
5) Conclusions about gaps between needs and current programmes and activities.

It is important to insist that, even if no data is available, the background document touches on all the eight areas identified in the AA-HA! (i.e. unintentional injury, violence, sexual and reproductive health, including HIV, communicable diseases, non-communicable diseases and malnutrition, mental health, substance use and self-harm, burdens in humanitarian and fragile settings (if applicable)). For example, a country doesn't have any data on adolescent mental health. The report nevertheless should have a section called "mental health" that states that no sources could be identified to assess the levels and trends in adolescent mortality and morbidity from mental health disorders, nor risk factors for adolescent mental health. Such a statement is actionable, in the sense that the conclusion for such data gap is that the future strategy may have as its starting point the commitment to collect data on mental health. If not, countries tend to go back to the same topics they usually address, without exploring the situation related to other topics that might be relevant but neglected.

Following the AA-HA! guidance, Pakistan conducted needs assessment and landscape analysis. Even though data on mental health issues and services were extremely scarce, the background document devotes serious attention to mental health. Where national data is not available, the document acknowledges this weakness and makes references to global and regional estimates. In the analysis of services, the document acknowledges that "Health services in Pakistan are severely ill equipped to deal with mental health issues" and makes reference to the WHO Mental Health Gap Action Program (mhGAP) that provides an evidence-based solution to bridge the existing huge treatment gap in mental, neurological and substance use disorders. In Annex C.4 we provide an extract from the background document of Pakistan as an example of how to deal with situations when data is not available.

STEP 3

WORKSHOP TO TRAIN MEMBERS OF THE TECHNICAL WORKING GROUP

CONCEPT NOTE FOR THE WORKSHOP TO TRAIN MEMBERS OF THE TWG

OBJECTIVE

- To build competencies of national experts in facilitating national AA-HA! workshops, and in applying the AA-HA! guidance for national priority-setting, programming, monitoring and evaluation in the context of developing national adolescent health strategies and plans.
- To build understanding of the adolescent health module of the OneHealth costing tool and other programmatic tools, and their application in support of RMNCAH strategic and operational planning.

TARGET GROUP

The training is directed to people that will be intimately involved in the development of the national adolescent health strategy. This may include:

- members of the TWG
- provincial/regional and district level policy makers
- staff from key UN agencies
- young leaders

FACILITATORS

Regional experts that have been trained during national and regional AA-HA! workshops in 2017-2019. These include WHO staff and other UN agency staff, as well as national experts. The list of trained people is available from WHO regional focal points for adolescent health.

CONTENTS

- Overview of, and practical exercises in, using the AA-HA! systematic process to develop national adolescent health strategies and plans.
- Overview of the AA-HA! manual to facilitate the process of developing national adolescent health strategies and plans.
- Overview of the adolescent health module of the OneHealth costing tool and other programmatic tools to support RMNCAH strategic and operational planning.

METHODS

- Facilitated discussion
- Presentations
- Individual and group work using handouts from the AA-HA! manual
- Case studies from AA-HA! early adopter countries

EXPECTED OUTCOMES

At the end of the workshop participants will have the following competencies:

- familiarity with the documents included in the AA-HA! package, and their use for various audiences;
- understanding of the unique attributes of adolescents and why investing in them results in long-term societal benefits, and why lack of investment results in lost opportunities; and how to use the AA-HA! package to inform such understanding among national stakeholders;
- understanding the importance of adolescents' participation in developing and implementing strategies and plans, at national, district and local levels;
- understanding global, regional and national adolescent health profiles;
- ability to use the AA-HA! guidance to inform the process of needs assessment, landscape analysis and priority-setting;
- understanding the logical framework for adolescent health programming, and using the AA-HA! guidance and its annexes to inform programming for universal health coverage and to address broader determinants of health, including overcoming bottlenecks at country level to the scale up of effective interventions;
- understanding of key issues in monitoring and evaluating adolescent health programmes, and using the AA-HA! guidance and its annexes to inform monitoring and evaluation of the adolescent health components of national programmes and RMNCAH plans;
- understanding the application of the adolescent health module of the OneHealth costing tool and other programmatic tools to support RMNCAH strategic and operational planning;
- competence and confidence to facilitate national AA-HA! workshops.

- AA-HA! guidance, main document
- AA-HA! manual
- AA-HA! case studies

- In early adopter countries the workshop to train members of the TWG was delivered in 1 day. However, both facilitators and participants in Sudan and Barbados felt that to deliver the contents in 1 day was too challenging and strongly recommended using 2 days. In Sudan, participants at the facilitator workshop (members of the TWG, UN staff) felt it was very useful to build their capacity to use the AA-HA! guidance for national processes. They also recommended including district level managers in this workshop to secure the engagement of district level policy makers early in the process.
- In Cameroon, the national AA-HA! workshop was facilitated by representatives of Ministry of Public Health, Minister of Secondary Education, representative of a civil society organization, and representatives of UN agencies (UNAIDS, UNESCO, UNFPA, UNICEF, WHO).
- In the Caribbean and Latin America, national resource persons were trained in a multi-country training. If several countries express interest in developing or updating their national strategies and plans following the AA-HA! approach, the regional office may consider organizing the training in a multi-country format, bringing members of the TWGs from several countries together. In such cases, selection of the right persons is very important, as they should ideally have some experience with facilitation, and they should also have availability to support the subsequent process(es) in countries. If not, they might not be available when needed.

Make sure this background document and manual is shared with the facilitators and the members of the TWG at least one week in advance; strongly encourage them to become acquainted with the content in advance of the first national AA-HA! workshop and not arrive unprepared. Adolescent health fact sheets might be prepared as well to summarize key findings from the background document.

WORKSHOP TO TRAIN MEMBERS OF THE TWG AGENDA

	Day 1	Day 2
09:00	**SESSION 1:** Opening and introduction • Introduction of participants • Objectives, agenda and working methods • Global, regional and national commitments and initiatives for adolescent health • A global and regional overview of adolescent health	**SESSION 7:** Key areas for programming • Brief overview of this step • Getting acquainted with facilitators' reference materials • Planning the similar session in the first national AA-HA! meeting
10:30	**Break**	**Break**
10:45	**SESSION 2:** An overview of the AA-HA! package **SESSION 3:** Key findings from the national AA-HA! background document **SESSION 4:** Needs assessment • Brief overview of this step • Getting acquainted with facilitators' reference materials • Planning the similar session in the first national AA-HA! meeting	**SESSION 7:** (cont.): Key areas for programming • Brief overview of this step • Getting acquainted with facilitators' reference materials • Planning the similar session in the first national AA-HA! meeting **SESSION 8:** Planning for monitoring and evaluation • Brief overview of this step • Getting acquainted with facilitators' reference materials • Planning the similar session in the first national AA-HA! meeting
12:30	**Lunch**	**Lunch**
13:30	**SESSION 4:** (cont.): Needs assessment **SESSION 5:** Landscape analysis • Brief overview of this step • Getting acquainted with facilitators' reference materials • Planning the similar session in the first national AA-HA! meeting	**SESSION 9:** Adolescents participation • Brief overview of the relevant AA-HA! content • Planning the similar session in the first national AA-HA! meeting **SESSION 10:** Governance structure • Brief overview of the relevant AA-HA! content • Planning the similar session in the first national AA-HA! meeting

	Day 1	Day 2
15:30	**Break**	**Break**
15:45	**SESSION 6:** National prioritization • Brief overview of this step • Getting acquainted with facilitators' reference materials • Planning the similar session in the first national AA-HA! meeting	**SESSION 11:** Financing adolescent health programmes. The adolescent health module of the OneHealth costing tool • Overview of key actions to secure financial resources for adolescent health programmes • Brief overview of the adolescent health module of the OneHealth costing tool • Planning the similar session in the first national AA-HA! meeting **SESSION 12:** Other programmatic tools to support the implementation of adolescent health programmes • Brief overview of the web platform for the implementation of Global Standards for quality health care services for adolescents • Brief overview of Core competencies in adolescent health and development for primary care providers • Brief overview of Handbook for Conducting an Adolescent Health Services Barriers Assessment (AHSBA) with a Focus on Disadvantaged Adolescents **SESSION 13:** Next steps • Activities • Stakeholders • Responsible person(s) • Timeframes • Required technical assistance
17:30	**Close**	**Close**

GENERIC TIPS TO PLAN WORKSHOPS AND SESSIONS

Below is a suggested checklist of details that the facilitators and members of the TWG should review during their meeting prior to the workshops. Items on this list are not exhaustive and will depend on the setting of the workshop and available resources.

- Visit venue to arrange where and how plenary and group sessions will be held.
- Confirm equipment and materials needed for the Workshop are going to be available:
  - power point projector and screen for plenary sessions;
  - laptop computer(s) and USB flash drives for the preparation of plenary presentations by groups and for the use within the group work;
  - print materials ahead of time;
  - printer access;
  - flipcharts, flipchart stands (one per group) and marker pens.
- Review number of participants attending workshop:
  - MOH should take the lead and send invitation letters well ahead of time, with reminders just before the event, and ensure that participation of different stakeholders including adolescents and youth is secured.
  - Confirm sufficient catering (lunches, tea-breaks) is ordered.
  - Seating arrangements should be thought of in advance to facilitate interactions.
- Confirm materials for participants are prepared:
  - printed materials and/or USB flash drives with materials (for group work sessions and/or all participants);
  - note-paper and pens;
  - remind participants to bring data, strategic plans, and laptops to workshop.

Starting group work after a plenary session, or a plenary session after group work might be severely delayed if logistics are not planned in advance. Below are some examples of guiding questions that might help to anticipate and prevent delays:

- How will participants be divided into groups?
- How will participants know how to find the breakout rooms?
- Is there a generic template for reporting back, and if so, who is going to ensure that each group has it?
- How will the results of the group work be recorded and reported back (e.g. flipcharts, USB sticks), and who will ensure that these materials are available?
- What handouts will be used during the group work, and is it necessary to print materials in advance?
- Will all groups report back, or only some, with others only being asked to add things that have not been mentioned already (if more than one group discussed the same topic)?
- If an official report from the workshop is planned, who will write it and how will the writer(s) get all necessary inputs?

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SESSION 1

Detailed outline

Opening and introduction

Day 1, 9:00-10:30

OBJECTIVES

At the end of the session participants will:

- Understand the benefits of investing in adolescent health.
- Know about global, regional and national commitments and initiatives for adolescent health.
- Understand the process of developing the national adolescent health strategy using the AA-HA! guidance.

KEY MESSAGES

- Disease and injury burdens in adolescents are considerable, and largely preventable, by actions in health and other sectors.
- The distinctive physical, cognitive, social, emotional and sexual development that takes place during adolescence demands special attention in national development policies, programmes and plans.
- Investing in adolescents brings a triple dividend: benefits for adolescents now, for their future adult lives and for their children.
- The national government is committed to invest in adolescent health.

MATERIALS & REFERENCES

- AA-HA! guidance, main document
- Terms of reference for the TWG
- Concept note for the workshop to train members of the TWG
- Agenda

	METHODOLOGY	TIMING
Opening		
Short statement/presentation from senior official from Ministry of Health (MOH), Director General, etc.		10 minutes
Short statement/presentation from WHO Representative		10 minutes
Short statement/presentation from MOH focal point for adolescent health: • including a description of the process envisaged for the development of the national adolescent health strategy (as explained in Figure 2)		10 minutes
Introduction of participants		10 minutes
Objectives, agenda and working methods		
Oral presentation or Power Point: • Generally, describe the purpose of this workshop, its objectives and working methods, as described in the "Concept note for the workshop to train members of the TWG" • Refer to the role of the TWG in the context of the development of the national adolescent health strategy, as explained in the "Outline of terms of reference for the Technical Working Group to steer the process of developing a national adolescent strategy" • Make an overview of the 2 days agenda		20 minutes
Power Point presentation(s) on: • Global, regional and national commitments for adolescent health • The global and regional status of adolescent health		30 minutes

SESSION 2

Detailed outline

An overview of the Global AA-HA! guidance and its application in countries

Day 1, 10:45-11:45

OBJECTIVES

At the end of the session participants will have:

- Basic understanding of the key messages and content of the Global AA-HA! guidance, and its' use for a variety of purposes.

KEY MESSAGES

- The Global AA-HA! guidance package consists of 5 documents: main document, summary, comic book, brochure, and manual. There also separate annexes.
- The AA-HA! guidance provides evidence-based information to policy-makers, programme managers, practitioners, researchers, educators, young people, donors, and civil society organizations – including the most up to-date data on the major disease and injury burdens that affect adolescents. It supports the implementation of the Global Strategy by providing the comprehensive information that countries need to decide ***what*** to do for adolescent health and ***how*** to do it.
- The AA-HA! guidance not only provides information on what needs to be done – it demonstrates what is already being done. More than 70 case studies from across the globe provide concrete examples of how countries have implemented what is being promoted.
- The AA-HA! guidance advocates for a comprehensive approach for adolescent health, meaning that programmes and policies should take into consideration a broad spectrum of conditions that contribute to disease and injury burdens in adolescents – unintentional injury, violence, sexual and reproductive health, including HIV, communicable diseases, non-communicable diseases and malnutrition, mental health, substance use and self-harm, burdens in humanitarian and fragile settings. For each of these conditions, the AA-HA! guidance summarizes evidence-based interventions at different levels of the ecological framework.
- The AA-HA! guidance makes the case for an "Adolescent Health in All Policies" approach. In that respect, the guidance recommends key actions that are needed in key sectors: education, financing, social protection, youth and sports, roads and transport, telecommunications, housing and urban planning, energy, water and sanitation, environment, and criminal justice.
- Countries should ensure that adolescents' expectations and perspectives are included in national programming processes and that adolescents and representatives from key sectors are involved in the process of strategy development from the beginning.
- The application of the AA-HA! process in early adopter countries is documented, and lessons learned can guide participants to improve the process.
- The AA-HA! manual to facilitate the process of developing national adolescent health strategies and plans summarizes the experience of the application of the AA-HA! guidance in many regions and countries to develop national adolescent health strategies. It is intended to help national experts who want to facilitate similar processes in their countries.

MATERIALS & REFERENCES

- The AA-HA! guidance, main document
- The AA-HA! summary
- The AA-HA! comic book
- The AA-HA! brochure
- The AA-HA! manual to facilitate the process of developing national adolescent health strategies and plans
- Case studies from Sudan C.2, Barbados C.3 and Belize C.1

METHODOLOGY	TIMING
An overview of the Global AA-HA! guidance package	
Power Point overview of the AA-HA! documents, brief overview of their contents and target audiences: • The AA-HA! guidance, main document is intended for policy-makers and programme managers who are responsible for adolescent health programming in countries. • The AA-HA! summary document is intended for a broader audience of policy-makers and government representatives in health and other sectors. • The AA-HA! comic book has been written for young adolescents to inform them of the key messages in the AA-HA! approach. • The AA-HA! brochure aims to facilitate dissemination of the overarching messages and to inform the public about the AA-HA! approach. • The AA-HA! manual to facilitate the process of developing national adolescent health strategies and plans is intended for national and subnational programme managers in charge of adolescent health, and national and international trainers/consultants/ facilitators supporting national governments in developing national adolescent health strategies and plans.	60 minutes

SESSION 3

Detailed outline

Key findings from the national AA-HA! background document

Day 1, 11:45-12:05

OBJECTIVES

At the end of the session participants will:

- Understand the methods used to produce the background document, and its key findings.

KEY MESSAGES

The key messages in this session will depend on the findings and data gaps identified by the consultant who prepared the background document. Generally, they should reflect the following topics:

- Data sources and data gaps for a comprehensive analysis of adolescent health in the country
- Key findings from needs assessment
- Key findings from landscape analysis
- Recommendations for further data collection and finalization of the report

MATERIALS & REFERENCES

- National AA-HA! background document
- National adolescent health profiles

METHODOLOGY | TIMING

Key findings from the national AA-HA! background document

Power Point synthesis of the national AA-HA! background document: 20 minutes

- Data sources used and data gaps for a comprehensive analysis of adolescent health in the country
- Key findings from needs assessment
- Key findings from landscape analysis
- Recommendations for further data collection and finalization of the report

SESSION 4

Detailed outline

Needs assessment

Day 1, 12:05-14:00 (including lunch break)

OBJECTIVES

At the end of the session participants will:

- Understand how to use the AA-HA! guidance and manual to inform and facilitate the process of needs assessment.
- Have clarity on roles and responsibilities in facilitating a similar session during the first national AA-HA! workshop.

KEY MESSAGES

- The nature, scale and impact of adolescent health needs are unique in each country. Governments must evaluate their country's adolescent health needs before developing – or improving upon – adolescent health programming.
- Needs assessment identifies which conditions have the greatest impact on adolescent health and development, both among adolescents, by age, sex and part of the country, and among those most vulnerable.
- Needs assessment includes not only the analysis of conditions that contribute to greatest disease and injury burdens, but also adolescent behaviours most closely linked to these conditions and future health problems, harmful practices affecting adolescents, sociocultural context of adolescents' lives, including risk and protective factors at various ecological levels, and subgroups of adolescents who may be in the greatest need of services and programmes.
- The national AA-HA! background document provides a starting point for discussing the needs assessment findings. Inputs from the first national AA-HA! workshop will guide the TWG in finalizing the needs assessment.

MATERIALS & REFERENCES

- AA-HA! guidance, main document, section 4.1
- National AA-HA! background document
- Handout No.1 "General principles to facilitate group discussions"
- Handout No.2 "Needs assessment"

METHODOLOGY	TIMING
Introduction to the needs assessment	
• Power Point overview of needs assessment as explained in the AA-HA! guidance, main document. • Explanation by facilitator of the group work on needs assessment during the first national AA-HA! workshop, and Handouts No.1&2.	10 minutes
Individual reading of Handouts No.1&2	10 minutes
Q&A: clarifications from participants on Handouts No.1&2	5 minutes
Planning the corresponding session during the first national AA-HA! workshop: • Reminder about general principles to facilitate group discussions (Handout No.1). • How to divide participants (options: by area of expertise (e.g. nutrition, mental health, etc.) or mixed groups. • Who will facilitate each group, and the role of each facilitator within the group. • Planning the necessary space (breakout rooms) and materials (printout handouts).	30 minutes

- Make sure the background document is shared with participants at least one week in advance so they have plenty of time to get acquainted with it before the first national AA-HA! workshop.
- It is recommended that groups are divided by areas of expertise (e.g. violence, SRH, nutrition) and keep the same group composition for all steps during the first national AA-HA! workshop. This way all topics are discussed in-depth. The disadvantage of this approach is that not every participant gets exposed to areas outside their usual areas of interest. This is mitigated by the fact that everybody gets exposure to all topics in plenary and has the chance to contribute. However, if, for some areas there is no expertise or only 1-2 representatives, then groups can be mixed by combining expertise from interdependent areas (e.g. mental health and substance use, or SRH and HIV).

See how the team from Belize used evidence to inform the adolescent health strategic plan (Annex C.1, access the link to the full story).

SESSION 5

Detailed outline

Landscape analysis

Day 1, 14:00-15:30

OBJECTIVES

At the end of the session participants will:

- Understand how to use the AA-HA! guidance and manual to inform and facilitate the process of landscape analysis.
- Have clarity on roles and responsibilities in facilitating a similar session during the first national AA-HA! workshop.

KEY MESSAGES

- A landscape analysis consists of a review of existing adolescent health programmes, policies, legislation, capacity and resources within the country, as well as a review of current global and local guidance on evidence-based interventions. The landscape analysis helps to identify policy and programmatic gaps.
- The national AA-HA! background document provides a starting point for discussing the findings from the landscape analysis. Inputs from the first national AA-HA! workshop will guide the TWG in finalizing the landscape analysis.

MATERIALS & REFERENCES

- AA-HA! guidance, main document, section 4.2
- National AA-HA! background document
- Handout No.1 "General principles to facilitate group discussions"
- Handout No.3 "Landscape analysis"

	METHODOLOGY	TIMING
Introduction to landscape analysis		
	• Power Point overview of the landscape analysis as explained in the AA-HA! main document. • Explanation by facilitator of the group work on landscape analysis during the first national AA-HA! workshop, and Handout No.3.	15 minutes
	Individual reading of Handout No.3	5 minutes
	Q&A: clarifications from participants on Handout No.3	10 minutes
	Planning the corresponding session during the first national AA-HA! workshop: • How to divide participants (recommended option: keep the same group composition as for needs assessment). Ensure even distribution of key participants. E.g. if you had 4 youths in the meeting and you had 4 groups, ensure 1 youth member is in each group • Determine who will facilitate each group, and the role of each facilitator within the group • Identify the necessary space (breakout rooms) and materials (printout handouts)	60 minutes

SESSION 6

Detailed outline

National prioritization

Day 1, 15:45-17:30

OBJECTIVES

At the end of the session participants will:

- Understand why prioritization is necessary.
- Understand how to use the AA-HA! guidance and manual to inform and facilitate the process of national prioritization.
- Have clarity on roles and responsibilities in facilitating a similar session during the first national AA-HA! meeting.

KEY MESSAGES

- All governments face resource constraints, so they must make difficult choices to ensure their adolescent health resources are used most effectively. Prioritization of key issues and interventions is therefore necessary.
- Over time, countries should reassess their adolescent health priorities and programming to ensure that they still meet changing adolescent needs.
- When prioritizing health areas and interventions, the following criteria should be considered: magnitude and public health importance of the problem; the size of the population affected; whether effective interventions are available and the degree of the effectiveness of the interventions; whether the interventions are likely to address the needs of vulnerable populations/underserved groups; feasibility of delivering the interventions (e.g. funds, infrastructure, personnel, acceptability, political support); potential to deliver interventions at scale within the time frame considered.
- The process of national prioritization should include a broad range of stakeholders in order to have the buy-in for implementation.

MATERIALS & REFERENCES

- AA-HA! guidance, main document, section 4.3
- Handout No.1 "General principles to facilitate group discussions"
- Handout No.4 "Setting priorities"

METHODOLOGY	TIMING
National prioritization	
• Power Point overview of the national prioritization as explained in the AA-HA! guidance, main document. • Explanation by facilitator of the group work on national prioritization during the first national AA-HA! workshop, and Handout No.4.	30 minutes
Individual reading of Handout No.4 and AA-HA! guidance, main document, section 4.3	30 minutes
Q&A: clarifications from participants on Handout No.4	20 minutes
Planning the corresponding session during the first national AA-HA! workshop: • How to divide participants (recommended option: keep the same group composition as for needs assessment and landscape analysis). • Determine who will facilitate each group, and the role of each facilitator within the group. • Identify the necessary space (breakout rooms) and materials (printout handouts).	25 minutes

SESSION 7

Detailed outline

Key areas for programming

Day 2, 09:00–11.15 (including morning break)

OBJECTIVES

At the end of the session participants will:

- Understand how the AA-HA! logical framework can guide programming.
- Understand how to use the AA-HA! guidance and manual to inform and facilitate the process of programming.
- Have clarity on roles and responsibilities in facilitating a similar session during the first national AA-HA! meeting.

KEY MESSAGES

- Programming – the process of translating newly identified priorities into operational plans – has common elements such as adopting adolescent protective laws and policies; deciding on service delivery platforms; addressing weaknesses in workforce capacity; improving supply systems, technology and infrastructure; improving (health) management and information systems; engaging communities to build support for adolescents' use of services; establishing leadership and governance arrangements for implementation; and estimating resource needs and securing funding for national, district and local actions.
- The AA-HA! logical framework is a tool that summarizes these elements, and guides users to make explicit the links between the programmes' goals, objectives, key interventions, implementation strategies and activities.

MATERIALS & REFERENCES

- AA-HA! guidance, main document, section 5
- AA-HA! logical framework for programming (AA-HA! guidance, main document, page 81)
- Handout No.1 "General principles to facilitate group discussions"
- Handout No.5 "Key areas for programming"

	METHODOLOGY	TIMING
Key Areas for Programming		
	• Power Point overview of the programming process as explained in the AA-HA! guidance, main document. • Explanation by the facilitator of the group work on programming during the first national AA-HA! workshop, and Handout No.5	30 minutes
	Individual reading of Handout No.5 and AA-HA! guidance, main document, sections 5.1; 5.5; 5.6.1; 5.7	40 minutes
	Q&A: clarifications from participants on Handout No.5	20 minutes
	Planning the corresponding session during the first national AA-HA! workshop: • How to divide participants (recommended option: keep the same group composition as for needs assessment and landscape analysis). • Determine who will facilitate each group, and the role of each facilitator within the group. • Identify the necessary space (breakout rooms) and materials (printout handouts).	30 minutes

SESSION 8

Detailed outline

Planning for monitoring and evaluation

Day 2, 11.15–12:30

OBJECTIVES

At the end of the session participants will:

- Understand principles of selecting indicators and setting targets for monitoring and evaluation of national adolescent health strategies and plans.
- Know sources for internationally agreed impact indicators.
- Have clarity on roles and responsibilities in facilitating a similar session during the first national AA-HA! workshop.

KEY MESSAGES

- The rapid physical, emotional and social changes across the adolescent period pose special challenges for adolescent health programmes, making it essential to disaggregate data by age (five-year age spans) and sex.
- It is essential for adolescent health programmes to monitor the full range of indicators from inputs and processes to outputs, outcomes and impact – as they answer different questions and are useful for different purposes.
- Periodic evaluations of adolescent health programmes are essential and should build on routinely collected monitoring data.
- Internationally agreed impact indicators for adolescent health and development – for example the 43 adolescent-specific indicators of the Global Strategy for Women's, Children's and Adolescents' Health (2016–2030) – constitute a good starting point to plan for the monitoring and evaluation of the national adolescent health programmes. Input, process, output and to some degree outcome indicators are more context specific and will need to be developed in line with national priorities and planned activities.

MATERIALS & REFERENCES

- AA-HA! guidance, main document, section 6
- Power Point presentation "Selecting indicators, setting targets and monitoring and evaluation of adolescent health programmes"
- Handout No.6 Selecting indicators, setting targets and monitoring and evaluation of adolescent health programmes
- Case study of monitoring and evaluation framework applied in another country

METHODOLOGY	TIMING
Overview of the AA-HA! section 6 "Monitoring, evaluation and research"	
Power Point overview of the section 6 "Monitoring, evaluation and research"	20 minutes
Q&A	10 minutes
Examples of indicators to monitor three specific adolescent health programmes	
Guide participants through Tables 6.1 and 6.2 in the AA-HA! guidance, main document, giving examples of indicators for common types of programmes. • Programmes to ensure that the national health system is adolescent-responsive. • Programmes to reduce adolescent pregnancies. • School health programmes. • Adolescent mental health programmes. This can be done in plenary or by dividing participants in 4 groups. In the latter case, give each group time to read about one type of programme (10 min), and debrief in plenary (5 min each group).	15 minutes

Case study from another country experience

- Case study presentation of monitoring and evaluation framework applied in another country (Ethiopia, Annex C.5). — 10 minutes
- Prime the group to pay attention to indicators at different levels of the logical framework: input, process, output, outcome, impact.

Planning the corresponding session during the first national AA-HA! workshop

- Determine who will facilitate each sub session. — 20 minutes
- Identify and prepare the necessary materials (printouts of case studies).

See the example of the Monitoring and Evaluation Matrix from Ethiopia National Adolescent and Youth Health Strategy (2016-2020) (Annex C.5)

SESSION 9
Detailed outline
Adolescents' participation
Day 2, 13.30–14:30

OBJECTIVES

At the end of the session participants will:

- Understand the benefits of involving adolescents in programmes that affect their lives.
- Understand what the key recommended actions are to ensure adolescent leadership and participation in programmes.
- Know practical resources that can guide the country team in facilitating youth engagement.
- Have clarity on roles and responsibilities in facilitating a similar session during the first national AA-HA! workshop?

KEY MESSAGES

- Countries should ensure that adolescents' expectations and perspectives are included in national programming processes. Adolescent leadership and participation should be institutionalized and actively supported during the design, implementation, monitoring and evaluation of adolescent health programmes.
- Section 5.3 of the AA-HA! guidance, main document, lists key area of focus to ensure adolescent leadership and participation, and includes reference to other practical resources to facilitate youth engagement.

MATERIALS & REFERENCES

- AA-HA! guidance, main document, section 5.3
- AA-HA case studies : A3.1, A3.13, A3.14, A3.2, A5.5, A5.6
- Handout No.7 « Resources to plan Meaningful Adolescent & Youth Engagement »

METHODOLOGY

TIMING

Overview of the AA-HA! recommendations

Power Point presentation on the benefits of involving adolescents in programmes that affect their lives, key recommended actions are to ensure adolescent leadership and participation in programmes — 15 minutes

Practical ways and resources to facilitate youth engagement

Guided plenary discussion on participants' experiences in youth engagement, and reference to some key practical resources as listed in Handout No.1	15 minutes

Case study on adolescent participation in developing the national adolescent health strategy

• Case study presentation on involving adolescents and youth in the design and implementation of adolescent health programme (example from Belize, Annex C.1).	10 minutes
• Prime the group to pay attention to the fact that adolescents were not merely invited to workshop, but were members of the TWG, and that consultations with adolescents were also held at district levels. • Additional case studies that can be used in this session are available in the annexes of the AA-HA! guidance, main document: A3.1, A3.13, A3.14, A3.2, A5.5, A5.6.	10 minutes

Planning the corresponding session during the first national AA-HA! workshop

• Determine who will facilitate each sub session. • Identify and prepare the necessary materials (printouts of case studies).	20 minutes

- See the case study from Belize on developing an Adolescent Health National Strategic Plan for Belize (Annex C.1, access the link to the full story).
- In Guyana adolescents participated actively in the AA-HA! process. Around one-third of the participants in the national workshop were adolescents and youth. The organizers also made efforts to engage young people representing vulnerable groups, such as indigenous youth from the hinterland.
- See the video examples of how adolescents and young people are being involved in the HIV response. http://apps.who.int/adolescent/hiv-testing-treatment/page/involving_adolescents
- The Child and Youth Mental Health and Substance Use Collaborative was formed because stakeholders were worried about the uncoordinated system of mental health care for children, youth, and families in British Columbia in Canada. As a first of its kind in Canada, the Collaborative decided to explore new ways of working together to increase the number of children, youth, and families seeking and receiving timely access to integrated mental health and substance use services and supports. Learn more about how youth and families, family doctors, paediatricians, psychiatrists, mental health clinicians, school counsellors, teachers and principals were involved in shaping and implementing the initiative. http://www.collaborativetoolbox.ca/legacy-magazine

SESSION 10

Detailed outline

Governance structure

Day 2, 14:30–15:30

OBJECTIVES

At the end of the session participants will:

- Understand why leadership for adolescent health is needed both within the ministry of health and at the highest level of government, as well as at district level.
- Understand practical considerations in planning and managing an intersectoral programme.
- Make a preliminary proposal for a governance structure for the national adolescent health strategy.

KEY MESSAGES

- To support the development and the implementation of the strategy, it is necessary to establish a national-level mechanism, or use existing platforms, to oversee and coordinate efforts for adolescent health and well-being across sectors and government ministries. Such a mechanism would facilitate engagement of relevant agencies and civil society organizations, including adolescents themselves.
- Investments should be made in planning and managing intersectoral actions to anticipate the negative effects of behavioural and structural barriers.
- Investments should be made in political and administrative capacity of subnational (e.g. district-level) managers to involve them from the start.

MATERIALS & REFERENCES

- AA-HA! guidance, main document, sections 5.2, 5.6.2

METHODOLOGY	TIMING
Overview of AA-HA! recommendations	
Power Point presentation "Leadership for adolescent health within the ministry of health and across the government".	20 minutes
Case study on governance structure for the national adolescent health strategy	
• Case study presentation on governance structure for the national adolescent health strategy in Ethiopia, and roles and responsibilities of various stakeholders (Ethiopia C.5). • Prime the group to pay attention to the fact that governance structure spans the 3 levels of decision making (national, subnational, and local) and that leading and supporting roles are clearly articulated for each of the key sectors and agencies.	5 minutes
Making a preliminary proposal for a governance structure for the national adolescent health strategy	
Guided plenary discussion on the participants' proposal for a governance structure for the national adolescent health strategy.	20 minutes
Planning the corresponding session during the first national AA-HA! workshop	
• Determine who will facilitate each sub session? • Identify and prepare the necessary materials (printouts of case studies).	15 minutes

See Annex C.5 for the governance structure of the national adolescent health strategy in Ethiopia.

AA-HA! Box 5.4. Practical considerations in planning and managing an intersectoral programme (AA-HA! guidance, main document, pages 111-112).

SESSION 11

Detailed outline

Financing adolescent health programmes. The adolescent health module of the OneHealth costing tool

Day 2, 15:45–16:30

OBJECTIVES

At the end of the session participants will:

- Understand the importance of making the case for adolescent health during operational planning cycles.
- Understand the importance of having a costed implementation plan to raise resources for adolescent health programmes.
- Understand the principles of the adolescent health module of the OneHealth costing tool.
- Understand AA-HA! recommendations regarding financial protection of adolescents.

KEY MESSAGES

- A case for investment in adolescent health will be much stronger if it is fully costed.
- The national package of adolescent health interventions should be an instrument to guide purchasing decisions and benefit packages, and inform operational planning cycles.
- Investments should be made in building the capacity of national and district project managers to leverage external funds for adolescent health priorities using opportunities. provided by the UHC agenda, Global Financing Facility and strategic investments by the Global Fund and GAVI the Vaccine Alliance, among others.
- National plans should include financial risk protection measures to ensure that health services and commodities are free or more affordable to adolescents at the point of use.

MATERIALS & REFERENCES

- AA-HA! guidance, main document, section 5.4.1

	METHODOLOGY	TIMING
Overview of AA-HA! recommendations		
	Power Point presentation "Financial resources for adolescent health programming, and financial risk protection for adolescent health".	20 minutes
Overview of the adolescent health module of the OneHealth costing tool		
	Power Point presentation "Adolescent health module of the OneHealth costing tool".	15 minutes
Discussion		
	Q&A from participants	10 minutes

Burundi used the AA-HA! Guidance in preparing the proposal that was submitted to and approved by the European Union.

Inspired by the AA HA! guidance, the WHO country office in Burundi prepared a proposal for the project "Resilience of populations" supported by the European Union. The submission as successful, and the project will be implemented over a period of 36 months for an amount of nearly three million euros with one million one hundred and eighty-two thousand, nine hundred and fifty euros (1,182,950 Euros) for the sexual and reproductive health of adolescents and young people. The interventions included in the adolescent health project refer to the evidence outlined in the AA-HA! guidance.

SESSION 12

Detailed outline

Other programmatic tools to support the implementation of adolescent health programmes

Day 2, 16:30 -17:05

OBJECTIVES

At the end of the session participants will:

- Understand AA-HA! recommendations regarding quality of care and workforce capacity for adolescent health care.
- Understand how the digital platform for the implementation of Global Standards for quality health care services for adolescents can facilitate quality improvement.
- Understand WHO tools and approaches in strengthening pre-service training in adolescent health.
- Understand how the application of the Handbook for Conducting an Adolescent Health Services Barriers Assessment (AHSBA) can inform needs assessment and landscape analysis with a focus on disadvantaged adolescents.

KEY MESSAGES

- A transition is needed from "adolescent-friendly" projects to adolescent-responsive primary and referral level care.
- Digital solutions such as the WHO digital platform for the implementation of Global Standards for quality health care services for adolescents can facilitate quality measurement and improvement.
- Adolescents are not simply older children or younger adults. All health workers who are in places that adolescents visit should have core competencies in adolescent health and development. WHO tools exist to guide countries in making this happen.
- A needs assessment and landscape analysis should include the identification of barriers that prevent disadvantaged adolescents from accessing effective health services, so that the strategy has provision for remedial actions.

MATERIALS & REFERENCES

- AA-HA! guidance, main document, sections 5.5.1.2 and 5.5.1.3
- Core competencies in adolescent health and development for primary care providers
- Global standards for quality health care services for adolescents
- Handbook for Conducting an Adolescent Health Services Barriers Assessment (AHSBA) with a Focus on Disadvantaged Adolescents https://apps.who.int/iris/bitstream/handle/10665/310990/9789241515078-eng.pdf?sequence=1&isAllowed=y
- Adolescent job aid (WHO, 2010). http://whqlibdoc.who.int/publications/2010/9789241599962_eng.pdf?ua=1

METHODOLOGY TIMING

Overview of AA-HA! recommendations

Power Point presentation summarizing AA-HA! recommendations regarding quality of care and workforce capacity for adolescent health care.	10 minutes

Overview of selected tools to support AA-HA! implementation

Power Point presentation on 3 tools, and their application in countries: 15 minutes

- WHO/UNAIDS Global Standards for quality health care services for adolescents, and their digital platform.
- WHO Core competencies in adolescent health and development for primary care providers.
- Handbook for Conducting an Adolescent Health Services Barriers Assessment (AHSBA) with a Focus on Disadvantaged Adolescents.

Discussion

Q&A from participants 10 minutes

SESSION 13

Detailed outline

Next steps

Day 2, 17:05–17:30

OBJECTIVES

At the end of the session participants will be able to:

- Plan the steps that will need to occur to finalize the national adolescent health strategy.
- Indicate the need for technical assistance.

KEY MESSAGES

- The work started at the first national AA-HA! workshop will need to be completed after the workshop.
- For the copmpletion of each step, responsible person(s) should be identified, as well as modalities, timeframes, and the need for technical assistance.

MATERIALS & REFERENCES

- Handout No.8 "Next Steps"

METHODOLOGY TIMING

Planning next steps and the needs for technical assistance

The coordinator of the TWG leads the plenary discussion on the next steps and required technical assistance. The slide with the table summarizing elements to be discussed is projected onto the screen so all participants can see it. The table is filled in during plenary. 25 minutes

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STEP 4

FIRST NATIONAL AA-HA! WORKSHOP

CONCEPT NOTE FOR THE FIRST NATIONAL AA-HA! WORKSHOP

OBJECTIVE

- To understand global, regional and national benefits of investing in adolescent health and development.
- To become familiar with the contents of the AA-HA! guidance and its use for the development of national adolescent health strategy.
- To discuss the findings of the background document, and complete/complement the needs assessment and landscape analysis, identify gaps and propose further sources for data collection to finalize these steps.
- To start the process of national prioritization and programming, and understand key issues in monitoring and evaluating adolescent health programmes, to inform the national strategy.
- To understanding the importance of governance mechanisms, financing and adolescent participation in the development and implementation of adolescent health programmes, and propose a governance mechanism for the new strategy.
- To understand the application of selected tools to support implementation.
- To develop a country road-map for further development of the national adolescent health strategy and its implementation plan.

TARGET GROUP

- Ministry of Health focal points for adolescent health and school health (i.e. in addition to those that are already members of the TWG).
- Ministry of Health focal points for quality of care, primary care.
- Representatives from other relevant Ministries such as Ministry of Education, Ministry of Finance, Family, Welfare and Social Protection, Youth and Sport (i.e. in addition to those that are already members of the TWG).
- Researchers or academics working on the different areas of adolescent health (e.g. nutrition, mental health, injury and violence prevention, sexual and reproductive health).
- Representatives of civil society (e.g. young people, youth-led and youth-serving NGOs as well as NGOs providing services in the area of adolescent empowerment and participation, education, health and health services, violence against women and children, child marriage, professional bodies or associations (e.g. medical associations).
- National representatives of the UN H6 plus UNESCO agencies.

FACILITATORS

Members of the TWG

CONTENTS

- Global, regional and national adolescent health profiles and commitments in adolescent health.
- Overview of the AA-HA! systematic process to develop national adolescent health strategies and plans.
- Overview of the selected tools to support implementation and monitoring.

METHODS

- Facilitated discussion
- Presentations
- Individual and group work using handouts from the AA-HA! manual
- Case studies from AA-HA! early adopter countries

EXPECTED OUTCOMES

At the end of the workshop participants will achieve:

- Understanding of global, regional and national adolescent health profiles, and why investing in them results in long-term societal benefits.
- Familiarity with the documents included in the AA-HA! guidance package, and their use for the development of the national strategy.
- Understanding of the importance of adolescents' participation in developing and implementing national strategies and plans, at national, district and local levels.
- Advances in needs assessment, landscape analysis, priority-setting and programming.
- Understanding of the key issues in monitoring and evaluating adolescent health programmes and using the AA-HA! guidance, main document and its annexes.
- Familiarity with selected tools to support implementation,
- Ability to plan a country road-map to finalize the development of the national adolescent health strategy and its implementation plan.

- AA-HA! guidance, main document
- AA-HA! manual
- AA-HA! case studies

Adolescents may not feel comfortable discussing potentially sensitive or personal issues, such as SRH and mental health, with adults in the same group. It is suggested therefore that a trained adolescent facilitator conducts pre-workshop orientation for adolescents to explain the task, answer questions, and build their capacity to meaningfully contribute. During the workshop adolescents might be mixed in working groups with adults (if they feel comfortable), or work in separate group of adolescents. If the former is chosen, the facilitator of the group work should ensure that adolescent voices are heard, and that they feel comfortable during discussions.

- In early adopter countries the national AA-HA! workshop was delivered in 2 days (Sudan C.2, Barbados C.3) and 4 days (Haiti). However, both facilitators and participants felt that to deliver the contents in 2 days is challenging. If a 2 days format is chosen, more work will need to be done after the workshop by the TWG.
- In Sudan adolescents did not participate in the first national AA-HA! workshop but, through focus group discussions after the workshop, were involved throughout the process of developing the national strategy.

FIRST NATIONAL AA-HA! WORKSHOP AGENDA

	Day 1	Day 2	Day 3
08:45		**Recap of Day 1**	**Recap of Day 2**
09:00	**REGISTRATION** **SESSION 1:** Opening and introduction • Objectives, agenda and working methods • Introduction of participants	**SESSION 4:** Needs assessment (cont.) • Group work (cont.) • Report back in plenary	**SESSION 7:** Key areas for programming (cont.) • Group work
10:30	**Break**	**Break**	
10:45	**SESSION 1:** (cont.) • A global and regional overview of adolescent health • A national overview of the status of adolescent health, and national response • UN H6 plus UNESCO panel	**SESSION 5:** Landscape analysis • Brief overview of this step • Group work	**SESSION 7:** Key areas for programming (cont.) • Group work (cont.) • Report back in plenary **SESSION 8:** Planning for monitoring and evaluation • Brief overview of relevant AA-HA! content • Case study
12:30	**Lunch**	**Lunch**	
13:30	**SESSION 2:** An overview of the Global AA-HA! guidance package and its application in countries • Overview of AA-HA! documents • Lessons learned from the application in countries	**SESSION 5:** Landscape analysis (cont.) • Group work (cont.) • Report back in plenary **SESSION 6:** National prioritization • Brief overview of this step • Group work	**SESSION 9:** Adolescents participation • Brief overview of the relevant AA-HA! content • Case study **SESSION 10:** Governance structure • Brief overview of the relevant AA-HA! content • Case study **SESSION 11:** Financing adolescent health programmes. • Overview of key actions to secure financial resources for adolescent health programmes

	Day 1	Day 2	Day 3
15:30	**Break**	**Break**	
15:45	**SESSION 3:** Key findings from the national AA-HA! background document • Overview of key findings • Q&A from participants **SESSION 4:** Needs assessment • Brief overview of this step • Group work	**SESSION 6:** National prioritization (cont.) • Group work (cont.) • Report back in plenary **SESSION 7:** Key areas for programming • Brief overview of this step	**SESSION 11:** Financing adolescent health programmes (cont.) • Brief overview of the adolescent health module of the OneHealth costing tool **SESSION 12:** Other programmatic tools to support the implementation of adolescent health programmes • the web platform for the implementation of Global Standards for quality health care services for adolescents • Core competencies in adolescent health and development for primary care providers • the Handbook for Conducting an Adolescent Health Services Barriers Assessment with a Focus on Disadvantaged Adolescents **SESSION 13:** Next steps • Activities • Stakeholders • Responsible person(s) • Timeframes • Required technical assistance
17:30	**Close**	**Close**	

- Review the resource ***Generic tips to plan workshops and sessions (page 14)***
- Make sure to share the background document with participants at least one week in advance so they have time to get acquainted with it ahead of the workshop, and strongly encourage them to do this and not to arrive unprepared. Adolescent health fact sheets might be prepared as well to summarize key findings from the background report.
- In the sign-in sheet, ask for participants' phone numbers, in case there's a need to follow up for more information.
- Get results of the group work by the end of each day.

SESSION 1

Detailed outline

Opening and introduction

Day 1, 9:00-12:30 (including 15 min break)

OBJECTIVES

At the end of the session participants will:

- Understand why to invest in adolescent health.
- Understand the global, regional and national adolescent health profiles and commitments for adolescent health.
- Understand the process of developing the national adolescent health strategy, and the supporting role of UN agencies.

KEY MESSAGES

- Disease and injury burdens in adolescents are considerable, and largely preventable.
- The distinctive physical, cognitive, social, emotional and sexual development that takes place during adolescence demands special attention in national development policies, programmes and plans.
- Investing in adolescents brings a triple dividend: benefits for adolescents now, for their future adult lives and for their children.
- The national government is committed to invest in adolescent health.

MATERIALS & REFERENCES

- AA-HA! guidance
- Terms of reference for the TWG
- Concept note for the first national AA-HA! workshop
- Agenda

	METHODOLOGY	TIMING
Opening		
Registration		30 minutes
Short statement/presentation from senior official from Ministry of Health (MOH), Director General, etc.		10 minutes
Short statement/presentation from WHO Representative or senior official at WHO.		10 minutes
Short statement/presentation from MOH focal point for adolescent health, including a description of the process envisaged for the development of the national adolescent health strategy (as explained in Figure 1).		10 minutes
Introduction of participants		10 minutes
Objectives, agenda and working methods		
Oral presentation or Power Point: • Generally, describe the purpose of this workshop, its objectives and working methods, as described in the "Concept note for the first national AA-HA! workshop". • Refer to the role of the TWG in the context of the development of the national adolescent health strategy, as explained in the "Outline of terms of reference for the Technical Working Group to steer the process of developing a national adolescent strategy". • Make an overview of the 3 days agenda.		20 minutes

Global and regional overview of the status of adolescent health, and commitments

Power Point presentation(s) on: 30 minutes

- Global, regional and national commitments for adolescent health.
- The global and regional status of adolescent health.

A National overview of the status of adolescent health, and national response

Power Point presentation(s) on: 40 minutes

- The status of adolescent health in the country
- Existing programmes, projects, and initiatives
- Q&A

UN panel

- Moderated discussion with representatives of key UN agencies on their 'agencies efforts to support the government in the area of adolescent health. 35 minutes
- Q&A

Agenda

List of participants

Concept note for the first national AA-HA! workshop

SESSION 2

Detailed outline

An overview of the Global AA-HA! guidance and its application in countries

Day 1, 13:30-15:30

OBJECTIVES

At the end of the session participants will have:

- Basic understanding of the content of the Global AA-HA! guidance, and the use of the various AA-HA! tools.
- Learned key lessons from the application of the AA-HA! process in early adopter countries.

KEY MESSAGES

- The AA-HA! guidance package consists of 5 documents: main document, summary, comic book, brochure, and manual. There are also separate annexes.
- The AA-HA! guidance provides evidence-based information to policy-makers, practitioners, researchers, educators, donors, and civil society organizations – including the most up to-date data on the major disease and injury burdens that affect adolescents. It supports the implementation of the Global Strategy by providing the comprehensive information that countries need to decide ***what*** to do for adolescent health and ***how*** to do it.
- The AA-HA! guidance not only provides information on what needs to be done – it demonstrates what is already being done. More than 70 case studies from across the globe provide concrete examples of how countries have implemented what is being promoted.
- The AA-HA! guidance advocates for a comprehensive approach for adolescent health, meaning that programmes and policies should take into consideration a broad spectrum of conditions that contribute to disease and injury burdens in adolescents – unintentional injury, violence, sexual and reproductive health, including HIV, communicable diseases, non-communicable diseases and malnutrition, mental health, substance use and self-harm, burdens in humanitarian and fragile settings. For each of these conditions, the AA-HA! guidance summarizes evidence-based interventions at different levels of the ecological framework.

- The AA-HA! guidance makes the case for an "Adolescent Health in All Policies" approach. In that respect, the guidance recommends key actions that are needed in key sectors: financing, social protection, roads and transport, telecommunications, housing and urban planning, energy, water and sanitation, environment, and criminal justice.
- Countries should ensure that adolescents' expectations and perspectives are included in national programming processes and that adolescents and representatives from keys sectors are involved in the process of strategy development from the beginning.
- The application of the AA-HA! process in early adopter countries is documented, and lessons learned can guide participants to improve the process.
- The AA-HA! manual to facilitate the process of developing national adolescent health strategies and plans summarizes the experience of the application of the AA-HA! guidance in many regions and countries to develop national adolescent health strategies. It is intended to help national experts who want to facilitate similar processes in their own countries.

MATERIALS & REFERENCES

- The AA-HA! guidance, main document.
- The AA-HA! summary.
- The AA-HA! comic book.
- The AA-HA! brochure.
- The AA-HA! manual to facilitate the process of developing national adolescent health strategies and plans
- Case studies from Sudan C.2, Barbados C.3, and Belize C.1.

	METHODOLOGY	TIMING
An overview of the Global AA-HA! guidance package		
	Power Point overview of the AA-HA! documents, brief overview of their contents and target audiences: • The AA-HA! guidance, main document is intended for policy-makers and programme managers who are responsible for adolescent health programming in countries. • The AA-HA! summary document is intended for a broader audience of policy-makers and government representatives in health and other sectors. • The AA-HA! comic book has been written for young adolescents to inform them of the key messages in the AA-HA! approach. • The AA-HA! brochure aims to facilitate dissemination of the overarching messages and to inform the public about the AA-HA! • The AA-HA! manual to facilitate the process of developing national adolescent health strategies and plans is intended for national and subnational programme managers in charge of adolescent health, and national and international trainers/consultants/ facilitators supporting national governments in planning and programming for reproductive, maternal, child and adolescent health.	60 minutes
	Q&A	20 minutes
Lessons learned from the application of the AA-HA! guidance in countries		
	• Power point summarizing key lessons learned from the application of the AA-HA! guidance in countries with illustrative examples of governance, adolescent participation, priority setting, milestone activities and costing. • Reference to case studies from Barbados C.3, Sudan C.2 and Belize C.1.	20 minutes
	Q&A	20 minutes
	If possible, each participant should have: • The AA-HA! guidance, main document. • The AA-HA! summary. • The AA-HA! comic book. • The AA-HA! brochure.	

SESSION 3

Detailed outline

Key findings from the national AA-HA! background document

Day 1, 15:45-16:20

OBJECTIVES

At the end of the session participants will:

- Understand the methods used to produce the background document, and its key findings.

KEY MESSAGES

The key messages in this session will depend on the findings and data gaps identified by the consultant who prepared the background document. Generally, they should reflect the following topics:

- Data sources and data gaps for a comprehensive analysis of adolescent health in the country
- Key findings from needs assessment
- Key findings from landscape analysis
- Recommendations for further data collection and finalization of the report

MATERIALS & REFERENCES

- National AA-HA! background document
- National adolescent health profiles

	METHODOLOGY	TIMING
Key findings from the national AA-HA! background document		
Power Point synthesis of the national AA-HA! background document: • Data sources used and data gaps for a comprehensive analysis of adolescent health in the country • Key findings from needs assessment • Key findings from landscape analysis • Recommendations for further data collection and finalization of the report		30 minutes
Q&A		15 minutes
	• National AA-HA! background document • National adolescent health profiles	

SESSION 4

Detailed outline

Needs assessment

Day 1, 16:30-17:30
Day 2, 09:00–10:30

OBJECTIVES

By the end of the session participants will:

- Understand what type of information should be gathered and analysed during needs assessment.
- Advance needs assessment based on the background document, identify gaps and propose further sources for data collection to finalize needs assessment.

KEY MESSAGES

- The nature, scale and impact of adolescent health needs are unique in each country. Governments must evaluate their country's adolescent health needs before developing – or improving upon – adolescent health programming
- Needs assessment identifies which conditions have the greatest impact on adolescent health and development, both among all adolescents, by age, sex and part of the country, and among those most vulnerable.
- Needs assessment includes not only the analysis of conditions that contributes to greatest disease and injury burdens, but also adolescent behaviours most closely linked to these conditions and future health problems, harmful practices affecting adolescents, sociocultural context of adolescents' lives, including risk and protective factors at various ecological levels, and subgroups of adolescents who may be in the greatest need of services and programmes.
- The national AA-HA! background document provides a starting point for discussing the findings from the needs assessment. Inputs from the first national AA-HA! workshop will guide the TWG in finalization the needs assessment.

MATERIALS & REFERENCES

- AA-HA! guidance main document, section 4.1
- National AA-HA! background document
- Handout No.1 "General principles to facilitate group discussions"
- Handout No.2 "Needs assessment"

METHODOLOGY	TIMING
Introduction to the needs assessment	
• Power Point overview of the needs assessment as explained in the AA-HA! guidance, main document	15 minutes
Group work to complete the needs assessment	
• Explanation by facilitator of the group work on needs assessment based in Handout No.2 • Divide participants into groups, indicate the designated location, and identify the main facilitator in each group • Q&A: clarifications from participants	15 minutes
• Group work following Handout No. 2 • During the group work, make sure general principles are followed as explained in Handout No. 1	60 minutes

Report back, debrief and consolidation

Since groups discussed different areas, facilitate a discussion to get feedback by each group on the other's work, making adjustments so that a collective vision is achieved. 60 minutes

- National AA-HA! background document
- Handout No. 2 "Needs assessment" but without the part "tips for facilitators"

- Make sure the background document is shared with participants at least one week in advance so they have plenty of time to get acquainted with it before of the first national AA-HA! workshop
- It is recommended that groups are divided by areas of expertise (e.g. violence, SRH, nutrition) and the same group composition is maintained for all steps during the first national AA-HA! workshop. This way all topics are discussed in-depth. The disadvantage of this approach is that not every participant gets exposed to areas outside their usual areas of interest. This is mitigated by the fact that everybody gets exposure to all topics in plenary and has the chance to contribute. However, if for some areas there is no expertise, or only 1-2 representatives, then groups can be mixed by combining expertise from interdependent areas (e.g. mental health and substance use, or SRH and HIV).

See how the team from Belize used evidence to inform the adolescent health strategic plan (Annex C.1, access the link to the full story)

SESSION 5

Detailed outline

Landscape analysis

Day 2, 10:45-14:15 (including 60 minutes lunch break)

OBJECTIVES

By the end of the session participants will:

- Understand what type of information should be gathered and analysed during landscape analysis.
- Advance landscape analysis based on the background document, identify gaps and propose further sources for data collection to finalize landscape analysis.

KEY MESSAGES

- A landscape analysis consists of a review of existing adolescent health programmes, policies, legislation, capacity and resources within the country, as well as a review of current global and local guidance on evidence-based interventions. The landscape analysis helps to identify policy and programmatic gaps.
- The national AA-HA! background document provides a starting point for discussing the findings from the landscape analysis. Inputs from the first national AA-HA! workshop will guide the TWG in finalizing the landscape analysis.

MATERIALS & REFERENCES

- AA-HA! guidance, main document, section 4.2
- National AA-HA! background document
- Handout No. 1 "General principles to facilitate group discussions"
- Handout No. 3 "Landscape analysis"

METHODOLOGY	TIMING
Introduction to landscape analysis	
• Power Point overview of the landscape analysis as explained in the AA-HA! guidance, main document	15 minutes
Group work to complete landscape analysis	
• Explanation by facilitator of the group work on landscape analysis based on Handout No. 3 • Divide participants in groups, indicate the designated location, and identify the main facilitator for each group • Q&A: clarifications from participants	15 minutes
• Group work following Handout No. 3 • During the group work, make sure general principles are followed as explained in Handout No. 1	60 minutes
Report back, debrief and consolidation	
Since groups discussed different areas, facilitate a discussion to get feedback by each group on the other's work, making adjustments so that a collective vision is achieved	60 minutes
• National AA-HA! background document • Handout No.3 landscape analysis but without the part "tips for facilitators"	

SESSION 6

Detailed outline

National prioritization

Day 2, 14:15-17:00 (including 15 minutes break)

OBJECTIVES

By the end of the session participants will:

- Understand why prioritization is necessary.
- Understand criteria to prioritize health priorities and interventions.
- Apply these criteria to start identifying key health priorities for the national adolescent health strategy.
- Prioritize interventions for one health priority.
- Feel confident to apply the criteria to finalize national prioritization after the first national AA-HA! workshop.

KEY MESSAGES

- All governments face resource constraints, so they must make difficult choices to ensure their adolescent health resources are used most effectively. Prioritization of key issues and interventions is therefore necessary.
- Over time, countries should reassess their adolescent health priorities and programming to ensure that they still meet changing adolescent needs.
- When prioritizing health areas and interventions, the following criteria should be considered: magnitude and public health importance of the problem; the size of the population affected; whether effective interventions are available and the degree of the effectiveness of the interventions; whether the interventions are likely to address the needs of vulnerable populations/underserved groups; feasibility of delivering the interventions (e.g. funds, infrastructure, personnel, acceptability, political support); potential to deliver interventions at scale within the time frame considered.
- The process of national prioritization should include a broad range of stakeholders to have the buy-in for the implementation.

MATERIALS & REFERENCES

- AA-HA! guidance, main document, section 4.3
- Handout No.1 "General principles to facilitate group discussions"
- Handout No.4 "Setting priorities"

	METHODOLOGY	TIMING
National prioritization		
	• Power Point overview of the national prioritization as explained in the AA-HA! main document	15 minutes
Group work to start national prioritization		
	• Explanation by facilitator of the group work on national prioritization based on Handout No.4 • Divide participants in groups, indicate the designated location, and identify the main facilitator for each group • Q&A: clarifications from participants	15 minutes
	• Group work following Handout No.4 • During the group work, make sure general principles are followed as explained in Handout No.1	60 minutes
Report back, debrief and consolidation		
	Facilitate a discussion to achieve a collective vision	60 minutes
	• National AA-HA! background document • Handout No.4 "Setting priorities" but without the part "tips for facilitators"	

SESSION 7

Detailed outline

Key areas for programming

Day 2, 17:00–17:30
Day 3, 09:00–11.30 (including 15 minutes morning break)

OBJECTIVES

By the end of the session participants will:

- Understand how the AA-HA! logical framework can guide programming
- Understand how to translate newly identified priorities into operational plans and activities
- Apply the AA-HA! logical framework for programming to propose activities for 2 interventions
- Understand how to plan integrated activities and services
- Feel confident to apply the logical framework for programming to propose activities for all priority interventions after the first national AA-HA! workshop

KEY MESSAGES

- Programming – the process of translating newly identified priorities into operational plans – has common elements such as adopting adolescent protective laws and policies; deciding on service delivery platforms; addressing weaknesses in workforce capacity; improving supply systems, technology and infrastructure; improving (health) management and information systems; engaging communities to build support for adolescents' use of services; establishing leadership and governance arrangements for implementation; and estimating resource need and secure funding for national, district and local actions.
- The AA-HA! logical framework is a tool that summarizes these elements, and guide users to make explicit the links between the programme's goals, objectives, key interventions, implementation strategies and activities.

MATERIALS & REFERENCES

- AA-HA! guidance, main document, section 5
- AA-HA! logical framework for programming (AA-HA! guidance, main document, page 81)
- Handout No.1 "General principles to facilitate group discussions"
- Handout No.5 "Key areas for programming"

METHODOLOGY	TIMING
Key areas for programming	
• Power Point overview of the programming process as explained in the AA-HA! guidance, main document	25 minutes
Group work to start national programming	
• Explanation by facilitator of the group work on programming based in Handout No.5 • Divide participants in groups, indicate the designated location, and explain who the main facilitator in each group will be • Q&A: clarifications from participants	15 minutes
• Group work following Handout No.5 • During the group work, make sure general principles are followed as explained in Handout No. 1	80 minutes
Report back, debrief and consolidation	
Facilitate a discussion to achieve a collective vision	60 minutes
• National AA-HA! background document • AA-HA! logical framework for programming (AA-HA! guidance, main document, page 80) • Handout No.5 "Key areas for programming" but without the part "tips for facilitators"	

SESSION 8

Detailed outline

Planning for monitoring and evaluation

Day 3, 11:30–12:30

OBJECTIVES

At the end of the session participants will:

- Understand principles of selecting indicators and setting targets for monitoring and evaluation of national adolescent health strategies and plans.
- Know sources for internationally agreed impact indicators.

KEY MESSAGES

- The rapid physical, emotional and social changes across the adolescent period pose special challenges for adolescent health programmes, making it essential to disaggregate data by age (five-year age spans) and sex.
- It is essential for adolescent health programmes to monitor the full range of indicators from inputs and processes to outputs, outcomes and impact – they answer different questions and are useful for different purposes.
- Periodic evaluations of adolescent health programmes are essential and should build on routinely collected monitoring data.
- Internationally agreed impact indicators for adolescent health and development – for example the 43 adolescent-specific indicators of the Global Strategy for Women's, Children's and Adolescents' Health (2016–2030) – constitute a good starting point to plan for the monitoring and evaluation of the national adolescent health programmes. Input, process, output and to some degree outcome indicators are more context specific and will need to be developed in line with national priorities and planned activities.

MATERIALS & REFERENCES

- AA-HA! Guidance, main document, section 6
- Power Point presentation "Selecting indicators, setting targets and monitoring and evaluation of adolescent health programmes"
- Handout No.6 Selecting indicators, setting targets and monitoring and evaluation of adolescent health programmes
- Case study of monitoring and evaluation framework applied in another country

	METHODOLOGY	TIMING
Overview of the AA-HA! section 6 "Monitoring, evaluation and research"		
Power Point overview of the section 6 "Monitoring, evaluation and research"		20 minutes
Q&A		10 minutes
Examples of indicators to monitor three specific adolescent health programme		
Guide participants through Tables 6.1 and 6.2 in the AA-HA! guidance main document, giving examples of indicators for common types of programmes. • Programmes to ensure that the national health system is adolescent-responsive. • Programmes to reduce adolescent pregnancies. • School health programmes. • Adolescent mental health programmes. This can be done in plenary or by dividing participants in 4 groups. In the latter case, give each group time to read about one type of programme (10 min), and debrief in plenary (5 min each group).		15 minutes

Case study from another country experience

- Case study presentation of monitoring and evaluation framework applied in another country (Ethiopia, Annex C.5). — 10 minutes
- Prime the group to pay attention to indicators at different levels of the logical framework: input, process, output, outcome and impact.

- Case study from Ethiopia, Annex C.5.
- Handout No.6. Selecting indicators, setting targets and monitoring and evaluation of adolescent health programmes

See the example of the Monitoring and Evaluation Matrix from Ethiopia National Adolescent and Youth Health Strategy (2016-2020) (Annex C.5)

SESSION 9

Detailed outline

Adolescents' participation

Day 3, 13.30–14:25

OBJECTIVES

At the end of the session participants will:

- Understand the benefits of involving adolescents in programmes that affect their lives.
- Understand what the key recommended actions are to ensure adolescent leadership and participation in programmes.
- Know where to find practical resources that can guide the country team in facilitating youth engagement.

KEY MESSAGES

- Countries should ensure that adolescents' expectations and perspectives are included in national programming processes. Adolescent leadership and participation should be institutionalized and actively supported during the design, implementation, monitoring and evaluation of adolescent health programmes.
- Section 5.3 of the AA-HA! guidance, main document, lists key area of focus to ensure adolescent leadership and participation, and includes reference to other practical resources to facilitate youth engagement.

MATERIALS & REFERENCES

- AA-HA! guidance, main document, section 5.3
- AA-HA! guidance, main document case studies A3.1, A3.13, A3.14, A3.2, A5.5, A5.6

METHODOLOGY — TIMING

Overview of the AA-HA! recommendations

- Power Point presentation on the benefits of involving adolescents in programmes that affect their lives, key recommended actions are to ensure adolescent leadership and participation in programmes. — 30 minutes

Practical ways and resources to facilitate youth engagement

Guided plenary discussion on participants' experiences in youth engagement, and reference to some key practical resources as listed in the Handout No. 1. — 15 minutes

Case study on adolescent participation in developing the national adolescent health strategy in Belize

- Case study presentation on involving adolescents and youth in the design and implementation of adolescent health programme (example from Belize, Annex C.1). 10 minutes
- Prime the group to pay attention to the fact that adolescents were not merely invited to workshop, but were members of the TWG, and that consultations with adolescents were also held at district levels.
- Additional case studies that can be used in this session are available in the annexes of the AA-HA! guidance, see case studies A3.1, A3.13, A3.14, A3.2, A5.5, A5.6

- See the case study from Belize on developing an Adolescent Health National Strategic Plan for Belize (Annex C.1, access the link to the full story).
- In Guyana adolescents participated actively in the AA-HA! process, around one-third of the participants in the national workshop were adolescents and youth. The organizers also made efforts to engage young people representing vulnerable groups, such as indigenous youth from the hinterland.
- See the video examples of how adolescents and young people are being involved in the HIV response. http://apps.who.int/adolescent/hiv-testing-treatment/page/involving_adolescents
- The Child and Youth Mental Health and Substance Use Collaborative was formed because stakeholders were worried about the uncoordinated system of mental health care for children, youth, and families in British Columbia in Canada. As a first of its kind in Canada, the Collaborative decided to explore new ways of working together to increase the number of children, youth, and families seeking and receiving timely access to integrated mental health and substance use services and support. Learn more about how youth and families, family doctors, paediatricians, psychiatrists, mental health clinicians, school counsellors, teachers and principals were involved in shaping and implementing the initiative. http://www.collaborativetoolbox.ca/legacy-magazine

- Case study from Belize on developing an Adolescent Health National Strategic Plan for Belize (Annex C.1, print from the link to the full story)
- Handout No.6

SESSION 10

Detailed outline

Governance structure

Day 3, 14:25–15:10

OBJECTIVES

At the end of the session participants will:

- Understand why leadership for adolescent health is needed both within the ministry of health and at a highest level of the government, as well as at district level.
- Understand practical considerations in planning and managing an intersectoral programme.
- Make a preliminary proposal for a governance structure for the national adolescent health strategy.

KEY MESSAGES

- To support the development and the implementation of the strategy, it is necessary to establish a national-level mechanism, or use existing platforms, to oversee and coordinate efforts for adolescent health and well-being across sectors and government ministries. Such a mechanism would facilitate engagement of relevant agencies and civil society organizations, including adolescents themselves.
- Investments should be made in planning and managing intersectoral actions to anticipate the negative effects of behavioural and structural barriers.
- Investments should also be made in political and administrative capacity of subnational (e.g. district-level) managers to involve them from the start.

MATERIALS & REFERENCES

- AA-HA! guidance, main document, sections 5.2, 5.6.2

	METHODOLOGY	TIMING
Overview of AA-HA! recommendations		
	Power Point presentation "Leadership for adolescent health within the ministry of health and across the government"	20 minutes
Case study on governance structure for the national adolescent health strategy in Ethiopia		
	• Case study presentation on a governance structure for the national adolescent health strategy in Ethiopia, and roles and responsibilities of various stakeholders (C.5). • Prime the group to ensure that the governance structure spans the 3 levels of decision making (national, subnational, local), and that leading and supporting roles are clearly articulated for each of the key sectors and agencies.	5 minutes
Making a preliminary proposal for the governance structure for the national adolescent health strategy		
	Guided plenary discussion on what is participants' proposal for the governance structure for the national adolescent health strategy	20 minutes

See Annex C.5 for the governance structure of the national adolescent health strategy in Ethiopia.

- AA-HA! Box 5.4. Practical considerations in planning and managing an intersectoral programme (AA-HA! guidance, main document, pages 111-112).
- Case study on governance structure for the national adolescent health strategy in Ethiopia, (C.5).

SESSION 11

Detailed outline

Financing adolescent health programmes. The adolescent health module of the OneHealth costing tool

Day 3, 15:10–16:10 (including 15 minutes break)

OBJECTIVES

At the end of the session participants will:

- Understand the importance of making the case for adolescent health during operational planning cycles.
- Understand the importance of having a costed implementation plan to raise resources for adolescent health programmes.
- Understand the principles of the adolescent health module of the OneHealth costing tool.
- Understand AA-HA! recommendations regarding financial protection of adolescents.

KEY MESSAGES

- A case for investment in adolescent health will be much stronger if it is fully costed.
- The national package of adolescent health interventions should be an instrument to guide purchasing decisions and benefit packages and inform operational planning cycles.
- Investments should be made in building the capacity of national and district project managers to leverage external funds for adolescent health priorities using opportunities provided by the UHC agenda, Global Financing Facility and strategic investments by the Global Fund and GAVI the Vaccine Alliance, among others.
- National plans should include financial risk protection measures to ensure that health services and commodities are free or more affordable to adolescents at the point of use.

MATERIALS & REFERENCES

- AA-HA! guidance main document, section 5.4.1

METHODOLOGY	TIMING
Overview of AA-HA! recommendations	
Power Point presentation "Financial resources for adolescent health programming, and financial risk protection for adolescent health"	20 minutes
Overview of the adolescent health module of the OneHealth costing tool	
Power Point presentation "Adolescent health module of the OneHealth costing tool"	15 minutes
Discussion	
Q&A from participants	10 minutes

Burundi used the AA-HA! Guidance in preparing the proposal that was submitted to and approved by the European Union.

Inspired by the AA HA! guidance, the WHO country office in Burundi prepared a proposal for the project "Resilience of populations" supported by the European Union. The submission as successful, and the project will be implemented over a period of 36 months for an amount of nearly three million euros with one million one hundred and eighty-two thousand, nine hundred and fifty euros (1,182,950 Euros) for the sexual and reproductive health of adolescents and young people. The interventions included in the adolescent health project refer to the evidence outlined in the AA-HA! guidance.

SESSION 12

Detailed outline

Other programmatic tools to support the implementation of adolescent health programmes

Day 3, 16:20-16:55

OBJECTIVES

At the end of the session participants will:

- Understand AA-HA! recommendations regarding quality of care and workforce capacity for adolescent health care.
- Understand how the digital platform for the implementation of Global Standards for quality health care services for adolescents can facilitate quality improvement.
- Understand WHO tools and approaches in strengthening pre-service training in adolescent health.
- Understand how the application of the Handbook for Conducting an Adolescent Health Services Barriers Assessment (AHSBA) can inform needs assessment and landscape analysis with a focus on disadvantaged adolescents.

KEY MESSAGES

- A transition is needed from "adolescent-friendly" projects to adolescent-responsive primary and referral level care.
- Digital solutions such as the WHO digital platform for the implementation of Global Standards for quality health care services for adolescents can facilitate quality measurement and improvement.
- Adolescents are not simply older children or younger adults. All health workers who are in places that adolescents visit should have core competencies in adolescent health and development. WHO tools exist to guide countries in making this happen.
- A needs assessment and landscape analysis should include the identification of barriers that prevent disadvantaged adolescents from accessing effective health services, so that the strategy has provision for remedial actions.

MATERIALS & REFERENCES

- AA-HA! guidance, main document, sections 5.5.1.2 and 5.5.1.3
- Core competencies in adolescent health and development for primary care providers
- Global standards for quality health care services for adolescents
- Handbook for Conducting an Adolescent Health Services Barriers Assessment (AHSBA) with a Focus on Disadvantaged Adolescents (2019). https://apps.who.int/iris/bitstream/handle/10665/310990/9789241515078-eng.pdf?sequence=1&isAllowed=y
- Adolescent job aid (WHO, 2010). http://whqlibdoc.who.int/publications/2010/9789241599962_eng.pdf?ua=1

	METHODOLOGY	TIMING
Overview of AA-HA! recommendations		
	Power Point presentation summarizing AA-HA! recommendations regarding quality of care and workforce capacity for adolescent health care	10 minutes
Overview of selected tools to support AA-HA! implementation		
	Power Point presentation on 3 tools, and their application in countries: • WHO/UNAIDS Global Standards for quality health care services for adolescents, and their digital platform. • WHO Core competencies in adolescent health and development for primary care providers. • Handbook for Conducting an Adolescent Health Services Barriers Assessment (AHSBA) with a Focus on Disadvantaged Adolescents.	15 minutes
Discussion		
	Q&A from participants	10 minutes

SESSION 13

Detailed outline

Next steps

Day 3, 16:55–17:30

OBJECTIVES

At the end of the session participants will:

- Plan the steps that will need to occur to finalize the national adolescent health strategy.
- Indicate the need for technical assistance.

KEY MESSAGES

- The work started during the first national AA-HA! workshop - e.g. prioritization, programming - will need to be completed after the workshop
- For the completion of each step, responsible person(s) should be identified, as well as modalities, timeframes, and the need for technical assistance.

MATERIALS & REFERENCES

- Handout No.8 “Next Steps”

	METHODOLOGY	TIMING
Planning next steps and the needs for technical assistance		
	• The coordinator of the TWG leads the plenary discussion on the next steps and required technical assistance. The slide with a table summarizing elements to be discussed is projected on the screen so all participants can see it. The table will be completed in plenary.	35 minutes

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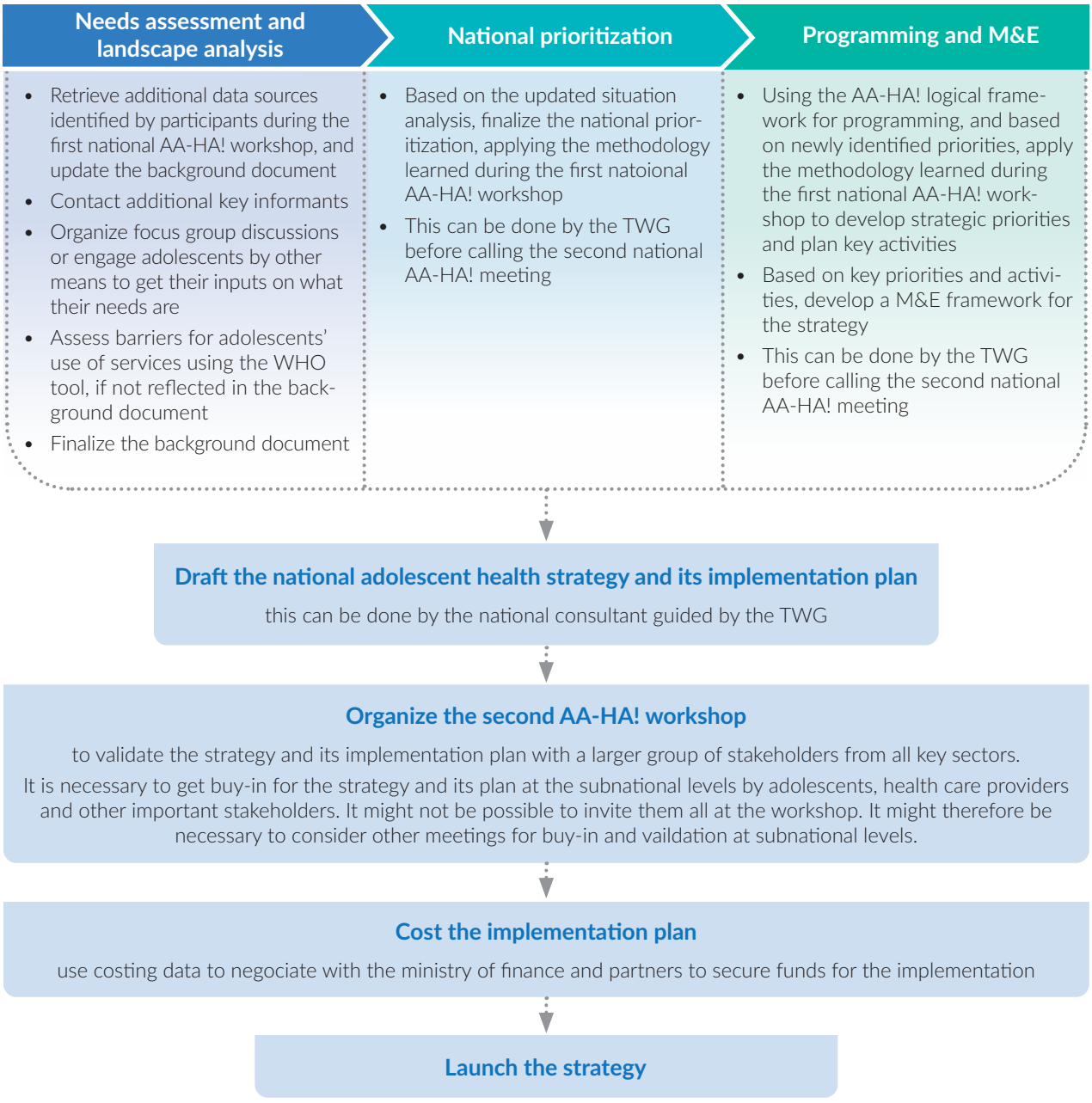
STEP 5

FINALIZATION OF THE NATIONAL ADOLESCENT HEALTH STRATEGY, AND ITS IMPLEMENTATION PLAN, INCLUDING A MONITORING & EVALUATION FRAMEWORK

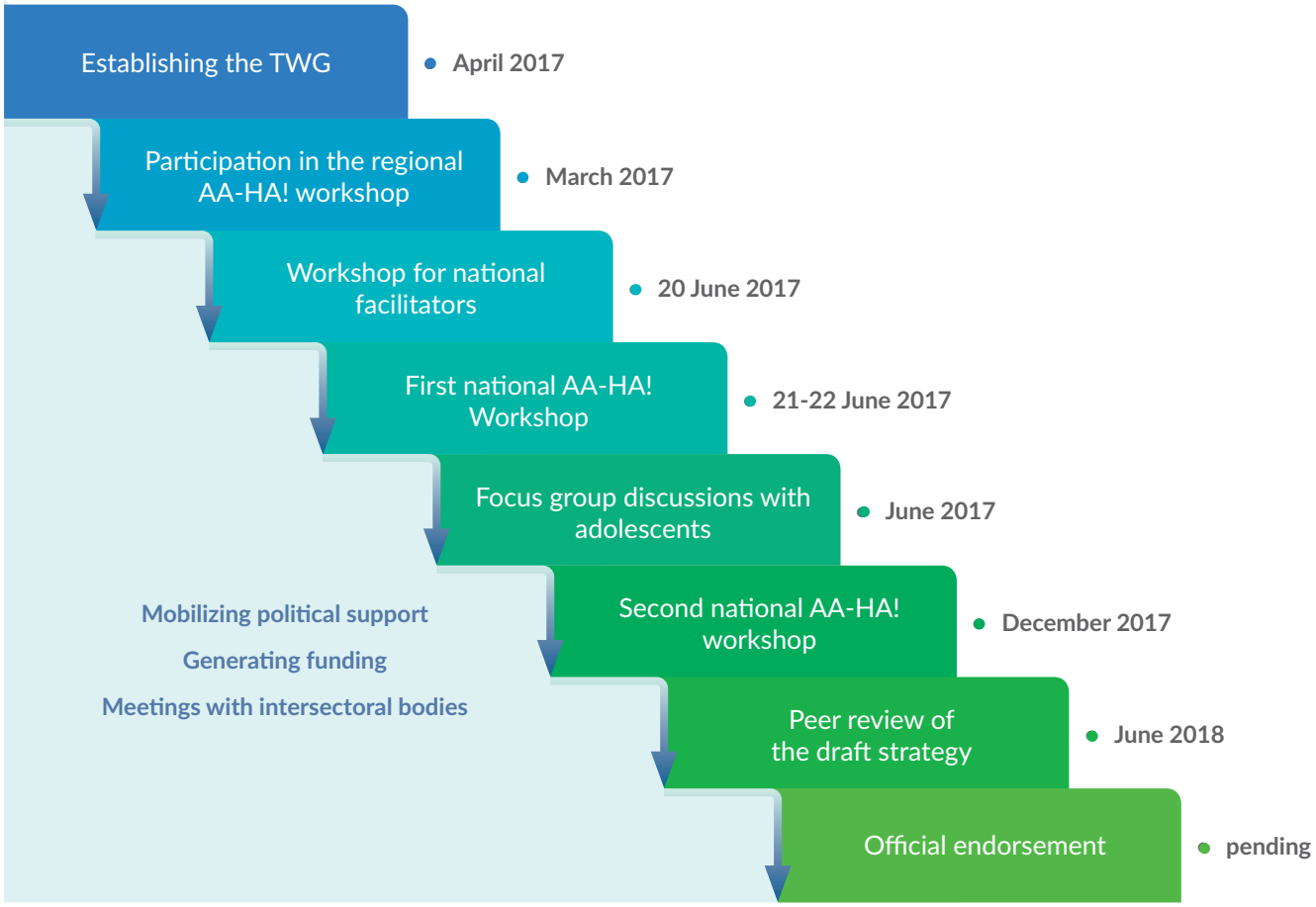
The outputs of the first national AA-HA! workshop constitute the basis for work to continue towards the finalization of the national adolescent health strategy, and its implementation plan. During the workshop participants advanced the needs assessment and landscape analysis, and learned the methodology of priority-setting, programming and developing a monitoring and evaluation framework. To finalize national prioritization, programming and the development of the implementation plan, participants will propose the next steps. These steps will guide the TWG in completion of the work. Although the tasks to be completed after the first national AA-HA! workshop will differ from country to country, they will likely include the tasks depicted in the roadmap below.

Figure 4. The roadmap towards the finalization of the national adolescent health strategy



In Sudan, for example, the process of development of the national adolescent health strategy included the following steps.

Overview of the process undertaken to develop the National Adolescent Health and Wellbeing Strategy of Sudan, 2018-2022



It is important to keep stakeholders that participated in the first national AA-HA workshop engaged during subsequent steps. To minimize costs, this could be done via webinars, for example to keep subnational level stakeholders engaged in the progress, and informed on progress. Follow up meetings with individuals and groups of stakeholders will be scheduled to seek additional inputs.

STEP 6

COSTING THE IMPLEMENTATION PLAN

For most countries, the key vehicle through which to expand resource allocation towards activities that benefit adolescent health is the budgeting process at national and subnational level. To access these funds, it is important to know how much the implementation of the strategy will cost.

Resource needs for implementing the adolescent health strategy will include resources for overall health systems and service delivery (e.g., health worker time and drugs for STI management for all age groups), as well as costs for adolescent-specific activities (e.g., media campaigns specifically targeting young adolescents). Depending on the objective of the costing, it may be important to consider both.

While the methods for the costing should be adapted to fit the policy question, one tool to consider is the joint UN -developed OneHealth Tool (OHT). The OHT was designed to enable the user to assess to what extent targets set within the plan are feasible, and to consider programme goals and health systems jointly. The tool can also be used to produce estimates of health impact related to changes in coverage and service delivery. The OHT covers the full health sector and has a specific module on adolescent health that allows a user to identify costs that are associated with delivering the adolescent health strategy. The tool can be used both for a stand-alone adolescent health plan, as well for considering adolescent health within a broader health strategy.

The OHT has been used in over 40 countries since 2012. Prior to country application, one of the first steps should therefore be to assess whether the tool has already been used in the country, and thus a pre-populated version exists that the analysis can draw upon. To learn more about previous country applications and for general guidance on country costing processes, contact WHO's CHOICE programme (whochoice@who.int).

The development of cost scenarios for future years may be done by a central team, or with the support of a consultant. Broad policy objectives need to be translated into activities and targets by year, to quantify the resources needed for implementation, estimate the related costs, and then assess aspects related to feasibility, affordability and efficiency (Stenberg & Rajan). Below are the generic terms of reference for estimating costs of the implementation plan. It should be noted that if there is a desire to use the OneHealth tool, this requires training and technical support if no previous experience exists. If the costing is done using the OneHealth Tool, WHO provides a review mechanism as support for quality assurance.

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ANNEXES

Annex A Terms of Reference

Annex A.1. Terms of Reference for the Technical Working Group to steer the process of developing a national adolescent strategy

Outline Terms of Reference for the Technical Working Group to steer the process of developing a national adolescent strategy

BACKGROUND

- Brief overview of global, regional and national commitments in the area of adolescent health and development
- Brief overview of the health situation of adolescents in the country: demography, mortality, morbidity, health-related behaviours and social determinants. Why there is pressure to invest in adolescent health.
- Why the need for an adolescent health strategy?
- How the strategy relates/builds on previous strategies and plans, and key gaps of the implementation or performance of the previous strategies ad plans
- What value will the strategy add to current/ongoing efforts

RATIONALE

- Why a Technical Working Group is needed

OVERALL OBJECTIVE

- Develop and adopt a national adolescent health strategy, and its costed implementation plan

SPECIFIC TASKS

- Ensure buy-in and commitment to the whole process from key stakeholders including representation from key sectors and adolescents
- Ensure that the principles of adolescent meaningful participation are upheld, and good practices followed, during the entire process of strategy development throughout the M&E process and implementation, and that adolescents are involved at various levels of decision making (national, district, local) (see also Handout No.7)
- Oversee and facilitate the process of needs assessment, landscape analysis, national prioritization, programming, and developing a monitoring and evaluation framework for the strategy
- Secure funding for the entire process of development of the national adolescent health strategy
- Contract and provide ongoing support to the national consultant
- If external technical assistance is required, secure support from the relevant partners

MEMBERSHIP

- Focal point(s) in the ministry of health for child, adolescent and school health and other key areas (e.g. immunizations, primary care, HIV, NCDs)
- Representatives of other key sectors (e.g. education, financing, social protection, roads and transport, youth and sports, telecommunications, housing and urban planning, energy, water and sanitation, environment, criminal justice)
- Adolescents and youth
- Health service providers and their representative organizations
- Academia
- UN agencies
- Civil society organizations

GOVERNANCE/ INTERACTION WITH KEY SECTORS AND SUBNATIONAL AUTHORITIES

- Reporting lines
- Communication with other sectors
- Communication with subnational authorities

DURATION AND TIMELINE

- Based on experiences in AA-HA! early adopter countries, this process might take between 10-12 months

- See the AA-HA! guidance, main document, section 5.3 to direct members of the TWG on key principles and good practices in adolescent meaningful participation

Annex A.2. Terms of Reference for national consultant to support the process of developing a national adolescent strategy

Outline Terms of Reference for national consultant to support the process of developing a national adolescent strategy

BACKGROUND

- Brief overview of global, regional and national commitments in adolescent health and development
- Brief overview of the health situation of adolescents in the country: demography, mortality, morbidity, health-related behaviours and social determinants. Explain why there is pressure to invest in adolescent health

RATIONALE

- Why the need for an adolescent health strategy?
- How the strategy relates/builds on previous strategies and plans
- What value will the strategy add to current/ongoing efforts ?

OVERALL OBJECTIVE

To facilitate the process of needs assessment, landscape analysis, national prioritization, programming, and developing a monitoring and evaluation framework for the national adolescent health strategy and its implementation plan.

DELIVERABLES

- Stakeholders mapping plan
- Draft report on needs assessment and landscape analysis, validated by key stakeholders
- Report from the national prioritization, programming and M&E workshop
- Draft strategy and its implementation plan, validated by key stakeholders

DURATION AND TIMELINE

Based on experiences in AA-HA! early adopter countries, the process of developing national strategies and plans might take between 10-12 months

GOVERNANCE/ MANAGEMENT OF CONSULTANCY

- Reporting lines
- Interactions with the TWG

QUALIFICATIONS AND EXPERIENCE

- Post graduate degree (e.g. in medical sciences, public health, social sciences or equivalent)
- Experience in developing adolescent and youth health policies, strategies in developing countries
- Experience in developing M&E plans in developing countries.
- Experience in working with government officials, donors, youth and civil society and able to interact with a variety of stakeholders at different levels;
- Strong analytic, writing and communication skills
- Fluency in required language(s)

BUDGET AND REMUNERATION

Based on qualifications and estimated number of days

In Rwanda, a consultant was contracted in 2019 to support the Reproductive, Maternal, Newborn and Child Health (RMNCH) Programme on the development of a comprehensive national strategy for adolescent health aligned with AA-HA! guidance and the WHO Flagship programme for adolescent health in the African Region.

The consultant will carry out the following activities:

1) Complete the baseline assessment tool including;
   a. Develop a situation analysis based on AA-HA! guidance and share it with the WHO/ MOH;
   b. Fill out the national situational analysis questionnaire with accurate and up-to-date information;
   c. Review current local ASRH, RH, Mental health, NCD guidelines, and other ADH documents from relevant ministries and map opportunities of harmonization with the AA-HA! Flagship initiative;
   d. Explore the role of each social Ministry to improve adolescent health;
   e. Produce a draft integrating all adolescent health services and related implementation plan;
   f. Produce a SWOT analysis for EACH of the innovations/interventions that could contribute to the integration /improvement of adolescent health from all social ministries.

2. Participate in stakeholders meeting to have a review of the baseline assessment with all components of adolescent health and all innovations/interventions in detail (including presenting results and co-facilitating and leading discussions as necessary).
3. Prepare final report on the stakeholder meeting with summary of the discussions, action points, and include this in the final version of the baseline assessment.

The consultant will report to FHP/WHO/Rwanda and to the Director of Clinical Services in the MOH, and will work in collaboration with WHO/Family Health Program/NPO and designated MOH focal point.

In Pakistan, an international consultant was contracted in 2019 for 25 days to work closely with a national consultant to support the process of conducting the adolescent situation health analysis and needs assessment, landscape analysis and prioritization to facilitate the development of national adolescent health strategic plan 2019-2025 applying the global AA-HA! implementation guidance.

Annex A.3. Terms of Reference for a consultant to support the process of costing the implementation plan of the national adolescent strategy

Outline Terms of Reference for a consultant to support the process of costing the implementation plan of the national adolescent strategy

BACKGROUND

- Brief overview of the health situation of adolescents in the country, and how the newly developed strategy aims to respond to these needs.

RATIONALE

- What value will be gained from having cost projections?
- How cost projections for the adolescent plan will link to the broader health sector cost and budget documents.
- How the cost projections will be used to generate funding for implementation.

OVERALL OBJECTIVE

Essential: estimate the financial cost of the national adolescent health strategy and its implementation plan, including overall cost, cost by health system blocks components and cost by strategy priorities.

Optional but desirable: costs are linked to different financing or budgetary mechanisms

DELIVERABLES

Cost projected for implementation plan, including:

- cost of providing drugs, supplies, medical equipment and diagnostics related to the proposed interventions;
- cost of programme management activities that facilitate the smooth and effective intervention delivery (e.g. advocacy & awareness, development & dissemination of guidelines, providers' training, IEC material development, supervision, monitoring and evaluation and research etc.);
- shared Health system costs (if applicable, depending on policy question and how the cost projections will be used): cost of human resource (wages and pre-service training costs), infrastructure (construction, maintenance, utilities, equipment, furniture and vehicles), logistics, and health information systems;

DELIVERABLES

- documented discussion around affordability and financing mechanisms;
- project the health impact or other benefits (optional).

It might be useful to sequence the deliverable by outputs throughout the process.

Output 1: A cost scoping document that confirms the details of actions to include as cost, and key informants. This document must be written based on the outcomes from the workshop of stakeholders for the national adolescent health strategy including the members of the TWG. It serves to ensure agreement from all parties on the scope of the costing, in particular the coverage and depth expected for each activity. This cost scoping document must be written in collaboration with the TWG or the lead person responsible for the development of the national adolescent health strategy. Depending on the policy context, it might be beneficial to consider more than one scenario that should be modelled – e.g., two or more scenarios that differ in level of ambition, or strategy focus.

Output 2: Costed implementation plan. This report must provide detailed cost estimates for each component of the implementation plan, including calculations and assumptions made. It should discuss methods used, providing citations for appropriateness where possible.

DURATION AND TIMELINE

Based on previous experiences in using the OneHealth Tool, a process which looks only at adolescent specific activities costing might require around 20 working days spread over about 3-4 months.

Below is an example of the sequence of activities:

Week 0 – consultant appointed;

Week 1 – discussions with the TWG /partners and MOH to agree of the scope of costing;

Week 2 – workshop of stakeholders for national strategy; write draft of cost scoping document (output 1) and submit to the MOH/partners;

Week 3 – receive feedback from stakeholders on draft cost scoping document. Revise and obtain approval from the MOH prior to proceeding with costing analyses;

Weeks 4-6 – perform costing estimation and analyses for all actions, working with MOH to determine parameters, assumptions, etc. Write draft of cost estimation analysis report (output 2) and submit to the MOH/ partners;

Week 7-8 – receive feedback from stakeholders on draft cost estimation analysis report. This should include sending the plan to WHO for review. Revise as necessary.

GOVERNANCE/ MANAGEMENT OF CONSULTANCY

- Reporting lines.
- Interactions with the TWG and key informants to gather costing data.

QUALIFICATIONS AND EXPERIENCE

Essential

- degree(s) in a health or economic field highly relevant to the nature of the work;
- demonstrable understanding of the development and content of national health policy documents and action plans;
- demonstrable experience with modelling cost; projections at state/provincial or national level
- strong writing skills in the required language with a clear, straightforward writing style;
- strong presentation and communication skills for achieving consensus amongst multiple stakeholders;
- familiarity with academic literature on health economics and available methods and tools (e.g, the OneHealth tool);
- research, analytical and summarising skills;
- appropriate IT/computer skills.

Desirable

- experience working with the MOH in the country;
- clear understanding of public health policy and response actions;
- clear understanding of M&E mechanisms and action plans for major health projects;
- experience working on adolescent health;
- hands-on experience with the implementation capacities and constraints of governments in developing countries, particularly low and middle income countries;
- experience with WHO or other international health bodies;
- master's degree or PhD in related field.

BUDGET AND REMUNERATION

The consultant is expected to undertake the following main tasks:

- Discuss and confirm the scope of the analyses, cost estimates, scheduling and details of the actions with MOH and collaborators. The scope will be determined initially from a workshop of stakeholders for national adolescent health strategy.
- Determine cost estimates for each of the strategic actions of the implementation plan of the national adolescent health strategy. A cost estimates report must be written, documenting the calculations, assumptions, etc.
- Discuss financing strategies, and possibly also projections of health impact.

The budget and remuneration will be based on qualifications and estimated number of days to complete the tasks.

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Annex B Handouts

HANDOUT No.1
General principles to facilitate group discussions

BEFORE THE START OF THE GROUP WORK

1. When registration is complete, the co-facilitators may quickly compare the preliminary group assignments to the list of individuals registered and present at the workshop. Participants may need to be added or moved to balance the groups. After the discussion of the goals and objectives, and while the participants are still together in plenary, explain the proposed membership of the groups and the rationale.
2. Divide the participants into groups with a facilitator assigned to each group. Then ask the participants to move into those groups by moving to different corners of the room or into breakout rooms.

AT THE BEGINNING

3. Restate the objectives of the group work, and the expected outcomes.
4. Remind participants how much time is allocated for the group work, and when the plenary will start.
5. Have the group select a note-taker to document the group's reflections and decisions and a rapporteur who will be ready to share these notes in plenary. These two roles may be assigned to the same person or to two different people. Decide if the reporting back will be done on a flip chart or using a Power Point presentation. Make sure you have the necessary logistics in place.
6. Depending on the task for the group work, participants might need time to get acquainted with resource materials. The group facilitator may allow time for participants to review relevant materials silently or may lead them through the materials.

ESTABLISH AND REINFORCE WORKING CULTURE

Some participants might be unfamiliar with participatory process. The group facilitator should observe and reinforce the following:

- staying engaged in activities and not using cell phones and looking at emails during group work;
- respecting everyone's right to speak and ensuring a balance in the members' contributions to discussions;
- encouraging the group to seek thoughts from young people.

Sometimes it may be useful for the group facilitator to have an individual discussion with a particular participant aside from the group to help facilitate the group's progress, or to ask the lead facilitator to do this. This may be needed, for example, to:

- address communication barriers that prevent certain participants from voicing their views in the group (such as a dominant participant, or a participant who is reticent to speak out in front of individuals who outrank them);
- discuss sensitive issues such as staff performance or relationships that participants may be unwilling to discuss in the group.

MONITOR TIME AND KEEP FOCUS

Often participants tend to include in the discussion issues that are beyond the group work's specific objectives, or they may start discussing topics that are planned for discussion later during the workshop. The following strategies might help the facilitator to monitor time and keep focus:

- reiterate the topic and specific objectives of the discussion;
- split the allocated time in segments, and decide what is to be achieved in each segment;
- For issues that are "off topic":
  - remind participants of the time when this subject will be discussed in the workshop, or if there is no such time planned;
  - acknowledge the importance of the topic, and be firm in stating that this will not be discussed in this workshop;
  - park important questions in a parking lot, and check with the lead facilitator the options available for addressing the topic.

HANDOUT No.2
Needs assessment

OBJECTIVES

By the end of the group work session, the group should have answered 3 questions.

1. What are the main health and development problems that adolescents in the country face (e.g. mental health, violence)? Discuss the type of data that are required for a needs assessment as outlined in the table below (mortality, morbidity, DALYs, QALYs, behaviours, social determinants – disaggregated by age (10-14 years, 15-19 years) and sex.
2. What are the key additional available sources of information that need to inform the needs assessment (e.g. Global Health Observatory data, survey reports, health reports, reports from research studies, etc.)? Which agencies/government sectors can provide these documents?
3. What are the data gaps? Discuss if all the types of data that were presented on the global and regional estimates are available at the country level? What needs to be done to fill data gaps?

INTRODUCTION

National adolescent health priority setting consists of 3 steps:

1 Needs assessment

To identify which conditions, health risks and social determinants have the greatest impact on adolescent health and development, both among adolescents in general and among those most vulnerable

2 Landscape analysis

Of existing adolescent health programmes, policies, legislation, capacity and resources within the country, as well as a review of current global and local guidance on evidence-based interventions

3 Setting priorities

Considering the urgency, frequency, scale and consequences of particular burdens, the existence of effective, appropriate and acceptable interventions to reduce them, the needs of vulnerable adolescents, and the availability of resources and capacity to implement or expand priority interventions equitably

This group work covers step 1, needs assessment. Guidance on this is given in Section 4.1 of the AA-HA! guidance, main document.

DISCUSSION POINTS

Participants should review the corresponding section of the background document, and with the 3 questions above in mind, discuss the following:

- main health issues and challenges affecting adolescents;
- adolescent behaviours most closely linked to these health challenges
- adolescent behaviours that could lead to health problems in the future (e.g. risk factors, including tobacco consumption, alcohol consumption, physical inactivity and poor nutrition);
- harmful practices affecting adolescents (e.g. levels of child marriage and female genital mutilation);
- sociocultural context of adolescents' lives, including risk and protective factors at various ecological levels (e.g. environmental, community, family, school, peers) and in different institutions (e.g. schools, health services and employment) that can influence risk; and
- influence of gender norms, roles and relations on the health of both girls and boys during adolescence;
- identify subgroups of adolescents who may be in the greatest need of services and programmes;
- who are the stakeholders, and what are the data sources, that can provide more information on gaps identified and need to be accessed to finalize the needs assessment?

- There is a risk that participants might discuss only issues they have data on and overlook issues where no national data exist or that the particular participants do not know. This risk is partially mitigated by dividing participants by areas so that for example mental health will be discussed because there is a specific mental health group. However, within mental health, if data on suicide exist but not on depression, the latter might be neglected. The role of the facilitator is to stimulate the discussion for all pertinent issues – if even to acknowledge the lack of data – using the AA-HA! guidance document as a reference for all the potentially important conditions.
- In the absence of data, participants may say that it is not possible to conduct a proper needs assessment. It is important to remind the participants that collectively they have the best available knowledge, and that their knowledge and experience can inform the process, while at the same time improvement of data should be included as a priority for the new plan.
- It is likely that participates will switch between discussing needs assessment and issues pertaining to landscape analysis. Remind participants that issues related to landscape analysis – e.g. existing programmes, laws, etc. – will be discussed in the next session.
- It is very likely that at this stage participants will try to prioritize problems (e.g. discussing the relative importance of addressing adolescent pregnancy or HIV). This too is premature. Remind participants that they should only map the needs, without trying to prioritize or choose between them, and that prioritization will be done at a later stage in the workshop.
- It is recommended that potential key informants are noted down so that other data sources can be accessed to provide more information on gaps identified to finalize the needs assessment.

HANDOUT No.3
Landscape analysis

OBJECTIVES

By the end of the session participants should be able to:

- Indicate the gaps in interventions that are currently recommended but not being delivered, or are not being delivered with sufficient quality or coverage.
- Indicate the key additional available sources of information that need to inform the landscape analysis (e.g. project's and programme's reports, etc.)? Which agencies/ government sectors can provide these documents?

INTRODUCTION

National adolescent health priority setting consists of 3 steps:

1 Needs assessment

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2 Landscape analysis

Of existing adolescent health programmes, policies, legislation, capacity and resources within the country, as well as a review of current global and local guidance on evidence-based interventions

3 Setting priorities

Considering the urgency, frequency, scale and consequences of particular burdens, the existence of effective, appropriate and acceptable interventions to reduce them, the needs of vulnerable adolescents, and the availability of resources and capacity to implement or expand priority interventions equitably

This group work covers step 2, landscape analysis. Guidance on this is given in Section 4.2 of the AA-HA! guidance, main document.

There are two types of gaps – things that are not being done at all, and things that are being done but are not being done with adequate quality and/or coverage. The first type of gap is identified by comparing what is currently being done with what is recommended. The second type is identified by determining problems or weaknesses in what is currently being done.

It is useful therefore to split this group work session into two parts.

PART I. GETTING ACQUAINTED WITH THE EVIDENCE-BASED INTERVENTIONS RECOMMENDED IN THE AA-HA! GUIDANCE

This group work session covers making participants familiar with evidence-based interventions recommended in the AA-HA! guidance for the key priority health areas and positive development. Evidence-based interventions are described in Section 3 of the AA-HA! guidance, main document.

For each of the health areas (e.g. NCDs), ask participants to read handouts 9 -16 summarizing evidence-based interventions that are taken from Section 3 of the Global AA-HA! guidance, main document.

In many countries where AA-HA! was applied, a common question was "What if we are currently delivering interventions that are not listed in the AA-HA!". The facilitator should state that AA-HA! synthesizes all we know to date regarding effective interventions. If an intervention is not in the guidance, it means one of the following: a) either there is not sufficient evidence for this intervention, or b) the evidence of effectiveness might exist somewhere but is not published, or c) there is evidence demonstrating the intervention is not effective (e.g. abstinence only programmes). In the case of a) – the country should critically consider if to continue directing limited resources into something that has not sufficient evidence. If b) – and the country is reluctant to discontinue the intervention because it seems to work, the country may consider planning a rigorous evaluation to prove that this is indeed the case. Finally, if c) – and there is evidence demonstrating the intervention is not effective, the country should consider abandoning the practice and readjusting the strategy.

A common example is youth centres. Youth centres have been popular for many years, and despite earlier literature reviews which did not identify youth centres as a cost-effective approach to promote the use of SRH services (clinical or non-clinical) by young people, they have continued to be used. A more recent rigorous systematic review of the literature on the effectiveness of youth centres concluded that overall, youth centres do not appear to be a cost-effective way

to increase the use of SRH services by young people, and a relatively expensive approach to increasing their empowerment.

PART 2: IDENTIFICATION OF POLICY AND PROGRAMMATIC GAPS BASED ON THE LANDSCAPE ANALYSIS

Let participants review the corresponding section of the background document, and discuss the following issues:

- Are the problems you identified in step 1 (needs assessment) covered to a sufficient extent in national plans and polices? What is the extent to which the national health plan integrates adolescents in its goals and programming?
- Are there specific laws or policies that may impede adolescents' access to health services?
- What are the existing interventions and programmes?
- What are the gaps in the delivery of programmes and services?
- Who are the key stakeholders and organizations involved in planning, managing, implementing and monitoring and evaluating these activities at the national and subnational level?
- What is the scale, scope, coverage and evidence of impact of existing adolescent health programmes in the country?
- How are interventions in relevant sectors targeted to reach particular groups of adolescents by age, sex, location, educational level and other socio-demographic variables?
- What is the level of funding to existing programmes and how are the available funds allocated? Are currently-funded activities aligned with the evidence-based practices recommended in the AA-HA! guidance (see Section 3 of the AA-HA! guidance, main document)?
- Are youth involved in the design, implementation and monitoring of the specified programmes?
- What supply and demand barriers to access quality services and financial protection are experienced by adolescents?
- What are the gaps (e.g. interventions that are currently not delivered but are recommended in the AA-HA! guidance)?
- Who are the stakeholders, and what are the data sources, that can provide more information on gaps identified and need to be accessed to finalize the landscape analysis?

- There is a risk that participants will discuss only laws, policies and initiatives pertinent to the health sector (i.e. because most of them are likely to represent the health sector). The role of the facilitator is to remind participants that the landscape analysis is about mapping the efforts of sectors that are relevant, hence the importance of having representatives from these sectors present, or subsequently involved in the completion of the analysis.
- It is recommended that existing programme reports as much as possible during the workshop. Inputs from the workshop are only summarized in key terms, therefore details of programmes can be missed out (e.g. scale, scope and coverage of programmes, especially at subnational level, as well as evidence of their impacts). These reports will need to be consulted or accessed later, and their findings reflected in the updated landscape analysis.
- It is suggested that notes are taken of the potential key informants, in case more details are needed on the existing programmes.
- Handouts 9 – 16 need to be available for each participants' review and reference.

HANDOUT No.4
National prioritization

OBJECTIVES

By the end of the session participants should be able to:

- Understand criteria to prioritize health priorities and interventions.
- Apply these criteria to start identifying key health priorities for the national adolescent health strategy.
- Prioritize interventions for ***one*** health priority.
- Feel confident to apply the prioritization criteria to finalize national prioritization after the first national AA-HA! workshop.

- The time allocated to this session, 1 h 45 min, is not sufficient to start ***and*** finalize national prioritization for all interventions across all areas. It is important therefore to explain participants that the purpose of the group work is to understand the methodology to be used and start the work. The national prioritization will need to be finalized by the TWG after the workshop.
- Another reason why national prioritization will need to be finalized after the first national AAHA! workshop, is because the background document prepared by the consultant is usually incomplete. The group work on needs assessment and landscape analysis, as explained above, aims to use participants' insights to suggest additional sources that might complete the picture. The TWG will therefore need to go back to retrieve new data, and only then finalize the prioritization of health interventions.

INTRODUCTION

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3 Setting priorities

Considering the urgency, frequency, scale and consequences of particular burdens, the existence of effective, appropriate and acceptable interventions to reduce them, the needs of vulnerable adolescents, and the availability of resources and capacity to implement or expand priority interventions equitably

This group work covers step 3, setting national priorities. Guidance on this is given in Section 4.3 of the AA-HA! guidance document.

A priority setting exercise considers the high-priority adolescent conditions and populations identified in needs assessment, and the evidence-based and feasible interventions and delivery mechanisms to address them, as identified in landscape analysis. Prioritization of both key issues and interventions is therefore necessary.

PART I. SELECTING HIGH-PRIORITY ADOLESCENT HEALTH AREAS

In this part of the group work, participants will use the outputs of the previous group work on needs assessment and landscape analysis to identify priority health areas for action (e.g. SRH, Mental health, Violence) based on national (and potentially subnational) data on the main causes of ill-health and future burden of disease, the availability of (cost-) effective interventions for those issues, and gaps or weaknesses in the existing response. Ask participants to apply the criteria listed in the Table 1 below to prioritize areas/key problems.

Table 1	
Criteria to prioritize areas/key problems:	
Criteria	**Explanation**
Magnitude and public health importance of the problem	Resources should be directed at the main causes of death and illness or injury, but, using a life-course approach, should also go beyond them to address risk behaviours and exposures that could affect adolescents' health now and, in the future, and strengthen positive adolescent development (e.g. resilience, connectedness, etc)
The size of the population affected	Considerations, such as the proportion of adolescent population affected by the problem, might help with prioritization.
Availability of effective interventions	Are interventions for the problem identified listed in the AA-HA! guidance? If not, are there other sources that the country team may rely upon to select interventions for the given problem?
Feasibility of delivering the intervention(s) in the context of the country	Social, economic and cultural constraints, including lack of recognition of adolescents' rights, may make it difficult to deliver certain interventions. Priority setting should be based on a careful and pragmatic analysis of the feasibility of delivering interventions proposed in the AA-HA! guidance at scale in the particular country context. Acceptability of the intervention by the communities and political support for it are important considerations when selecting interventions.
	• Participants might tend to discuss health area broadly (e.g. unintentional injuries) which is not helpful for prioritization. Unintentional injuries is a broad category that includes conditions that require different response (e.g. drowning, road traffic accidents, burns). The role of the facilitator is therefore to direct participants towards discussing the specifics, and prioritize not between large areas (e.g. unintentional injuries, mental health), but between more specific problems within areas (e.g. road traffic injuries, suicide). • The availability of effective interventions should be discussed irrespective of whether the country currently implements them or not. The question refers not to what the country is currently doing, but whether or not effective interventions have been recommended. • The facilitator should emphasise that the criterion of feasibility should not override other considerations, otherwise difficult and sensitive issues (e.g. those that may score low on political acceptance because of cultural contexts) will never be prioritized. • Handouts 9 -16 need to be available for each participants' review and reference • Facilitator needs to be familiar with the interventions and should be able to explain how each intervention works in which country and in what context
PART II. SELECTING INTERVENTIONS FOR EACH HEALTH AREA	To inform the strategy, the TWG will select interventions for each of the priority health areas that they have identified in Part I. However, in the first national AA-HA! workshop due to time constrains it is only necessary for the group to do this for ONE, or if they have time, TWO health areas. Give participants the following instructions: 1. Discuss the various criteria in Table 2 to ensure that every member of the groups is clear what is meant by each of the criteria. 2. Choose ONE intervention from ONE health area prioritized in Part I (e.g. graduated driving licencing to prevent road traffic injuries) 3. In Table 3, each member of the group should *individually* give a score from 1 to 5 to each criterion for this intervention, with a score of 5 meaning "fully meet the criteria" and score 1 meaning "does not meet the criteria". Individually, calculate the total score for each intervention.

PART II. SELECTING INTERVENTIONS FOR EACH HEALTH AREA

4. Compare the individual total scores for Intervention no. 1, and briefly discuss differences to arrive at a common understanding of how important this intervention is. Similar scores indicate convergence in opinion, therefore for an efficient use of time only important differences in scores should be discussed.
5. Repeat the same steps for the next intervention to prevent road traffic injuries (e.g. laws to reinforce seat-belt measures)
6. Enter the group's scores into Table 2.

After the group has completed the discussion of all potential interventions to prevent road traffic injuries, use the agreed scores to decide on the priority package of interventions for that priority health area.

- The scoring of interventions should be used as a basis for discussion, especially in situations where participants' scores diverge significantly, not as a recipe for a definite decision. Prioritization cannot be reduced to a mathematical exercise therefore the scores per see are useful to highlight differences in opinion, that can be subsequently explained or reconciled during the discussion.
- Facilitators need to be familiar with the interventions listed in handouts 9-16 and should be able to explain how each intervention works, in which country, and in what context

Table 2

Criteria	Explanation
Magnitude and public health importance of the issue the intervention addresses	Resources should be directed at the main causes of death and illness or injury, but, using a life-course approach, should also go beyond them to address risk behaviours and exposures that could affect adolescents' health now and, in the future, and strengthen positive adolescent development (e.g. resilience, connectedness, etc)
Equity – is the intervention likely to address the needs of vulnerable populations/ underserved groups?	All adolescents have health-related needs and can experience difficulties, but not all are equally vulnerable to health and social problems. Special consideration should be given to those interventions that are likely to address the needs of the adolescents who are most vulnerable and/or need them most
The effectiveness of the intervention(s)	It is important that scarce resources are used to deliver interventions that have the highest chance of effectiveness for the subpopulations of adolescents that need them the most. All interventions listed in Section 3 of the AA-HA! guidance are recommended by WHO and are known to be effective, but not all of them will address the issue in the specific country context with the same high impact. If you are currently implementing an intervention that is not listed in the AA-HA! guidance document, you should carefully review whether there is sufficient evidence of its effectiveness and cost-effectiveness to continue prioritizing it. The choice of interventions should be guided by the strongest available evidence on their effectiveness, and the impact they can make.
Feasibility of delivering the intervention(s)	Social, economic and cultural constraints, including lack of recognition of adolescents' rights, may make it difficult to deliver certain interventions. Priority setting should be based on a careful and pragmatic analysis of the feasibility of delivering each intervention at scale in the country context. Acceptability of the intervention by the communities and political support for it are important considerations when selecting interventions.
Potential to go to scale	A realistic comparison is required of the current capacity to deliver each intervention against the capacity that is necessary to deliver it with high-quality and good coverage. Strong government and community ownership and political will help drive scale-up. Costing exercises can inform overall resource needs, and how plans can be implemented in a phased approach.
Other criteria?	The group should consider whether any other locally important criteria need to be considered, such as religious or cultural considerations.

Table 3						
Scoring interventions						
Intervention	**Magnitude and public health importance of the issue the intervention addresses***	**Equity -is the intervention likely to address the needs of vulnerable populations/ underserved groups?**	**The degree of the effectiveness of the intervention**	**Feasibility of delivering the intervention (e.g. funds, infrastructure, personnel, acceptability, political support)**	**Potential to go to scale***	**Other criteria**
Intervention 1						
Intervention 2						
Intervention 3						
Etc.						

*For example, in violence prevention there are many interventions recommended, such as limiting access to weapons and limiting access to alcohol, among others. In different countries the magnitude of alcohol consumption and access to arms will be different. In a country where youth can relatively easily access weapons (guns, knives, etc.) this intervention will score high on this criterion, but in another context, it might score low. Similarly, in Muslim cultures limiting access to alcohol will score low because there is already limited access

**In thinking about potential to take the intervention to scale, have a 5-year time-frame in mind

HANDOUT No.5
Key areas for programming

OBJECTIVES

By the end of the session participants should be able to

- Understand how to translate newly identified priorities into operational plans and activities
- Apply the AA-HA! logical framework for programming to propose activities for 2 interventions
- Understand how to plan integrated activities and services
- Feel confident to apply the logical framework for programming to propose activities for all priority interventions after the first national AA-HA! workshop

- The time allocated to this session, 2 hrs, is not sufficient to start ***and*** finalize programming for all interventions across all areas. It is important therefore to explain to participants that the purpose of the group work is to understand the methodology, and start the work. The programming will need to be finalized by the TWG after the workshop.
- Another reason why programming will need to be finalized after the first national AAHA! workshop, is because the final prioritization of key health issues and interventions will be finalized after the workshop, when needs assessment and landscape analysis are fully completed.

INTRODUCTION

As explained in the plenary, for each intervention to be delivered at scale, actions should be planned around adopting adolescent protective laws and policies; deciding on service delivery platforms; addressing weaknesses in workforce capacity; improving supply systems, technology and infrastructure; improving (health) management and information systems; engaging communities to build support for adolescents' use of services; establishing leadership and governance arrangements for implementation; and estimating resource needs and securing funding for national, district and local actions.

In this group work, participants will plan such actions for 2 interventions prioritized in the previous group work.

PART I. IDENTIFY ACTIONS IN KEY AREAS TO DELIVER INTERVENTIONS AT SCALE

Ask participants to select 2 interventions in each health area, and to identify the key activities that they need to plan to deliver these two interventions. Do this separately for each intervention. The logical framework in Section 5 of the AA-HA! guidance, main document, provides a useful check-list for the key areas for programming (Figure. 5.1, AA-HA! Guidance, main document). These were reproduced in the first column of Table 4 below. For each of these key areas for programming, the group should think what the implications are in relation to the selected intervention. Table 4 below provides an example.

Participants should repeat this for each intervention.

Table 4		
Guiding questions to facilitate programming		
Key area for programming	Questions to be asked in relation to the intervention	Proposed activities
Establish leadership and governance structure for implementation	Who will oversee that the intervention is being delivered? Is there a national programme that could be responsible for it? If yes, what needs to be done to ensure that this programme includes this intervention in its activities? If not, what needs to be done to ensure that governance arrangements exist for the implementation of this intervention?	For guidance, see section 5.2
Create mechanisms for adolescents' participation in governance, programme design, implementation, monitoring and evaluation	Are there mechanisms for meaningful youth participation at the national, subnational and local levels? What are the current structures, and how they can be improved to institutionalize adolescent participation in dialogues about relevant areas of public policy, financing and programme implementation? Is there legal awareness and literacy among adolescents about their rights under the Convention on the Rights of the Child? Are there procedures to ensure adolescent participation in health services, including in their own care?	For guidance, see section 5.3
Estimate resource need and secure funding for national, district and local actions	Are there resources available to deliver this intervention and to implement all the actions you have listed above? If not, what can be done to generate resources?	For guidance, see section 5.4.1
Adopt adolescent protective laws and policies	Is the legal and normative framework supportive to deliver this intervention? If not, what laws and policies need to be updated/ changed to support the intervention?	For guidance, see sections 5.5.1.1 (health sector) 5.6.1 (other sectors)
Address adolescent competencies in pre-service and continuous professional education in key sectors	Are the key cadres that are supposed to deliver the intervention sufficiently trained? Cadres may include health care professionals, and/or cadres from other sectors. If not, what actions need to be taken to improve workforce capacity?	For guidance, see section 5.5.1.2

Improve supply systems, technology and infrastructure	Is the infrastructure (e.g. health or education facilities), supply system and/or technology adequate to deliver the intervention? If not, what are the problems (e.g. quality? coverage?) and what needs to be done?	For guidance on quality see Section 5.5.1.3
Improve (health) management and information systems	Are the necessary data available? Is data disaggregated by age and sex, and wherever possible include other relevant stratifiers, e.g. education, rural/urban, to enable decision-making? If not, what are the problems and what needs to be done?	For guidance, see section 5.5.1.4
Plan for the readiness of service delivery platforms to deliver interventions	What are the most suitable settings or delivery platforms for the interventions you propose? Do these have the capacity to deliver with quality and ensure high coverage?	For guidance, see section 5.5.1.3
Implement participatory learning and action approaches to engage and empower adolescents, families and communities	Do you think there is sufficient acceptance on the part of the community for this intervention to be delivered to adolescents? If not, why is there resistance and what could be done to improve community support?	Cross-cutting issue – reflected in many evidence-based interventions across priority health areas in section 3

PART II. IDENTIFY OPPORTUNITIES FOR INTEGRATION

A critical consideration in national adolescent health programming is integrating services at the delivery level. For example, integrating treatment of one complaint with another from a broader assessment by using the HEADSS checklist (home, education, activities/employment, drugs, suicidality, sex) is an opportunity to provide a context for anticipatory guidance and preventive interventions. In another example, if HPV vaccination and deworming for schistosomiasis are identified as priorities during the national priority-setting exercise, then co-delivery of HPV vaccination and deworming could be considered. Integration of services is important both to maximize efficiency and to improve system responsiveness to adolescents' needs.

Integration of planned activities is also important. If you plan to strengthen the capacity of health workers, for example, in sexual and reproductive health and nutrition-related issues, consider what are the best modalities for delivering this training in an integrated way.

After participants have identified activities for each intervention, the group should reflect on opportunities for integration. The following format might be used to map the opportunities for integration (Table 5):

Table 5		
Mapping opportunities for integration		
Key area for programming	**Proposed activities for all interventions**	**Reflections**
Establish leadership and governance structure for implementation	Intervention 1: Activity 1 Intervention 1: Activity 2 Intervention 2: Activity 1 Intervention 2: Activity 2 Intervention 2: Activity 3 Intervention 3: Activity 1 Intervention 3: Activity 2 Etc.	Is there a possibility for all or some of the activities to be delivered as a package?
Create mechanisms for adolescents' participation in governance, programme design, implementation, monitoring and evaluation	Intervention 1: Activity 1 Intervention 1: Activity 2 Intervention 2: Activity 1 Intervention 2: Activity 2 Intervention 2: Activity 3 Intervention 3: Activity 1 Intervention 3: Activity 2 Etc.	Is there a possibility for all or some of the activities to be delivered as a package??
Estimate resource need and secure funding for national, district and local actions	Intervention 1: Activity 1 Intervention 1: Activity 2 Intervention 2: Activity 1 Intervention 2: Activity 2 Intervention 2: Activity 3 Intervention 3: Activity 1 Intervention 3: Activity 2 Etc.	Is there a possibility for all or some of the activities to be delivered as a package?
Adopt adolescent protective laws and policies	Intervention 1: Activity 1 Intervention 1: Activity 2 Intervention 2: Activity 1 Intervention 2: Activity 2 Intervention 2: Activity 3 Intervention 3: Activity 1 Intervention 3: Activity 2 Etc.	Is there a possibility for all or some of the activities to be delivered as a package?
Address adolescent competencies in pre-service and continuous professional education in key sectors	Intervention 1: Activity 1 Intervention 1: Activity 2 Intervention 2: Activity 1 Intervention 2: Activity 2 Intervention 2: Activity 3 Intervention 3: Activity 1 Intervention 3: Activity 2 Etc.	Is there a possibility for all or some of the activities to be delivered as a package?

Improve supply systems, technology and infrastructure	Intervention 1: Activity 1 Intervention 1: Activity 2 Intervention 2: Activity 1 Intervention 2: Activity 2 Intervention 2: Activity 3 Intervention 3: Activity 1 Intervention 3: Activity 2 Etc.	Is there a possibility for all or some of the activities to be delivered as a package?
Improve (health) management and information systems	Intervention 1: Activity 1 Intervention 1: Activity 2 Intervention 2: Activity 1 Intervention 2: Activity 2 Intervention 2: Activity 3 Intervention 3: Activity 1 Intervention 3: Activity 2 Etc.	Is there a possibility for all or some of the activities to be delivered as a package?
Plan for the readiness of service delivery platforms to deliver interventions	Intervention 1: Activity 1 Intervention 1: Activity 2 Intervention 2: Activity 1 Intervention 2: Activity 2 Intervention 2: Activity 3 Intervention 3: Activity 1 Intervention 3: Activity 2 Etc.	Is there a possibility for all or some of the activities to be delivered as a package?
Implement participatory learning and action approaches to engage and empower adolescents, families and communities	Intervention 1: Activity 1 Intervention 1: Activity 2 Intervention 2: Activity 1 Intervention 2: Activity 2 Intervention 2: Activity 3 Intervention 3: Activity 1 Intervention 3: Activity 2 Etc.	Is there a possibility for all or some of the activities to be delivered as a package?

- The programming for interventions that pertain to the mandate of other sectors should be led by those respective sectors.
- In the context of programming, adopting adolescent protective laws and policies means discrete normative or legal provisions such as the provisions for the age of consent, the policy for user fees at the point of service, etc., and ***not*** national policy documents (e.g. National Youth Policy). The facilitator needs to make this clarification to avoid confusion during the group work.

HANDOUT No.6

Selecting indicators, setting targets and monitoring and evaluation of the implementation of adolescent health strategies, plans and programmes

Principles for selecting indicators

In order to monitor progress in the implementation of adolescent health strategies and plans, measurable indicators should be selected. The following principles apply when choosing the indicators:

1. ***Indicators for monitoring and evaluation of the implementation of national adolescent health strategies, plans and programmes should be aligned with existing global and regional monitoring frameworks as much as possible.*** Most countries have signed up to the Sustainable Development Goals (SDGs) and the Global Strategy for Women's, Children's and Adolescents' Health (2016-2030), and incorporated targets of these strategies into their national health strategies. Through commitments to these initiatives, countries have indicated that they will work towards meeting globally agreed targets.

   As a first step, the TWG should revisit the existing global and regional monitoring frameworks, and identify indicators that are relevant to the national adolescent health strategy and plan. The key global and regional monitoring frameworks to be reviewed include:

   - Global indicator framework for the SDGs and targets of the 2030 Agenda for Sustainable Development (https://undocs.org/A/RES/71/313). SGDs' targets that specifically address adolescents, are summarized in Box 1.1 of the AA-HA! Guidance, main document.
   - Indicator and Monitoring Framework for the Global Strategy for Women's, Children's and Adolescents' Health (2016-2030) (http://www.who.int/life-course/publications/gs-Indicator-and-monitoring-framework.pdf). The Global Strategy lists 60 indicators, 43 of which are either adolescent-specific (e.g. adolescent mortality rate) or include adolescents (e.g. experience of sexual violence). The Global Strategy indicators related to adolescents are mapped in Table A6.1 in the AA-HA! Guidance, Annex 6.1.
   - Global Reference List of Health Indicators for Adolescents (Aged 10-19 Years) (http://apps.who.int/iris/bitstream/handle/10665/204625/WHO_MCA_15.3_eng.pdf)

Where available, regional indicator frameworks such as regional action plans or strategies endorsed by WHO Regional Committees, should also be reviewed.

2. ***Indicators for monitoring and evaluation of the implementation of national adolescent health strategies and plans should be aligned with indicators that have been used in the past in the country as much as possible, so that in-country trends can be tracked.***
3. ***Where possible, the full range of indicators – including inputs and processes, outputs, outcomes and impact – should be used to monitor the implementation of national adolescent health strategies, plans and programmes.***

   These different indicators answer different questions, and will enable countries to adjust implementation in a timely manner:

   - Input indicators measure human and financial resources, physical facilities, equipment, and operational policies that enable programme activities to be implemented.
   - Process indicators measure the activities carried out to achieve the objectives of a programme and include both what is done and how well it is done.
   - Output indicators measure the results of the processes in terms of service access, availability, quality and safety.
   - Outcome indicators measure intermediate results of programmes measurable at the population level.
   - Impact indicators measure long-term outcomes that programmes are designed to affect, including decreases in mortality and morbidity.

(Reference: Moller AB, Newby H, Hanson C et al. Measures matter: A scoping review of maternal and newborn indicators. PLoS One 13(10):e0204763)

Section 6 of the AA-HA! Guidance, main document, provides examples of indicators of all of these types to measure the extent to which a programme is supporting an adolescent-responsive national health system. In addition, examples of three specific intersectoral programmes (to reduce adolescent pregnancies, a school health programme and an adolescent mental health programme) are outlined to illustrate how countries can measure each of their inputs and processes, outputs, outcomes and impacts.

Possible data sources for adolescent health-related indicators at the national level are also outlined in Section 6, including those that address adolescent health outcomes; service availability, provision and readiness; policies, legislation and regulation; programme funding and resources; and processes available to support an adolescent health programme.

Principles for setting targets

A target can be defined as an intermediate result towards an objective that a programme seeks to achieve, within a specified time frame. A target is more specific than an objective and lends itself more readily to being expressed in quantitative terms (WHO Terminology Information System [online glossary] http://www.who.int/health-systems-performance/docs/glossary.htm)

The core indicators identified to measure progress of the selected national adolescent health programmes and interventions should have clear baselines and targets that are well documented, relevant and measurable. A schedule for updating and reporting should be specified (IHP+, WHO. Monitoring, evaluation and review of national health strategies: a country-led platform for information and accountability. Geneva; 2011).

Different types of targets can be defined:

- An absolute target reports a simple change in the level of an indicator (e.g. an increase of vaccination coverage from 70% to 85% in five years).
- A relative target reports a relative change that is independent of the initial value of the starting point (e.g. a reduction of the under-five mortality rate by one third). Relative target-setting is often used when baselines are uncertain.
- An annual rate of change is a third option for setting targets. For example, the target could require that the annual rate of change increases from 2% per year to 4% per year. However, this requires data on the baseline trend rather than just its level and is often hard to measure.

Target-setting should be based on criteria related to the level of aspiration and feasibility desired. While aspirational targets are sometimes chosen to be in line with international targets such as the Sustainable Development Goals (MDGs), in any individual country, it is more appropriate for planning purposes to set realistic targets that can be achieved within a given time frame and resource envelope. A rational selection of targets is based on computations that include the likely availability of funding, on how this can be translated into intervention access and coverage, and ultimately on health impact.

Principles for monitoring and evaluation

A certain degree of flexibility can be introduced in the periodicity of data collection for the core indicators. Some will not be expected to change rapidly so will require relatively infrequent data collection. Indicators that are particularly sensitive to change will require more detailed data collection programmes. The frequency of measurement and reporting needs to be specified.

- Input and output indicators can change rapidly and should be measured frequently (at least annually), in conjunction with monitoring of annual operational plans.
- Outcome indicators – intervention coverage and selected risk behaviours – should be reported every two years, though they may be reported annually if rapid changes are expected and appropriate measurement systems are available. Some coverage indicators can be obtained on an annual basis from the health facility reports.
- Impact indicators should be reported once or twice every five years, which is the average duration of a national health strategy. This longer interval reflects the fact that changes in impact do not occur rapidly, and measurement is more complex and often based on recall of events.

The monitoring and evaluation work in the context of the national health strategy should be linked with the national health information system (HIS) strategy and plan. A HIS strategy is broader than a monitoring and evaluation strategy, as it should cover all details of the institutional requirements and procedures required of

the different producers and users of health information system. It should also include the role of information and communication technology. A HIS plan provides specific goals and milestones, as well as the costs (IHP+, WHO. Monitoring, evaluation and review of national health strategies: a country-led platform for information and accountability. Geneva; 2011).

Different country scenarios and tips

Countries may be faced with different situations when it comes to target setting, depending on the national availability of information on specific indicators:

Baseline and trend information exist

For indicators where baseline and trend information exist, this information should be used to formulate targets. Past trends will need to be analysed carefully, in order to set realistic yet aspirational targets.

Baseline information exists, but no information on trends

For indicators where baseline information exists, but no information on trends, it is recommended to review the situation of other countries with similar contexts where more information is available and where set targets have been achieved.

No information on baseline or trends

Collection of baseline information will be required as a first step. In the absence of baseline information, the country will not be able to set targets.

HANDOUT No.7
Resources to plan Meaningful Adolescent & Youth Engagement

1. **PMNCH and others**. Global consensus statement on meaningful adolescent & youth engagement. https://www.who.int/pmnch/mye-statement.pdf
2. **United Nations Major Group for Children and Youth (UN MGCY).** Principles and Barriers for Meaningful Youth Participation. 2017.
3. **AIDS Alliance: Aiming High: 10 Strategies for Meaningful Youth Engagement** – This outlines and explains 10 key strategies for MYE.
4. **CHOICE for Youth and Sexuality: The A-Z of MYP: How to integrate Meaningful Youth Participation into your organization and program**, 2nd edition, January 2018 – This provides all the tips, tools and information necessary to conduct a three-day training on MYP, including draft resources and pull-outs. It has a notable Flower of Participation graphic which aids in understanding MYP easily. Additionally, it presents a series of checklists to help young people to measure the different elements of youth participation and develop graphs to represent how well agencies are engaging in MYP.
5. **DFID: CSO Youth Working Group, Youth Participation in Development: A Guide for Development Agencies and Policy Makers, 2010** – This document targets donor agencies and policy makers and the processes they employ for the engagement of young people. It outlines and displays the three-lens approach to youth participation and makes a case for why donors and policy-makers should engage with youth in a meaningful way. It explores policy frameworks and national policies and has a series of 20 case-studies exploring youth engagement issues in different countries and organisations. Additionally, it presents relevant resources including a youth scorecard template and a list of indicators from Youth Development Index.
6. **Advocates for Youth: Youth Participation Guide: Assessment, Planning, and Implementation** – This document targets organisational staff involved in implementing activities, and youth who may be engaged at all levels of an organisation. It has a series of pull-out handouts covering aspects of MYE which can be used in conducting trainings. Additionally, it has a youth-adult partnership training curriculum and accompanying slides, designed to build the skills of individuals and organizations to involve youth reproductive health (RH) and HIV/AIDS program design, development, implementation, and evaluation.
7. **IPPF: Setting Standards for Youth Participation** – This document was aimed at agencies engaging in planning their development work with young people. It highlights the continuum of youth participation and presents the advantages, disadvantages and some programmatic examples of aspects of the continuum. It also outlines 15 tips for good participation practice and has a series of self-assessment questions targeted at adults working with young people.
8. **IPPF & USAID: Forging Youth-Adult Partnerships on the Board, IPPFAR induction guide for board members** – This document targets Board members of IPPF highlighting methods through which young people can be integrated meaningfully. It has a series of activities and pull-outs to conduct a training session on MYE.
9. **IWHC: Ensuring Youth Participation in Sexual and Reproductive Health Policies and Programs: What we Know** – This has a brief but thorough summary of policy obligations, that are the series of commitments that have been made by governments to realise the right of young people to participation and decision making, including in SRHR programs. It also provides a comprehensive definition of youth participation.
10. **PMNCH/Women Deliver: Advocating for change for adolescents: A Practical Toolkit** – This document aims at engaging young people meaningfully in advocacy through providing practical information to guide the design, implementation and monitoring of advocacy action roadmaps.

11. **UNICEF: Adolescent and Youth Engagement Strategic Framework** – This highlights the distinction between participation and engagement and delineates the key principles that are necessary for AYE to be effective, ethical, systematic and sustainable.
12. **USAID: Youth Engagement in Development: Effective Approaches and Action-Oriented Recommendations for the Field** – This document has a thorough explanation of the Hart's Ladder of Participation and a series of action-oriented approaches to youth engagement.
13. **WHO/UNAIDS/UNESCO/UNFPA/UNICEF/UN Women/World Bank/PMNCH/EWEC: Global AA-HA! (Accelerated Action for the Health of Adolescents). Guidance to Support Country Implementation** – This set of documents aim to give countries evidence-based guidance as they decide what they will do for adolescent health and how they will do this. Throughout them, they reinforce the importance of meaningful adolescent and youth engagement.
14. **Women Deliver: A Discussion Paper on Meaningful Youth Development** – This provides a comprehensive definition of Meaningful Youth Engagement and explored key elements, which was achieved through a widespread, multi-layered consultation about youth engagement. It also highlights the major barriers to young people's engagement in SRHR advocacy.
15. **World YOUTH Report: Chapter 10: Youth Participation in Decision-making** – This highlights the benefits of youth participation and the consequences of failing to give young people a voice, identified models of youth participations and itemizes a list processes which young people can be engaged.
16. **Youth Coalition & CHOICE for Youth and Sexuality: A step by step guide to creating sustainable youth-led organisations working on Sexual and Reproductive Health and Rights** – This document is a guide which tackles the establishment and sustainability of youth-led organizations on SRHR. It clearly shows key lessons in ensuring organizational sustainability and identifies challenges and strategies to overcome them. It also identifies additional resources for young people interested in creating, maintaining or strengthening youth-led SRHR organizations.

HANDOUT No.8
Next steps

Objectives At the end of the session participants will:

- Plan the steps that will need to occur to finalize the national adolescent health strategy.
- Indicate the need for technical assistance.

Planning next steps Ask participants to propose next steps using the format below

ACTIVITIES	WHO WILL BE IN CHARGE?	WHAT STAKEHOLDERS NEED TO BE INVOLVED?	HOW WILL IT BE DONE?	WHAT IS THE TIMEFRAME?	WHAT TECHNICAL SUPPORT WILL BE REQUIRED?
Establishing governance mechanism for the strategy					
1					
2 etc					
Financing and costing of the implementation plan					
1					
2 etc					
Ensuring adolescents are involved					
1					
2 etc					
Finalizing needs assessment and landscape analysis, prioritization and programming					
1					
2 etc					
Developing a M&E plan					
1					
2 etc					

HANDOUT No.9

AA-HA! interventions to prevent and mitigate unintentional injuries

AA-HA! interventions to prevent and mitigate road traffic injuries among adolescents

ECOLOGICAL LEVEL	INTERVENTION	FURTHER EXPLANATION
Structural	**Drinking age laws**	Raising the legal drinking age to 21 years reduces drinking, driving after drinking and alcohol-related crashes and injuries among youth.
	Blood alcohol concentration laws	Set a lower permitted blood alcohol concentration limit (0.02 g/dl) for young drivers than recommended for older drivers (0.05 g/dl). Enforce blood alcohol concentration limits, e.g. random breath testing of all drivers at a certain point, or only those who appear to be alcohol-impaired.
	Seat-belt laws	When laws requiring seat-belt use are enforced, rates of use increase, and fatality rates decrease. Although most countries now have such laws, half or more of all vehicles in LICs lack properly functioning seat-belts.
	Helmet laws	Create mandatory helmet laws for two-wheeled vehicles and enforce them. Establish a required safety standard for helmets that are effective in reducing head injuries.
	Mobile phone laws	There is little information on the effectiveness of these relatively new driving interventions. However, 142 countries prohibit the use of hand-held phones, 34 prohibit hands-free phones and 42 prohibit text messaging.
	Speed limits	Roads with high pedestrian, child or cyclist activity should allow speeds no higher than 30 km/h. Limits should be enforced in such a way that drivers believe there is a high chance of being caught if they speed.
	Restriction of young or inexperienced drivers	A graduated licensing system phases in young driver privileges over time, such as first an extended learner period involving training and low-risk, supervised driving; then a licence with temporary restrictions; and finally a full licence (e.g. Case study 2 in the AA-HA! guidance, main document).
	Restriction of availability of alcohol to young drivers	Reducing hours, days or locations where alcohol can be sold, and reducing demand through appropriate taxation and pricing mechanisms, are a cost-effective way to reduce drink driving among young people.
	Legal disincentives to drive unsafely	Make unsafe behaviour less attractive, e.g. give penalty points or take away licences if people drive while impaired.
Environmental	**Traffic calming and safety measures**	Examples include infrastructural engineering measures (e.g. speed humps, mini-roundabouts or designated pedestrian crossings); visual changes (e.g. road lighting or surface treatment); redistribution of traffic (e.g. one-way streets); and promotion of safe public transport.
Organizational	**Pre-hospital care**	Standardize formal emergency medical services, including equipping vehicles with supplies and devices for children as well as adults. Where no pre-hospital trauma care system exists: teach interested community members basic first aid techniques; build on existing, informal systems of pre-hospital care and transport; and initiate emergency services on busy roads with high-frequency crash sites.
	Hospital care	Improve the organization and planning of trauma care services in an affordable and sustainable way to raise the quality and outcome of care
	Rehabilitation	Improve services in health-care facilities and community-based rehabilitation to minimize the extent of disability after injury, and help adolescents with persistent disability to achieve their highest potential.

ECOLOGICAL LEVEL	INTERVENTION	FURTHER EXPLANATION
Community	**Alcohol campaigns**	Make drinking and driving less publicly acceptable; alert people to risk of detection, arrest and its consequences; and raise public support for enforcement.
	Designated driver campaigns	Designated drivers choose not to drink alcohol so they may safely drive others who have drunk alcohol. Such initiatives should only be targeted at young people over the minimum drinking age, so as not to promote underage drinking.
	Seat-belt campaigns	Public campaigns about seat-belt laws can target adolescents to increase awareness and change risk-taking social norms.
	Helmet campaigns	Educate adolescents about the benefits of wearing helmets on two-wheeled vehicles, using peer pressure to change youth norms regarding helmet acceptability and to reinforce helmet-wearing laws.
	Community-based projects	Community projects can employ parents and peers to encourage adolescents to wear seat-belts.
Individual	**Helmet distribution**	Programmes that provide helmets at reduced or no cost enable adolescents with little disposable income to use them. Distribution can be taken to scale through the school system.
	Motorized two-wheeler interventions	Promote use of daytime running lights; reflective or fluorescent clothing; light-coloured clothing and helmets; and reflectors on the back of vehicles to reduce injury.
	Cyclist interventions	Promote front, rear and wheel reflectors; bicycle lamps; reflective jackets or vests; and helmets to reduce injury.
	Pedestrian interventions	Promote white or light-coloured clothing for visibility; reflective strips on clothing or articles like backpacks; walking in good lighting; and walking facing oncoming traffic to reduce injury.

Sources: (118); (168); (250).

AA-HA! interventions to prevent drowning

INTERVENTIONS TO PREVENT DROWNING	
Strategies targeting the general population	Improved community infrastructure (e.G. Barriers to water supply, bridges and levees)
	Installing barriers controlling access to water
	Teaching school-aged children basic swimming, water safety and safe rescue skills (i.E. Implement a survival swimming curriculum)
	Training community members in safe rescue and resuscitation
	Strengthening public awareness of adolescent vulnerability to drowning (because they tend to be less supervised than small children and are more likely to consume alcohol and engage in other risky behaviour around water).
Appropriate policies and Legislation	Setting and enforcing safe boating, shipping and ferry regulations;
	Building resilience and managing flood risks locally and nationally
	Coordinating drowning-prevention efforts with those of other sectors and agendas
	Developing a national water safety plan

HANDOUT No.10

AA-HA! interventions to promote positive adolescent development

Interventions to promote positive adolescent development

ECOLOGICAL LEVEL	INTERVENTION	FURTHER EXPLANATION
Structural and organizational	**Adolescent-friendly health services**	Health-care should be accessible and acceptable, promote health literacy and provide an appropriate package of services, including routine, age-appropriate appointments (e.g. vaccinations). Adolescent-friendly sexual and reproductive health (SRH) services are especially important, as stigma and discrimination prohibit adolescents from accessing them in many settings. Also see AA-HA! guidance, Annex A3.1.1.
	Health-promoting schools, including health education	Make every school a health-promoting school in line with WHO guidance. Skills-based health education, including comprehensive sexuality education (CSE), focuses on the development of knowledge, attitudes, values and life skills needed to make, and act on, the most appropriate and positive decisions concerning health. Also see AA-HA! guidance, Annex A3.1.2.
	Comprehensive school nutrition services	Establish and implement standards for meals provided in schools, or food and beverages sold in schools, which meet healthy nutrition guidelines. Implement school feeding programmes as needed. Also see AA-HA! guidance, Annex A3.1.2.
	School hygiene interventions	Of the many changes during puberty, the United Nations Education, Scientific and Cultural Organization (UNESCO) considers menstruation to have the most pronounced effect on the school attendance, quality and enjoyment of education. Ensure girls have the materials they need for menstrual hygiene management. Safe water and sanitation facilities include lockable, single-sex, private toilets with water and soap for washing, as well as a suitable private space where girls can dry wet menstrual cloths and/or a closed bin or incinerator for used menstrual pads (e.g. Case study 1). Also see AA-HA! guidance, Annex A3.1.2.
	Child online protection	Develop and implement a national strategy for child online protection, including a legal framework, law enforcement resources and reporting mechanisms, and education and awareness resources. Also see AA-HA! guidance, Annex A3.1.3.
	e-health and m-health interventions for health education and adolescent involvement in their own care	Explore the potential of adolescent e-health and m-health interventions focused on particular issues (e.g. chronic illness management; SRH education, such as STI prevention), and employing a variety of approaches (e.g. web-based learning, active video games, text messaging and mobile phone or tablet software programme apps). Also see AA-HA! guidance, Annex A3.1.3.
	Adolescent participation initiatives	Facilitation of adolescent participation includes involving them in programme design, implementation, governance and monitoring and evaluation. Also see AA-HA! guidance, Annex A3.1.3.

ECOLOGICAL LEVEL	INTERVENTION	FURTHER EXPLANATION
Community and interpersonal	**Interventions to promote the 5 Cs**	Interventions to promote adolescent competence, confidence, connection, character and caring involve diverse approaches, including those focused on (a) increasing adolescent resilience (e.g. mentoring); and (b) building knowledge, skills and resources (e.g. educational programmes for at-risk youth; vocational training). Also see AA-HA! guidance, Annex A3.1.3.
	Parenting or caregiver interventions	Work with parents to promote positive, stable emotional connections with their adolescent children, promoting connection, regulation, psychological autonomy, modelling and provision/protection. See guidance to health workers in non-specialized health settings on psychoeducation for parents to promote adolescent well-being AA-HA! guidance, (Section A3.7.1.1 in Annex 3). Parents can also be supported to communicate with their children about SRH, as a complement to school-based CSE. Also see section 3.7.
Individual	**HEADSSS assessment**	A HEADSSS assessment in primary care evaluates an adolescent's home, education, employment, eating, activity, drugs, sexuality, safety, suicidal thinking and depression status to prevent and respond to related concerns. Also see AA-HA! guidance, AA-HA! guidance, Annex A3.1.1.
	Brief, sexuality-related communication	Trained health workers should provide a brief, sexuality-related communication to promote adolescent sexual well-being, help them establish clear personal goals and address gaps between intention and behaviour. Also see AA-HA! guidance, Annex A3.1.1.

HANDOUT No.11
AA-HA! interventions for mental health

Interventions to prevent adolescent suicide

ECOLOGICAL LEVEL	INTERVENTION	FURTHER EXPLANATION
Structural and environmental	**Adoption of national mental health policies**	Related to suicide, these should focus on: strengthening effective leadership and governance; providing comprehensive, integrated and responsive services in community-based settings; implementing strategies for prevention; and strengthening information systems, evidence and research.
	Policies to reduce harmful use of alcohol	Policy options outlined in the 2010 WHO Global Strategy to Reduce the Harmful Use of Alcohol also support suicide prevention, including policies related to drink-driving and the marketing and availability of alcohol (102).
	Surveillance of suicide and suicide attempts	Sustainable and long-term surveillance of suicide cases, and hospital presentations due to suicide attempts and self-harm, provide critical information for prevention, intervention and treatment.
	Improved access to health-care	Adequate, prompt and accessible treatment for mental and substance use disorders can reduce the risk of suicidal behaviour. Implementing health-literacy policies and practices throughout health systems and institutions is also key.
	Restriction of access to means	Restriction includes legislation to limit access to pesticides, firearms and medications commonly used in suicide and safer storage and disposal of each, as well as environmental interventions to prevent suicide by jumping.
	Responsible media reporting	Media guidelines should stress: avoidance of detailed descriptions of suicidal acts; sensationalism; glamorization and oversimplification; use of responsible language; minimizing the prominence of suicide reports; and educating the public about suicide and available treatments.
	Electronic media strategies for service delivery	Online suicide prevention strategies include self-help programmes and professionals engaging in chats or therapy with suicidal individuals. Text messaging is an alternative, particularly when the internet is not accessible.
	Raising awareness about mental health, substance use disorders and suicide	Awareness-raising campaigns aim to reduce stigma and promote help-seeking and access to care. Different types of exposure (e.g. television, print media, the internet, social media and posters) can reinforce key messages. At the local level, awareness raising can target specific vulnerable populations.

ECOLOGICAL LEVEL	INTERVENTION	FURTHER EXPLANATION
Community and interpersonal	**Interventions for vulnerable groups with a higher risk of suicide**	These interventions should be tailored and targeted toward groups that are most at risk of suicide in particular settings. For example, interventions targeting lesbian, gay, bisexual, transgender and intersex (LGBTI) adolescents should focus on addressing risk factors such as mental disorders, substance abuse, stigma, prejudice and individual and institutional discrimination.
	Gatekeeper training	For people in a position to identify whether someone may be contemplating suicide (e.g. clinicians or teachers), gatekeeper training develops knowledge, attitudes and skills for identifying adolescents at risk, determining the level of risk and referring at-risk adolescents for treatment.
	Crisis helplines	Crisis helplines are public call centres that people can turn to when other social support or professional care is unavailable or not preferred. Helplines can be in place for the wider population or may target certain vulnerable groups, e.g. with peer assistance.
Individual	**Assessment and management of suicidal behaviours**	The 2016 WHO mhGAP intervention guide recommends assessing comprehensively everyone presenting with thoughts, plans or acts of self-harm (37). The guide recommends asking any person over 10 years of age who is experiencing a priority mental, neurological or substance-use disorder – or chronic pain or acute emotional distress – about his or her thoughts, plans or acts related to self-harm and suicide.
	Assessment and management of mental & substance use disorders	This involves training primary health-care workers to recognize depression and other mental and substance use disorders, and to perform detailed evaluations of suicide risk. Training should take place repeatedly over years and should involve the majority of health workers in a country.
	Follow-up and community support	Repeated follow-up by health workers for patients discharged after suicide attempts, and community support, are low-cost, effective interventions that are easy to implement. Follow-up can include postcards, telephone calls or brief in-person visits.

AA-HA! interventions for other mental health conditions

CONDITION	INTERVENTIONS
Developmental delays	Parental psychoeducation for an adolescent with developmental delay or disorder Care for children with developmental delays
Anxiety, depression, post-traumatic stress disorder	Psychosocial support and related services for adolescent mental health and well-being • treatment of emotional disorders such as depression and anxiety through: – Psychological interventions such as cognitive behavioural therapy, – interpersonal psychotherapy and – caregiver skills training • strengthening adolescents' emotional resilience and cognitive skills to avoid or to manage anxiety disorders • cognitive-behavioural therapy as an early intervention method to prevent post-traumatic stress disorder, • short-term cognitive workshops for those who have experienced a first panic attack

CONDITION	INTERVENTIONS
Depression	Universal interventions to prevent depression • school-based programmes focused on cognitive, problem-solving and social skills • community-based interventions to reduce child abuse, neglect and bullying
	Selective interventions with adolescents who are at relatively high risk of depression • interventions to help coping with major life events (e.g. parental death or divorce), or those seeking to block the transgenerational transfer of depression and related problems (e.g. adolescents with depressed parents).
	Indicated interventions for adolescents with elevated levels of depressive symptoms, but no depressive disorder • group work with at-risk adolescents to promote positive thinking, challenge negative thinking styles and improve problem-solving skills • anxiety prevention programmes
Behavioural disorders in adolescents	Parent skills training, as appropriate, for managing behavioural disorders in adolescents
Across conditions	Promote parenting skills to: • promote positive, stable emotional connections between parents and adolescents (e.g. to enhance adolescent self-esteem and social competence); • assist parents to establish rules, communicate expectations and learn to exercise consistent and effective monitoring of adolescent behaviours (e.g. to reduce adolescent risk-related sexual behaviour, substance use and delinquency); • assist parents to respect the individuality of adolescents and to avoid intrusive, manipulative and unduly controlling behaviours (e.g. to reduce adolescent antisocial behaviours); and • encourage parents to adopt attitudes and behaviours that are supportive of health (e.g. not smoking) while also reflecting supportive prevailing social norms (e.g. positively to influence adolescent behaviour).

HANDOUT No.12

AA-HA! interventions for substance use prevention, detection and management of hazardous and harmful substance use

Interventions to reduce adolescent tobacco use and exposure

ECOLOGICAL LEVEL	INTERVENTION	FURTHER EXPLANATION
Structural and environmental	**Reduce the affordability of tobacco**	Reduce affordability of tobacco products by increasing tobacco excise taxes.
	Ban tobacco advertising	Enforce comprehensive bans on tobacco advertising, promotion and sponsorship, including cross-border advertising, internet and social media. Also actively promote the entertainment media, cinema and drama as smoke-free.
	Smoke-free environments	Create bylaws ensuring completely smoke-free environments in all schools, recreational areas, indoor workplaces, public places and public transport.
Organizational and community	**Campaigns to raise awareness of the dangers of tobacco**	Conduct regular and effective mass-media campaigns to raise awareness of the dangers of tobacco.
	Tobacco prevention within school programmes	Integrate tobacco prevention within school policies, skills-based health education and health services. See Tobacco Use: An Important Entry Point for the Development of Health-Promoting Schools for age-appropriate knowledge, attitude and skills-building targets. In no circumstances should these programmes be implemented in collaboration with or funded by the tobacco industry.
Interpersonal and individual	**Guidance on stopping tobacco use**	Clinicians should encourage all non-smokers not to start smoking; strongly advise all smokers to stop smoking, and support them in their efforts; and advise individuals who use other forms of tobacco to quit. See Toolkit for Delivering the 5A's and 5R's Brief Tobacco Interventions in Primary Care for more specific guidance.

Interventions to prevent alcohol and drug use disorders and management of hazardous and harmful substance use

AREA	INTERVENTIONS
Prevention of alcohol and drug use disorders	• Mobilize communities to prevent the selling of alcohol to, and consumption of alcohol by, underage drinkers. • Develop and support alcohol-free environments, especially for youth and other at-risk groups. • Establish an appropriate minimum age for purchase or consumption of alcoholic beverages and other policies to prevent sales to, and consumption of, alcoholic beverages by those below the legal age, and introduce mechanisms for placing liability on sellers and servers. • Implement an effective and efficient system for taxation matched by adequate tax collection and enforcement, because young people are sensitive to changes in the price of drinks. • Protect young people from the content of alcohol marketing, particularly in LMICs where adolescents have currently a low prevalence of alcohol consumption and are being targeted as new markets. • Reduce the density of alcohol outlets and the hours or days when alcoholic beverages can be sold, because for young people such interventions are associated with decreased levels of alcohol consumption, assault and other harm such as homicide, self-inflicted injury and road traffic injuries. • mass-media drink-driving campaigns (with no enforcement); • placement of warning labels and signs, including on bottles; social marketing; • online education through social media and websites
Detection and management of hazardous and harmful substance use	• Assessment and management of different patterns of alcohol and drug use • psychoeducation for adolescent substance-use disorders • self-help groups and harm-reduction strategies. • Pharmacotherapy interventions, e.g. for management of withdrawal, continued treatment and relapse prevention

HANDOUT No.13

AA-HA! interventions for the prevention, detection and treatment of communicable diseases, including tuberculosis

DISEASE	INTERVENTIONS
TB	Targeting adolescents with TB vaccines
	Prevention of environmental risk factors, such as exposure to tobacco smoke or household air pollution
	Implement policies for the transition of adolescents from paediatric to adult TB services.
Other infections	Routine vaccinations, e.g. human papillomavirus, hepatitis B, diphtheria-tetanus, rubella, measles
Malaria	• argue for increased local, district and national support for malaria prevention interventions in schools; • develop supportive environments through vector control, house spraying and the use of long-lasting insecticidal bed nets; • modify and expand current health services to create more effective school health promotion programmes; • identify skills that young people need to develop and maintain behaviours that reduce their risk of infection; and • mobilize community action to implement and strengthen school programmes Teach adolescents simple but effective malaria prevention techniques, including: • always sleep under insecticide-treated nets; • control environmental factors conducive to mosquito breeding; • receive intermittent preventive treatment during pregnancy; • recognize symptoms of malaria and seek early treatment especially if a member of a risk group; • request effective antimalarial drugs and complete the treatment cycle; • learn at an early age the seriousness of malaria and the danger that the disease poses to health and individual well-being; and • use mosquito repellents, if available, and other locally recommended and available methods of personal protection screening and treatment, and intermittent preventive treatment
Lower respiratory infections	Reduce adolescent and general population exposure to indoor air pollution while meeting household energy needs and decreasing the amount of fuel needed. Measures include: • switching from wood, dung or charcoal to more efficient, modern and less polluting fuels; • locating a stove outside of a home or in a well-ventilated area; • ventilating cooking areas through the use of eaves and smoke hoods; and • changing behaviours, such as keeping children away from the smoking hearths, drying fuel wood before use, using lids on pots to shorten cooking time and improving ventilation by opening windows and doors.

DISEASE	INTERVENTIONS
Diarrhoeal diseases, general interventions	Collaborate with the WASH sector on intensive initiatives to raise awareness, advocate and ensure the improvement of WASH systems. This includes: • implementation of water safety plans and guidelines for drinking-water quality at a national level; • implementation of sanitation safety plans and guidelines for safe use and disposal of wastewater, greywater and excreta; • policies and programmes to promote the widespread adoption of appropriate hand washing practices; • effective and consistent application of household water treatment; • safe storage of household water; • increased access to basic sanitation at the household level (e.g. AA-HA! guidance, main document, Case study 6); and • improved sanitation in households (e.g. flushing to a pit or septic tank; dry pit latrine with slab; or composting toilet
Diarrhoeal diseases, targeted adolescent-specific WASH interventions	• safe water and sanitation facilities in schools; • health and hygiene education in schools, including food safety; and • immunization of adolescents against specific diarrhoeal diseases (e.g. typhoid and cholera) in select conditions, e.g. in affected urban slum or emergency settings.
Meningitis	• vaccinating all 1- to 29-year-olds in the African meningitis belt with the meningococcal A conjugate vaccine • prompt and appropriate case management with reactive mass vaccination of populations not already protected through vaccination
All infections	Early detection and management of communicable diseases

WHO recommendations on access to safe environment and hygiene

ECOLOGICAL LEVEL	IMPLEMENTATION CONSIDERATIONS	GUIDELINE TITLE (YEAR)	WHO RECOMMENDATIONS ON NUTRITION-RELATED POLICIES AND INTERVENTIONS FOR ADOLESCENTS
Community level	Improve access to safe water, sanitation and hygiene services, and practices to reduce the incidence of infections and improve nutritional outcomes Promote preventive chemotherapy, or the periodic large-scale administration of anthelminthic medicines to populations at risk, to dramatically reduce the burden of worms caused by soil-transmitted helminth infections	*Preventive chemotherapy to control soil-transmitted helminth infections in at-risk population groups* (2017)	• Preventive chemotherapy (deworming), using annual or biannual single-dose albendazole (400 mg) or mebendazole (500 mg), is recommended as a public health intervention for all young children (12–23 months), preschool (24–59 months) and school-age children living in areas where the baseline prevalence of any soil-transmitted infection is 20% or higher among children, in order to reduce the worm burden of soil-transmitted helminth infections. • Preventive chemotherapy (deworming), using annual or biannual single-dose albendazole (400 mg) or mebendazole (500 mg), is recommended as a public health intervention for all non-pregnant adolescent girls (10–19 years) and non-pregnant women of reproductive age (15–49 years) living in areas where the baseline prevalence of any soil-transmitted helminth infection is 20% or higher among non-pregnant adolescent girls and non-pregnant women of reproductive age, in order to reduce the worm burden of soil-transmitted helminth infection. • Preventive chemotherapy (deworming) using single-dose albendazole (400 mg) or mebendazole (500 mg), is recommended as a public health intervention for pregnant women, after the first trimester, living in areas where both: (i) the baseline prevalence of hookworm and/or *Trichuris trichiura* infection is 20% or higher among pregnant women, and (ii) anaemia is a severe public health problem, with a prevalence of 40% or higher among pregnant women, in order to reduce the worm burden of hookworm or *T. trichiura* infection.

HANDOUT No.14

AA-HA! interventions to promote healthy lifestyles, prevent and manage non-communicable diseases

WHO recommendations for healthy diets in adolescents

ECOLOGICAL LEVEL	ACTIONS AND IMPLEMENTATION CONSIDERATIONS	GUIDELINE TITLE (YEAR)	WHO RECOMMENDATIONS ON NUTRITION-RELATED POLICIES AND INTERVENTIONS FOR ADOLESCENTS
Macro (public policy) level	Develop food policies and standards Set clear definitions for the key components of food policies, thereby allowing for a standard implementation process Ensure government regulatory policies support healthier composition of staple foods	*Sugars intake for adults and children* (2015)	• WHO recommends a reduced intake of free sugars throughout the life course. • In both adults and children, WHO recommends reducing the intake of free sugars to less than 10% of total energy intake. • WHO suggests a further reduction of the intake of free sugars to below 5% of total energy intake.
		Potassium intake for adults and children (2012)	• WHO suggests an increase in potassium intake from food to control blood pressure in children aged 2–15 years. The recommended potassium intake of at least 90 mmol/day in adults should be adjusted downward for children, based on the energy requirements of children relative to those of adults.
		Sodium intake for adults and children (2012)	• WHO recommends a reduction in sodium intake to control blood pressure in children aged 2–15 years. The recommended maximum level of intake of 2 g/day sodium in adults should be adjusted downward based on the energy requirements of children relative to those of adults.

AA-HA! interventions to promote adolescents having healthy diets

ECOLOGICAL LEVEL	INTERVENTION	FURTHER EXPLANATION
Structural and environmental	**Nutrient profiles**	Develop and use nutrient profiles to identify unhealthy foods and beverages.
	Nutrient labelling system	Implement a standardized global nutrient labelling system; control the use of misleading health and nutrition claims; and implement mandatory front-of-pack labelling.
	Reduce affordability of unhealthy foods and beverages	Tax and increase the pricing of energy-dense, nutrient-poor foods and sugar-sweetened beverages.
	Reduce the impact of marketing of unhealthy foods and beverages	Reduce the impact of marketing of foods and beverages high in sugar, salt and fat. Establish cooperation between Member States related to cross-border marketing. Implement the Set of Recommendations on the Marketing of Foods and Non-alcoholic Beverages to Children.

ECOLOGICAL LEVEL	INTERVENTION	FURTHER EXPLANATION
Organizational and community	**Nutrition literacy campaigns**	Ensure that appropriate and context-specific nutrition information and guidelines are developed and disseminated in a simple, understandable and accessible manner to all.
	Healthy food environments in schools and other public institutions	Require settings frequented by adolescents (e.g. schools, childcare settings, children's sports facilities and events and youth workplaces) to create healthy food environments (e.g. AA-HA! guidance, main document, Case study 7).
	Improved access to healthy food	Improve the availability and affordability of healthy foods in public institutions and settings, particularly in disadvantaged communities.
	Campaigns to raise awareness of adolescent obesity	Campaigns should target policy-makers, medical staff and adults, adolescents and children in general, promoting capacity building related to adolescent obesity and its risk factors.
Interpersonal and individual	**Guidance on a healthy diet**	For example, clinical dietary guidance for older adolescents (18–19 years) includes: • Restrict salt to less than 5 g (one teaspoon) per day, reduce it when cooking, and limit processed and fast foods. • Restrict free sugars to less than 10% of total energy intake. A further reduction to below 5% or roughly 25 g (six teaspoons) per day would provide additional health benefits. • Have five servings (400–500 g) of fruit and vegetables per day. One serving is equivalent to one orange, apple, mango or banana or three tablespoons of cooked vegetables. • Limit fatty meat, dairy fat and cooking oil (less than two tablespoons per day); replace palm and coconut oil with olive, soya, corn, rapeseed or safflower oil; replace other meat with chicken (without skin).
	Weight management interventions for obese adolescents	Develop and support family-based, multicomponent, lifestyle weight management services for adolescents who are overweight (including nutrition, physical activity and psychosocial support). These should be delivered by multiprofessional teams as part of universal health coverage.

AA-HA! interventions to promote adolescent physical activity

ECOLOGICAL LEVEL	INTERVENTION	FURTHER EXPLANATION
Structural and environmental	**Urban planning policies**	Governments should partner with communities, the private sector and NGOs to develop safe spaces for physical activity and facilities for sports, recreation and leisure. Active transport policies should ensure that walking, cycling and other non-motorized transport are accessible and safe for all.
	School and public facilities	Adequate facilities should be available on school premises, youth workplaces and in public spaces for physical activity during recreational time for all adolescents (including those with disabilities), with the provision of gender-friendly spaces where appropriate.
Organizational and community	**Public awareness programmes on physical activity**	Provide guidance to children and adolescents, their parents, caregivers, teachers and health professionals on healthy body size, physical activity, sleep behaviours and appropriate use of screen-based entertainment.
	Physical education curricula in schools	A good physical education curriculum develops abilities and conditioning; provides activity for specific needs and to all children; encourages continued sports and physical activity into later life; and provides recreation and relaxation.
	Regular, structured sports activities	Regular, structured sports activities among adolescents strengthens the link between physical activity, sports and health, and reduces sedentary behaviours.
Interpersonal and individual	**Guidance on physical activity for younger adolescents**	Clinical guidance for adolescents aged 10–17 years recommends: • At least 60 minutes of moderate- to vigorous-intensity physical activity daily. • Amounts of physical activity greater than 60 minutes provide additional health benefits. • Most of the daily physical activity should be aerobic. Vigorous-intensity activities should be incorporated, including those that strengthen muscle and bone, at least three times per week.
	Guidance on physical activity for older adolescents	Clinical guidance for adolescents aged 18–19 years recommends: • At least 150 minutes of moderate-intensity aerobic physical activity throughout the week, or at least 75 minutes of vigorous-intensity aerobic physical activity throughout the week (or an equivalent combination of moderate- and vigorous-intensity activity). • Aerobic activity should be performed in bouts of at least 10 minutes duration. • For additional health benefits, increase moderate-intensity aerobic physical activity to 300 minutes per week, or engage in 150 minutes of vigorous-intensity aerobic physical activity per week, or an equivalent combination of moderate- and vigorous-intensity activity. • Muscle-strengthening activities should be done involving major muscle groups on two or more days a week.

WHO recommendations on micronutrients including fortification and supplementation in adolescents

ECOLOGICAL LEVEL	ACTIONS AND IMPLEMENTATION CONSIDERATIONS	GUIDELINE TITLE (YEAR)	WHO RECOMMENDATIONS ON NUTRITION-RELATED POLICIES AND INTERVENTIONS FOR ADOLESCENTS
Macro (public policy) level	Prevent and control iron deficiency and iron deficiency anaemia Prevent and control iodine deficiency disorders Reduce the risk of folic acid deficiencies and occurrence of births with neural tube defects Fortify staple foods such as flour with micronutrients Fortify condiments such as salt with appropriate fortificants	*Fortification of maize flour and corn meal with vitamins and minerals* (2016)	• Fortification of maize flour and corn meal with iron is recommended to prevent iron deficiency in populations, particularly vulnerable groups such as children and women. • Fortification of maize flour and corn meal with folic acid is recommended to reduce the risk of occurrence of births with neural tube defects.
		Fortification of food-grade salt with iodine for the prevention and control of iodine deficiency disorders (2014)	• All food-grade salt, used in household and food processing, should be fortified with iodine as a safe and effective strategy for the prevention and control of iodine deficiency disorders in populations living in stable and emergency settings.
		Optimal serum and red blood cell folate concentrations in women of reproductive age for prevention of neural tube defects (2015)	• At the population level, red blood cell folate concentrations should be above 400 ng/mL (906 nmol/L) in women of reproductive age, to achieve the greatest reduction of NTDs. • The above red blood cell folate threshold can be used as an indicator of folate insufficiency in women of reproductive age. Because low folate concentrations cannot explain all cases of NTDs, this threshold cannot predict the individual risk of having a NTD-affected pregnancy, and thus it is only useful at the population level. • No serum folate threshold is recommended for prevention of NTDs in women of reproductive age at the population level. Countries interested in using this indicator may consider first establishing the relationship between both serum and red blood cell folate and use the threshold value for red blood cell folate to establish the corresponding threshold in serum. • Microbiological assay is recommended as the most reliable choice to obtain comparable results for red blood cell folate across countries.
Community level	Prevent and control micronutrient deficiency among vulnerable groups Set distribution mechanisms to reach menstruating adolescent girls in areas where anaemia is a significant public health problem	*Daily iron supplementation in adult women and adolescent girls* (2016)	• Daily iron supplementation is recommended as a public health intervention in menstruating adult women and adolescent girls, living in settings where anaemia is highly prevalent (40% or higher prevalence of anaemia), for the prevention of anaemia and iron deficiency.
		Intermittent iron and folic acid supplementation in menstruating women (2011)	• Intermittent iron and folic acid supplementation is recommended as a public health intervention in menstruating women living in settings where anaemia is highly prevalent, to improve haemoglobin concentration and iron status and reduce the risk of anaemia in populations where the prevalence of anaemia among non-pregnant women of reproductive age is 20% or higher.

ECOLOGICAL LEVEL	ACTIONS AND IMPLEMENTATION CONSIDERATIONS	GUIDELINE TITLE (YEAR)	WHO RECOMMENDATIONS ON NUTRITION-RELATED POLICIES AND INTERVENTIONS FOR ADOLESCENTS
Community level	Prevent and control micronutrient deficiency among vulnerable groups Set distribution mechanisms to reach menstruating adolescent girls in areas where anaemia is a significant public health problem	*Daily iron supplementation in infants and children* (2016)	• Daily iron supplementation is recommended as a public health intervention in school-age children aged 60 months and older living in settings where anaemia is highly prevalent, for preventing iron deficiency and anaemia. • In malaria-endemic areas, the provision of iron supplementation in infants and children should be done in conjunction with public health measures to prevent, diagnose and treat malaria.
		Intermittent iron supplementation in preschool and school-age children (2011)	• Intermittent iron supplementation is recommended as a public health intervention in preschool and school-age children to improve iron status and reduce the risk of anaemia in settings where the prevalence of anaemia in preschool or school-age children is 20% or higher.
		Iron supplementation in postpartum women (2016)	• Oral iron supplementation, either alone or in combination with folic acid supplementation, may be provided to postpartum women for 6–12 weeks following delivery for reducing the risk of anaemia in settings where gestational anaemia is of public health concern.
		Use of multiple micronutrient powders for point-of-use fortification of foods consumed by pregnant women (2015)	• Routine use of multiple micronutrient powders during pregnancy is not recommended as an alternative to standard iron and folic supplementation during pregnancy for improving maternal and infant health outcomes.
		Vitamin A supplementation in postpartum women (2011)	• Vitamin A supplementation in postpartum women is not recommended for the prevention of maternal and infant morbidity and mortality.
Micro (individual) level	Treat anaemia among those diagnosed		• Follow national guidelines for the treatment of anaemia.

NTD, neural tube defect.

WHO recommendations on management of acute malnutrition

ECOLOGICAL LEVEL	IMPLEMENTATION CONSIDERATIONS	GUIDELINE TITLE (YEAR)	WHO RECOMMENDATIONS ON NUTRITION-RELATED POLICIES AND INTERVENTIONS FOR ADOLESCENTS
Micro (individual) level	All adolescents presenting with weight loss should be assessed for underlying causes and managed accordingly Offer nutritional counselling and information on optimal, healthy weight If available, enrol adolescents at risk of malnutrition in programmes where nutritional assessment, counselling and support are available An adequate diet, containing all essential macro- and micronutrients, is necessary for the well-being and health of all people, including those with tuberculosis or other infections. All people with active tuberculosis should receive tuberculosis diagnosis, treatment and care according to WHO guidelines and international standards of care	*Nutritional care and support for patients with tuberculosis* (2013)	• Management of severe acute malnutrition • School-age children and adolescents (5–19 years), and adults, including pregnant and lactating women, with active tuberculosis and severe acute malnutrition should be treated in accordance with the WHO recommendations for management of severe acute malnutrition. Management of moderate undernutrition • School-age children and adolescents (5–19 years), and adults, including lactating women, with active tuberculosis and moderate undernutrition, who fail to regain normal body mass index after 2 months' tuberculosis treatment, as well as those who are losing weight during tuberculosis treatment, should be evaluated for adherence and comorbid conditions. They should also receive nutrition assessment and counselling and, if indicated, be provided with locally available nutrient-rich or fortified supplementary foods, as necessary to restore normal nutritional status. • Pregnant women with active tuberculosis and moderate undernutrition or with inadequate weight gain should be provided with locally available nutrient-rich or fortified supplementary foods, as necessary to achieve an average weekly minimum weight gain of approximately 300 g in the second and third trimesters. • Patients with active multidrug-resistant tuberculosis and moderate undernutrition should be provided with locally available nutrient-rich or fortified supplementary foods, as necessary to restore normal nutritional status.

Other interventions for the prevention, detection and treatment of undernutrition and anaemia due to sickle-cell disease

Undernutrition in low-resource settings	• Address food insecurity, poverty (e.g. conditional cash transfers), • address causes, e.g. hygiene (e.g. handwashing promotion) and poor health (e.g. deworming and malaria-prevention or treatment). • school-based and community-based nutrition programmes in general adolescent populations; • case management of adolescent nutritional problems in routine health care; • prevention and management of severe malnutrition of adolescents in emergency situations School-based interventions such as: • offer many opportunities to promote healthy dietary patterns for children, including through health education; feeding programmes; • the physical environment; school health services; and community and family outreach
	Address causes associated with local context of undernutrition, e.g • malaria control in endemic areas (e.g. chemoprophylaxis/ intermittent preventative treatment, insecticide-treated nets and vector elimination); • early prevention interventions targeting adolescent girls, especially in areas with high adolescent birth rates and early marriages; • WASH interventions in order to reduce nutritional losses incurred by infection, and also to reduce inflammation; and • a baseline epidemiologic evaluation of both haemoglobin and iron indices in areas where haemoglobinopathies and other inherited red-cell disorders are likely to be prevalent, to establish the relative contributions of iron deficiency and non-iron deficiency to the overall burden of anaemia
Anaemia due to sickle-cell disease	The strategy identifies supportive activities for adolescents as a priority, including: • financial packages for case management • early diagnosis and treatment of complications • special transfusion regimens • surgery as needed • immunization • prophylactic antibiotics, folic acid and anti-malarials • special programmes for prenatal care, psychosocial and professional support • adaptive educational interventions.

HANDOUT No.15

AA-HA! interventions to promote SRH, preconception and antenatal nutrition, and prevent and manage HIV in adolescents

INTERVENTION	CHARACTERISTICS OF SUCCESSFUL PROGRAMME
Comprehensive sexuality education (CSE)	For each of the listed intervention, AA-HA! provides more information on characteristics of successful programmes (i.e. how to successfully implement CSE, etc.)
Information, counselling and services for comprehensive sexual and reproductive health, including contraception	
Prevention of and response to harmful practices, such as female genital mutilation and early and forced marriage	
Pre-pregnancy, pregnancy, birth, post pregnancy, abortion (where legal) and post abortion care	
Prevention, detection and treatment of sexually transmitted and reproductive tract infections, including HIV and syphilis	
Voluntary medical male circumcision (VMMC) in countries with generalized HIV epidemics	
Comprehensive care of children (including adolescents) living with, or exposed to, HIV	

WHO recommendations for the promotion of preconception and antenatal nutrition in adolescents

ECOLOGICAL LEVEL	ACTIONS AND IMPLEMENTATION CONSIDERATIONS	GUIDELINE TITLE (YEAR)	WHO RECOMMENDATIONS ON NUTRITION-RELATED POLICIES AND INTERVENTIONS FOR ADOLESCENTS
Community level	Ensure access to adolescent-friendly antenatal, maternity and newborn services Address delays in seeking and receiving appropriate maternal health care Ensure the availability of adolescent-friendly antenatal health services that are accessible, acceptable and appropriate for adolescents Expand availability of antenatal, childbirth and postnatal care to adolescents	*WHO recommendations on health promotion interventions for maternal and newborn health* (2015)	Birth preparedness and complication readiness • Birth preparedness and complication readiness interventions are recommended to increase the use of skilled care at birth and to increase the timely use of facility care for obstetric and newborn complications. Male involvement interventions for maternal and newborn health • Interventions to promote the involvement of men during pregnancy, childbirth and after birth are recommended to facilitate and support improved self-care of women, improved home care practices for women and newborns, improved use of skilled care during pregnancy, childbirth and the postnatal period for women and newborns, and increase the timely use of facility care for obstetric and newborn complications. • These interventions are recommended provided that they are implemented in a way that respects, promotes and facilitates women's choices and their autonomy in decision-making and supports women in taking care of themselves and their newborns. In order to ensure this, rigorous monitoring and evaluation of implementation is recommended. Partnership with traditional birth attendants • Where traditional birth attendants remain the main providers of care at birth, dialogue with traditional birth attendants, women, families, communities and service providers is recommended in order to define and agree on alternative roles for traditional birth attendants, recognizing the important role they can play in supporting the health of women and newborns. • Use of lay health workers, including trained traditional birth attendants, is recommended for promoting the uptake of a number of maternal- and newborn-related health-care behaviours and services, providing continuous social support during labour in the presence of a skilled birth attendant, and administering misoprostol to prevent postpartum haemorrhage. • Use of lay health workers, including trained traditional birth attendants, to deliver the following interventions is recommended, with targeted monitoring and evaluation: distribution of certain oral supplement-type interventions to pregnant women (calcium supplementation in women living in areas with known low levels of calcium intake; routine iron and folate supplementation in pregnant women; intermittent presumptive therapy in malaria in pregnant women living in endemic areas; vitamin A supplementation in pregnant women living in areas where severe vitamin A deficiency is a serious public health problem); and the initiation and maintenance of injectable contraceptives using a standard syringe.

ECOLOGICAL LEVEL	ACTIONS AND IMPLEMENTATION CONSIDERATIONS	GUIDELINE TITLE (YEAR)	WHO RECOMMENDATIONS ON NUTRITION-RELATED POLICIES AND INTERVENTIONS FOR ADOLESCENTS
Community level			Providing culturally appropriate skilled maternity care • Ongoing dialogue with communities is recommended as an essential component in defining the characteristics of culturally appropriate, quality maternity care services that address the needs of women and newborns and incorporate their cultural preferences. Mechanisms that ensure women's voices are meaningfully included in these dialogues are also recommended. Companion of choice at birth • Continuous companionship during labour and birth is recommended for improving women's satisfaction with services. • Continuous companionship during labour and birth is recommended for improving labour outcomes. Community mobilization through facilitated participatory learning and action cycles with women's groups • Implementation of community mobilization through facilitated participatory learning and action cycles with women's groups is recommended to improve maternal and newborn health, particularly in rural settings with low access to health services. • Implementation of facilitated participatory learning and action cycles with women's groups should focus on creating a space for discussion where women are able to identify priority problems and advocate for local solutions for maternal and newborn health. Community participation in quality-improvement processes • Community participation in quality-improvement processes for maternity care services is recommended to improve quality of care from the perspectives of women, communities and health-care providers. • Communities should be involved in jointly defining and assessing quality. Mechanisms that ensure women's voices are meaningfully included are also recommended. Community participation in programme planning and implementation • Community participation in programme planning, implementation and monitoring is recommended to improve use of skilled care during pregnancy, childbirth and the postnatal period for women and newborns, increase the timely use of facility care for obstetric and newborn complications and improve maternal and newborn health. Mechanisms that ensure women's voices are meaningfully included are also recommended.

ECOLOGICAL LEVEL	ACTIONS AND IMPLEMENTATION CONSIDERATIONS	GUIDELINE TITLE (YEAR)	WHO RECOMMENDATIONS ON NUTRITION-RELATED POLICIES AND INTERVENTIONS FOR ADOLESCENTS
Community level			Maternity waiting homes • Maternity waiting homes are recommended to be established close to a health facility where essential childbirth care and/or care for obstetric and newborn complications is provided to increase access to skilled care for populations living in remote areas or with limited access to services. Community-organized transport schemes • Community-organized transport schemes are recommended in settings where other sources of transport are less sustainable and not reliable. However, measures should be taken to ensure the sustainability, efficacy and reliability of these schemes while seeking long-term solutions to transport.
Micro (individual) level	Improve the use of antenatal, childbirth and postnatal care of pregnant adolescents Provide nutritional support during pregnancy	*WHO recommendations on antenatal care for a positive pregnancy experience* (2016) *Vitamin A supplementation in pregnancy for reducing the risk of mother-to-child transmission of HIV* (2011)	Maternity waiting homes • Maternity waiting homes are recommended to be established close to a health facility where essential childbirth care and/or care for obstetric and newborn complications is provided to increase access to skilled care for populations living in remote areas or with limited access to services. Community-organized transport schemes • Community-organized transport schemes are recommended in settings where other sources of transport are less sustainable and not reliable. However, measures should be taken to ensure the sustainability, efficacy and reliability of these schemes while seeking long-term solutions to transport.

HANDOUT No.16
AA-HA! interventions to prevent and respond to interpersonal violence

AA-HA! interventions to prevent youth violence

ECOLOGICAL LEVEL	INTERVENTION	FURTHER EXPLANATION
Structural	**Reduce access to and misuse of firearms**	Programmes may require new legislation, additional police to supervise implementation, public awareness campaigns and more elaborate monitoring systems.
	Reduce access to and the harmful use of alcohol	Regulate the marketing of alcohol to adolescents; restrict alcohol availability; reduce demand through taxation and pricing; raise awareness and support for policies; and implement interventions for the harmful use of alcohol.
	Financial incentives to attend school	Money is granted on a per-student or per-family basis, and is tied to 80% or higher school attendance. Grants may cover direct costs (e.g. school fees and supplies) and opportunity costs (e.g. when families lose income from child labour).
Environmental	**Spatial modifications and urban upgrading**	For areas with high levels of violence, situational crime prevention includes a security assessment, a stakeholder analysis, and a planning process involving communities, local government, and housing, transport and other sectors.
	Poverty de-concentration	These strategies offer vouchers or other incentives for residents of economically impoverished public housing complexes to move to less impoverished neighbourhoods.
	Hotspot policing	Police resources are deployed in areas where crime is prevalent. Mapping technology and geographic analysis help identify hotspots based on combined crime statistics, hospital emergency records, vandalism and shoplifting data and other sources.
Organizational	**Demand- and supply-side interventions for drug control**	Drug control may focus on reducing drug demand, drug supply or both. Most interventions require substantial technical capacity within health services and the police force.
	School-based bullying prevention	Teachers are trained to recognize and explain bullying to students, what to do when it occurs, effective relationship skills and skills for bystanders. Specialists work with students involved in bullying. School policies and procedures also may be established and parents may be trained.
Community	**Gang and street violence prevention interventions**	This may focus on reducing gang enrolment, helping members leave gangs and/or suppressing gang activities. Community leaders are engaged to convey a strong message that gang violence is unacceptable. Police involvement, vocational training, and personal development activities may also be included.
	Community- and problem-orientated policing	The systematic use of police-community partnerships and problem-solving techniques identifies and targets underlying problems to alleviate violence (e.g. Case study 3). Necessary preconditions are a legitimate, accountable, non-repressive, non-corrupt and professional policing system, and good relations between police, local government and the public.

ECOLOGICAL LEVEL	INTERVENTION	FURTHER EXPLANATION
Interpersonal	**Parenting programmes**	Goals are to promote parental understanding of adolescent development and to strengthen parents' ability to assist their adolescents in regulating their behaviour.
	Home visits	Home visiting programmes monitor and support families where there is a high risk of maltreatment (e.g. families living in highly deprived settings).
	Peer mediation	Peer mediators may be nominated by a class and receive 20–25 hours of training on how to mitigate peer conflicts and seek help if needed. Other students may also be trained in conflict resolution skills.
	Dating violence prevention	School-based or after-school participatory activities address the characteristics of caring and abusive relationships; how to develop a support structure of friends; communication skills; and where and how to seek help in case of sexual assault.
Individual	**Life-skills development and social and emotional learning**	These age-specific programmes help adolescents to understand and manage anger and other emotions, show empathy for others and establish relationships. They involve 20–150 classroom sessions over several years.
	After-school and other structured leisure time activities	Structured leisure time activities can include cognitive and academic skills development; arts, crafts, cooking, sport, music, dance and theatre; activities related to health and nutrition; and community and parental engagement.
	Academic enrichment	Adolescents are targeted through mass media, after-school lessons or private tutoring to help them keep up with school requirements and prevent them from dropping out of school.
	Vocational training	Vocational training for at-risk youth can have a meaningful impact on violence prevention if integrated with economic development and job creation. Ensure the capacity of training institutions, available technical equipment, existing cooperation with businesses and sustainable financing models.
	Mentoring	Volunteer mentors receive training on adolescent development, relationship-building, problem-solving, communicating and specific concerns (e.g. alcohol and drug use). A mentor shares knowledge, skills and perspective to promote an at-risk adolescent's positive development.
	Therapeutic approaches	Qualified mental health specialists or social workers work with individual adolescents on social skills and behavioural training, anger- and self-control techniques and cognitive elements (e.g. moral reasoning and perspective-taking to appreciate the negative impacts of violence on victims). Families and social networks of at-risk adolescents may also be targeted.

AA-HA! interventions for prevention and response to abuse to adolescents

INTERVENTIONS
Home visit programmes for at-risk families and training programmes for parents
Enhancement of professional training and education about the nature and impact of adolescent maltreatment
development and extension of prevention and treatment services for adolescent victims and their families
systems that better assess and intervene with maltreated adolescents
develop standards of health care and protection services for maltreated adolescents, e.g. standards for documentation of injuries; forensic assessment; psychosocial support; coordinated case management; court proceedings with adolescent witnesses; social service interventions with families; and alternative placements for adolescents

Prevention and response to sexual and other forms of gender based violence

	INTERVENTIONS
Early adolescents (10–14 years)	• interventions specifically for children exposed to such violence, such as psychological treatment to improve cognitive, emotional, and behavioural outcomes; • school-based training to help children recognize and potentially avoid sexually abusive situations; • school-based social and emotional skills development initiatives; • identifying and treating conduct and emotional disorders
Older adolescents (15–19 years)	• school-based programmes to prevent dating violence; • multicomponent violence-prevention programmes
All adolescents	• strategies to reduce access to and harmful use of alcohol; • interventions based on social norms theory and focused on changing social and cultural gender norms; • media-awareness campaigns; • targeted work with men and boys
Health services for adolescent survivors of sexual and/or intimate partner violence	• first-line support; • pregnancy testing and prevention (i.e. emergency contraception); • abortion services (to the full extent of the law), HIV prophylaxis, other STI prophylaxis and treatment of injuries; • mental health care in accordance with WHO guidelines; and • referral for other legal, psychosocial and shelter needs

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Annex C Case studies from countries

C.1 Belize

Developing an Adolescent Health National Strategic Plan for Belize: Country Experience and Lessons Learned

Belize is among the first countries globally to adopt the global guidance Accelerating Action for Health of Adolescents for development of a National Adolescent Health Strategic Plan. The process included a needs assessment that identified conditions with greatest impact on adolescent health and development. A comprehensive analysis and disaggregation of data contributed to the landscape analysis. An inventory of adolescent health programmes, policies, related legislation, capacity and resources was considered for the evidence-informed prioritization of interventions relevant for a national response.

The process adopted a participatory approach: two national and four district consultations with service providers and 233 adolescents reviewed the situation analysis of adolescent health as well as the first draft strategic plan. The consultations provided the opportunity for inputs from adolescents and services providers at both national and subnational levels.

The multi-agency and multi-sector collaboration was ensured throughout the entire process since planning. A three-day workshop with adolescents and service providers reviewed and validated the provisions (service packages) for adolescents, targeting priority areas identified earlier for improved adolescent health outcomes in Belize. Another workshop focused on defining the proposed provisions, potential interventions and collaboration opportunities.

The expected adolescent health outcomes reflected in key provisions will help them survive and thrive in a transformative environment in which they can realize their right to enjoy the highest attainable well-being. This human rights-based and life cycle approach enabled the planning of health response and improved investment in human capital development through seamless care, support, and services for positive transition to adulthood.

A link to the full story: https://spark.adobe.com/page/75Z3TpiUyN22V/

For further info, contact: Dr. Geffrey Nan Li nli@unicef.org, with Ms. Paulette Wade (pwade@unicef.org) and Dr. Susan Kasedde (skasedde@unicef.org) in cc.

C.2 Sudan

Sudan takes action to improve the health of its youth – AA-HA!

Globally more than 3000 adolescents die every day, totalling 1.2 million deaths a year. More than two-thirds of these deaths occur in low- and middle-income countries in Africa and South-East Asia. Road traffic injuries, lower respiratory infections, and suicide are the biggest causes of death among adolescents. But every country is different.

In Sudan more than 20% of the population are aged between 10 and 19 – these are the country's adolescents whose wellbeing is vital for healthy and sustainable future societies. However, many adolescents have little access to information about health and life-skills. In addition to deaths from road traffic injuries, violence and other injuries, there are high rates of sexually transmitted diseases, smoking is on the increase, and unhealthy eating habits result in poor nutrition or obesity. Knowledge of reproductive health and contraception is low, and early marriage frequently means early motherhood; childbirth complications are the leading causes of death among Sudanese girls aged 15 to 19 years.

Most adolescent deaths can be prevented with good health services, education and social support. But like many countries, Sudan's adolescents have been largely overlooked and are absent from national health plans. As important contributors to a country's development and growth, their neglect became a growing cause for concern.

"Adolescents face numerous health challenges that impact their ability to reach their full potential. Investing in adolescents will have a long-lasting impact on their health, and that of future generations," said Dr Amani El

Amin, Youth Health Unit, Federal Ministry of Youth and Sport. "This is why we have allocated a unit for Youth Health in our Ministry."

When WHO launched the ***Global accelerated action for the health of adolescents (AA-HA!): Guidance to support country implementation*** in 2017, Sudan took immediate steps to become an "early adopter"; it mobilized its partners nationwide and used the AA-HA! guidance to develop a robust national adolescent health strategy that would meet the needs of its youth.

The global AA-HA! guidance recommends actions by all sectors of society, including comprehensive sexuality education in schools; higher age limits for alcohol consumption; mandating car seat-belts and helmets through laws; reducing access to and misuse of firearms; reducing indoor air pollution through cleaner cooking fuels; and increasing access to safe water, sanitation, and hygiene.

Sudan applied the guidance to its own specific context. Led by the Directorate of Maternal and Child Health of Sudan's Federal Ministry of Health, it engaged the Ministries of General Education, Sport & Youth, Justice, Interior, and UN agencies – WHO, UNICEF, UNFPA, UNHCR and WFP- along with key civil society organizations – in a multi-sectoral effort to determine exactly who needs to do what to improve the health and wellbeing of Sudan's more than 8 million adolescents. Although much research is still needed, evidence-based effective interventions are available for countries like Sudan to act now.

"The AA-HA! process allowed us to engage with more partners and pull in more relevant specialized units within a particular sector. We learned so much about every aspect of adolescent health and the determinants of their wellbeing – that went way beyond health. AA-HA! helped us to organise our thoughts and be more thorough in our deliberations to identify the priority issues we needed to tackle in Sudan," stated Dr Manal Taha, Director of Child Health & Adolescents, Federal Ministry of Health.

Ensuring adolescent voices are heard

A country cannot develop an impactful adolescent health strategy without listening to the voices of its youth. Critical to the design, ownership and implementation of Sudan's adolescent health strategy was young people's engagement and participation in the process. The Youth Union of the national parliament was enlisted, and focus group discussions involving young men and women and vulnerable groups, shared their experiences of violence, substance abuse, mental health – among others – allowing decision-makers to tap into their unique perspectives and enhancing Sudan's understanding of adolescents' needs.

After months of intense sensitization and nationwide consultation driven by a high-level of political commitment, Sudan has finalised a plan to address the following priority areas: adolescent sexual and reproductive health; violence against adolescents; adolescent nutrition; unintentional injuries and the mental health of adolescents.

Good quality accessible services and adolescent-responsive policies

The plan includes the provision of adolescent-friendly services delivered through primary healthcare facilities, community outreach and schools; strengthening safety and rescue and first aid services for unintentional injuries especially as a result of traffic accidents; providing adolescent health awareness and training for health workers, and non-formal education for adolescents in life-skills, reproductive health and sexuality with a focus on the prevention of early "child" pregnancy; and, finally, offering counselling and psycho-social support to address mental health issues.

The National Strategy of Adolescent Health and Wellbeing 2018-2022 has ambitious targets which will need the same multi-sectoral effort that drove the development of the strategy if they are to succeed. Its targets include reductions in adolescent maternal deaths, reductions in the use of tobacco products by adolescents, and increases in the number of adolescents with valid health insurance cards.

Overall, the strategy aims to create a safe and supportive environment that offers protection and opportunities for healthy development, and the provision of much-needed health information and skills so that adolescents can understand and interact with the surrounding environment and society. This entails making good quality, accessible services to meet the needs of adolescents regardless of age, ethnicity, gender identity, disability, or socio-economic status.

Sudan's ***National Strategy of Adolescent Health and Wellbeing 2018-2022*** is now awaiting final government endorsement for anticipated implementation in the coming year. This is good news for Sudan, its adolescents and future generations to come.

C.3 Barbados

BARBADOS – meeting the health needs of its adolescents

Road traffic injuries, lower respiratory infections, and suicide are the biggest causes of death among adolescents. Globally more than 3000 adolescents die every day, totalling 1.2 million deaths a year.

Barbados, a small island in the Caribbean is defined as a high-income country, with an estimated population of 280,000 of which approximately 13.5% are adolescents – aged between 10 and 19 years.

Cultural influences, unhealthy diets and physical inactivity predisposes Barbadian adolescents to non-communicable diseases (NDCs), especially obesity and poor nutrition. Over 35% of girls aged between 13 – 15 years are overweight or obese, with 36% of adolescent boys and girls in that same age group drinking at least 2 or 3 sugary soda drinks every day. Other NDCs such as asthma, allergic disorders and diabetes are not only common, but difficult to manage in adolescents.

Engaging in risky sexual practices in Barbados increasingly starts from an early age. This leads to unintended pregnancy and sexually transmitted infections, including HIV. In 2011 the adolescent birth rate was 21.3 per thousand girls aged 15-19 year; over 12% of births occurred in women aged 19. In a survey of Barbadian women aged 15-19, 30% reported having sex with men ten years older than them. Most recent school surveys showed that other risky behaviours, such as alcohol and drug use, begin at age 14 years.

Over the last years Barbados has made huge efforts to provide adolescent services through a number of policy and strategy developments. However, without a dedicated and well-coordinated plan that includes all sectors, the myriad of youth programmes, projects and diverse providers has created fragmentation and stretched resources. The country's vital asset, it's young, do not have a comprehensive health strategy that addresses their well-being and offers targeted interventions that will help them develop into healthy and productive adults.

In addition, nearly half of the unemployed in Barbados (11.3%) are adolescents, and the current suboptimal economic development in Barbados has seen an increase in violence and gang crime. The main causes of adolescent deaths are largely preventable and include homicide, suicide, and traffic fatalities.

When WHO launched the ***Global accelerated action for the health of adolescents (AA-HA!): Guidance to support country implementation in 2017***, Barbados took immediate steps to become an "early adopter". It was the first country in the Caribbean to apply this approach to develop a comprehensive national adolescent health strategy that would meet the needs of its youth.

The global AA-HA! guidance recommends actions by all sectors of society, including comprehensive sexuality education in schools; higher age limits for alcohol consumption; mandating car seat-belts and helmets through laws; reducing access to and misuse of firearms; reducing indoor air pollution through cleaner cooking fuels; and increasing access to safe water, sanitation and hygiene.

Barbados applied the AA-HA! guidance to its own specific context. "We recognised that the solutions to adolescence health cannot only be championed by health care alone and will involve several agencies, including youth and sport, education, welfare, law enforcement and of course, the invaluable contributions from the non-governmental organisations and civil society." Acting Chief Medical Officer of Health (CMO), Dr. Kenneth George, 2017.

The Barbados Ministry of Health, supported by the Pan American Health Organisation (PAHO) engaged the Ministries of General Education, Sport & Youth, Justice, Interior, and UN agencies WHO and UNFPA, along with civil society organizations in a multi-sectoral effort to determine exactly who needs to do what to improve the health and wellbeing of the islands' adolescents.

With the guidance of the AA-HA! approach six priority areas were selected for the adolescent health strategy; positive development; violence, accidents and injury; sexual & reproductive health, including HIV; communicable diseases; non-communicable disease; and mental health, substance use and self-harm.

"We needed something that would respond to the changing demographics in Barbados, the economic down turns, globalization, environmental changes and the constant introduction of new communication technologies," said Dr.Kenneth George.

The resulting 10-year strategy targets the most at-risk adolescents by proposing the following actions:

- the provision of strategic information and innovation;
- creating enabling environments and developing evidence-based policies;
- building integrated and comprehensive health systems and services;
- enhancing human resource capacity;
- identifying family, community, and school-based interventions;
- forming strategic alliances and collaboration with other sectors;
- expanding social communication and media involvement.

Positive development

Positive development means creating an environment in which adolescents can thrive, are encouraged to seek help, and know where to go for support. Barbados plans to develop adolescent targeted messages and materials for communication and advocacy; use the internet and media to reach adolescents, key community members, parents and guardians; and ultimately design and provide adolescent friendly health services that can be delivered through health-promoting schools as well as developing parenting or caregiver interventions that directly address adolescents' needs.

Addressing violence and unintentional injuries

Addressing violence and unintentional injuries will require a top-down and grass-roots approach – engaging policy makers and key stakeholders to promote positive social norms, and empowering adolescents to cope with bullying and gang pressures. Barbados plans to enhance communication around violence, strengthen the capacity of the health and social protection systems to respond, develop programmes to mitigate age and gender-based violence, and collect data to better inform policy development. Interventions will include hotspot policing and demand for drug control, school-based bullying prevention, and the prevention of injuries.

Improving sexual and reproductive health in adolescents

Similarly, improving sexual and reproductive health in adolescents will be done by creating an enabling environment and strengthening legislation, policy development and implementation. Barbados plans to integrate and strengthen age appropriate comprehensive sexuality education programmes in schools and community-based settings, and implement a range of evidence based and effective interventions including the prevention of and response to harmful practices, such as transactional sex, intergenerational sex, and abuse.

Addressing communicable diseases

Communicable diseases such as hepatitis B, tetanus, rubella and vector borne diseases such dengue and salmonella were identified as highest among adolescents. Ensuring routine vaccination access, improving food safety, strengthening surveillance, health promotion, as well as actively engaging individuals and communities in prevention and detection of vector borne diseases are strategies that have been integrated into the plan.

Addressing non-communicable diseases

Comprehensive strategies to address non-communicable diseases (NCDs) will be mainstreamed into the health care, education and other systems which also reach out-of-school adolescents. Community based awareness campaigns will also be conducted on the importance of good nutrition, healthy foods and the consequences of malnutrition, anaemia and obesity on the overall development and growth of adolescents. The capacity of service providers to deliver effective nutrition counselling and services will be enhanced;

breastfeeding practices strengthened, physical activity promoted, and dietary regulatory and fiscal policies developed and implemented. Health promoting school initiatives will be initiated to tackle tobacco, alcohol and drug use and abuse, and promote healthy foods.

Improving mental health

Finally, reducing the stigma associated with mental ill health is a key element of the plan to promote mental health in adolescents and develop the capacity of the health sector to address mental health issues through screening for anxiety, stress, depression and suicidal tendencies. In addition, developing skills among adolescents to deal with stress, manage conflict and develop healthy relationships will be undertaken. Interventions include counselling, psychosocial support and related services for adolescent mental health and well-being, parental skills training, as appropriate, for managing behavioural disorders in adolescents, and the prevention of substance abuse

Overall ***the Barbados Adolescent Health Strategy (BADHS)*** aims to create a safe and supportive environment that offers protection and opportunities for healthy development, the provision of the much-needed health information and skills, enabling adolescents to better understand and interact with society. This entails making good quality accessible services to meet the needs of adolescents regardless of age, ethnicity, gender identity, disability, or socio-economic status.

Barbados expects endorsement and launch of the implementation of its strategy in August 2019. As a first adopter of AA-HA! the island leads the way in the Caribbean to improving the lives of its adolescents, and enhancing the future of Barbados with a healthier happier community.

C.4 Pakistan

ADOLESCENT HEALTH NEEDS ASSESSMENT, LANDSCAPE ANALYSIS AND PRIORITIZATION

An extract from the background report from Pakistan

Mental Health

Mental health appears to be one of the most neglected aspects of health in general and adolescent health in particular. Adolescents are at a stage when thinking capacities and changes in behavior and identity are taking place. They are faced with multiple challenges including academic stresses, challenges put forth by the digital age and the difficulties of entering the job market. These are exacerbated by the multiple socio-cultural challenges that Pakistani society places on adolescents including poverty, gender inequalities, high rates of school dropout, early marriage and humanitarian disasters. Additionally, as Consultant Psychiatrist and WHO mhGAP trainer, Dr Asma Humayun points out, “a little-known fact is that half of all mental illness begins in adolescence, and most cases go undetected and untreated because neither parents nor teachers are able to recognise common signs and symptoms.” Taboos and lack of information regarding mental health are major reasons for adolescents not getting the help they need.

Health services in Pakistan are severely ill equipped to deal with mental health issues. There is no expertise specific to mental health available at the primary care level, and most cases are dealt inadequately by untrained general practitioners or quacks. Furthermore, lack of expertise and unethical practices can lead to over medication and addiction to pharmaceutical drugs. Within the government system, mental health expertise is only found at psychiatric wards of DHQ and THQ hospitals. Dr Ayesha Mian, head of Psychiatry, Aga Khan Hospital, argues that the situation is even more dire for adolescents as there are only 4 psychiatrists all over Pakistan who have specialized in adolescent mental health issues.

While there are no national statistics regarding the mental health status of adolescents, world-wide depression is the third leading cause of illness and disability among adolescents, and suicide is the third leading cause of death in older adolescents between the ages of 15 and 19 years. In Pakistan recent incidences of adolescent suicide seem to be escalating and gaining some visibility, perhaps due to social medias reach. “Citing the National Poison Control Centre, at Jinnah Post Graduate Medical Centre, in Karachi, HRCP’s annual report for 2011, reported that there were 1,153 attempted suicides across Pakistan and 2,131 suicides in 2011 with five or six teenagers attempting suicide every day in Karachi. Of these, 60 per cent are teenage girls and families

are reluctant to register the case as attempted suicide."[1] Dr Murad Musa, a psychiatrist from AKU says "more girls than boys attempt suicide but more boys commit suicide than girls."[2] During a focus group in Shah Faisal Colony of Karachi, 3 out of 16 girls of the ages 15 to 19 years admitted to having attempted suicide, and except for emergency treatment none had received any form of counseling nor did they know of where to access such services. Girls said that they turned to suicide because their problems lay within their homes and they had nowhere else to go. Coupled with a lack of statistics; societal taboo, suicide being regarded a sin in Islam, and the criminalization of suicide, further exacerbate reporting of these cases.

"In 2013, the World Health Organisation made a comprehensive mental health action plan (2013-2020), which was adopted by the 66th World Health Assembly and signed by 194 states including Pakistan. Rooted in the principle of human rights, this action plan was considered a landmark achievement. The four major objectives of the action plan were to 1) strengthen effective leadership and governance for mental health; 2) to provide comprehensive, integrated and responsive mental health and social care services in community-based settings; 3) to implement strategies for promotion and prevention in mental health; and 4) to strengthen information systems, evidence and research for mental health.[3]" "Continued efforts to produce appropriate mental health legislation in Pakistan led to the Mental Health Ordinance of 2001. However, with the 18th amendment to the constitution and devolution of health responsibilities to the provincial governments, it became the task of the provinces to pass appropriate mental health legislation through their respective assemblies. According to Dr Asma Humayun, currently the mental health legislative picture is fragmented and unsatisfactory. Only the provinces of Sindh and Punjab have a mental health act in place and there is an urgent need for similar legislative frameworks in other provinces to protect the rights of those with mental illness."[4] None of the mental health policies in place specifically address the needs of adolescents.

WHO Mental Health Gap Action Program (mhGAP) provides an evidence-based solution to bridge the existing huge treatment gap in mental, neurological and substance use disorders. The program includes recommendations and strategies for adolescent mental health as well. It is currently being implemented by Ministry of National Health Services, Regulation and Coordination and supported by WHO Collaborating Center for Mental Health, located in the Institute of Psychiatry (IOP) Rawalpindi and through them being piloted in Hyderabad, Quetta, Rawalpindi and Peshawar since 2017, and upscaled to the 12 Family Practice Approach Program districts of WHO. This program aims to build the capacity of primary health providers including GPs and community workers to better diagnose, refer and treat mental health cases. According to Dr Shaheen Afridi, Peshawar, KP is the only province to have also translated and contextualized the mhGAP Community Health Worker training program for LHWs.

There is a dire need to upscale this program on a critical scale and support multiple partners in its up scaling. With increasing availability of mental health services at the primary care level, there is also a need for inclusion of age related mental health indicators as a part of the DHIS and ensure supply of psychotropic drugs to the BHU level.

Aga Khan University is planning to start a 2 year specialty in adolescent psychiatry. Other stakeholders working for mental health (including adolescents) in Pakistan include Karwan e Hayat, Coach Emad Foundation, The Color Blue, Rozan, Sahil and Mashal at Aman Foundation.

1 Ebrahim, Z. T. The alarming rise of teenage suicides in Pakistan. Dawn, Retrieved January 08, 2019, from https://www.dawn.com/news/724902

2 Ebrahim, Z. T. The alarming rise of teenage suicides in Pakistan. Dawn, Retrieved January 08, 2019, from https://www.dawn.com/news/724902

3 Humayun, A. Mental Health Reforms. Dawn, Retrieved January 08, 2019 from https://www.dawn.com/news/1449130

4 (PDF) Mental health law in Pakistan. Retrieved from: https://www.researchgate.net/publication/320888207_Mental_health_law_in_Pakistan [accessed Jan 08 2019]

C.5 Ethiopia

Ethiopia NATIONAL ADOLESCENT AND YOUTH HEALTH STRATEGY (2016-2020)

Monitoring and Evaluation Matrix

SN	INDICATOR	TYPE	2015	'16	'17	'18	'19	2020	FREQ	SOURCE
1	Mortality rate from all causes, age 10-14 (per 1,000 population)	Impact	TBD					↓ by 50%		
2	Mortality rate from all causes, age 15-19 (per 1,000 population)	Impact	5.73					2.86	5 years	DHS
3	Mortality rate from all causes, age 20-24 (per 1,000 population)	Impact	5.88					2.94	5 years	DHS
4	Maternal mortality ratio adolescent girls age 15-19 (per 100,000 LBs)	Impact	308					254	5 years	DHS
5	Maternal mortality ratio young women age 20-24 (per 100,000 LBs)	Impact	556					278	5 years	DHS
6	Adolescent pregnancy Rate (%)	Impact	12					3	5 years	DHS, PMA
7	HIV new infection among adolescents and youth 15-24 years	Impact	0.02					0.01	5 years	DHS
8	Contraceptive Prevalence Rate (CPR) among all young women (15-24) (%)	Outcome	18.3					30	1 or 5yearly	PMA/DHS
9	Unmet need for modern contraceptives among adolescents age 15-19 (%)	Outcome	32.8					10	5 years	EDHS
10	Unmet need for modern contraceptives among youth age 20-24 (%)	Outcome	21.8					10	5 years	EDHS
11	% of pregnant women age 15-24 who have ANC4+	Outcome	43					90	1 or 5 yearly	HMIS/DHS
12	% of pregnant women age 15-24 who deliver with SBA	Outcome	40					90	1 or 5 yearly	HMIS/DHS
13	Early PNC (≤7 days) coverage among pregnant women age15-24 (%)	Outcome	35					95	1 or 5 yearly	HMIS/DHS
14	% adolescents and youth(15-24 years)tested for HIV	Outcome	35.4					90	1 or 5 yearly	HMIS/DHS
15	HPV vaccination coverage among adolescents (9-13 Years)	Outcome	0					50	2-3 years	SS
16	Prevalence of IDA among female adolescents age 10-19	Outcome	30					15	2-3 or 5 years	SS/DHS
17	Prevalence of depression among adolescents and youth (15-24 years)	Outcome	12					6	2-3 years	SS
18	Prevalence of tobacco use among adolescents and youth (15-24 years)	Outcome	4.4					2.2	2-3 years	SS/DHS
19	Prevalence of Khat consumption among adolescents and youth (15-24 years)	Outcome	51					25.5	2-3years	SS/DHS

SN	INDICATOR	TYPE	2015	'16	'17	'18	'19	2020	FREQ	SOURCE
20	Prevalence of alcohol consumption among adolescents and youth (15-24 years)	Outcome	45.6					23	2-3years	SS/DHS
21	% of adolescents and youth (10-24 years) having access to comprehensive AYH information	Outcome						50	2-3 years	SS/DHS
22	% of adolescents and youth (10-24 years) having access to comprehensive sexuality education							62.5		
23	% of adolescents and youth having comprehensive knowledge on HIV/AIDS	Outcome	28.4					95	2-3 years	SS/DHS
24	Median age at first sex (years)	Outcome	16.5					≥18	1 or 5yearly	DHS/ PMA
25	Prevalence of child marriage<18 years (%)	Outcome	8					0.5	5 years	DHS
26	Median age at first marriage (years)	Outcome	16.4					≥18	5 years	DHS
27	Prevalence of FGM/C	Outcome	24.3%					<0.5%	5 years	DHS
28	Prevalence of injuries from RTAs among 15-29 years	Outcome	2.7%					2.02%	2,3 years	STEPS
29	Prevalence of injuries from non-RTAs among 15-29 years	Outcome	2.4%					1.8%	2,3 years	STEPS
30	Proportion of adolescent and youth engaged in regular physical activity	Outcome						40	2,3 years	SS
31	% adolescents and youth screened for hypertension (blood pressure) (15-29)	Outcome	17 (STEPS)					40	2,3 years	HMIS/ SS
32	% adolescents and youth screened for diabetes (blood glucose) (15-29)		1.6 (STEPS)							
33	% eligible adolescents and youth diagnosed and treated for STIs	Output	38					70	Annual	HMIS
34	% eligible adolescents and youth diagnosed and treated for rheumatic fever	Output						40	Annual	HMIS
35	% adolescents and youth who access health services and assessed and counseled for nutritional problems	Output						100	Annual	HMIS
36	% adolescent girls (10-19) provided with iron folate supplementation	Output						50	Annual	HMIS
37	Proportion of adolescents received de- worming tablets							75		
38	% vulnerable and marginalized adolescents and youth received AYH interventions	Output						60	Annual	Admin
39	% of adolescent and young pregnant women attending ANC develop birth preparedness and complication readiness plan	Output						90	Annual	Admin/ SS

SN	INDICATOR	TYPE	2015	'16	'17	'18	'19	2020	FREQ	SOURCE
40	% of WDGs/ MDGs trained and sensitized on AYH services	Output						80	Annual	Admin
41	% of HEWs providing AYH services	Output						80	Annual	Admin
42	% of health professionals trained and providing AYH services (disaggregated by category)	Output						100	Yearly	Admin
43	Number of School and TVET colleges providing AYFH services	Output						50	1 or 2-3 years	Re- ports/ Survey
44	Number of university clinics providing AYFH services							100	1 or 2-3 years	Re- ports/ Survey
45	% of public health facilities providing minimum package of AYFS	Output						100	1 or 2-3 years	Admin/ ESPA+
46	% of adolescents and youth utilizing need based, full range AYH care	Outcome						62.5	2-3 years	SS
47	% of facilities and Woreda Health Offices implementing CQI for AYH	Output						50	Yearly	Admin
48	Minimum AYH service package developed	Input						1	Once in 2016	Admin
49	% of adolescents and youth covered by health insurance scheme	Input						80	Once in 2016	Admin
50	% of adolescents and youth having access to m-health and e-health	Output						100	2-3 years	SS
51	AYH core indicators identified and integrated in HMIS and population based surveys such as DHS	Output						100	Yearly	Admin
52	Minimum number of AYH related research conducted and published	Output						≥10	Annually	Admin
53	National multi-sectoral coordination of AYH established (#)	Output						1	Once in 2016	Admin
54	Regional multi-sectoral coordination of AYH established (#)	Output						11	Once in 2016	Admin
55	National MOH AYH units established/ strengthened (#)	Output						1	Yearly	Admin
56	RHB AYH units established/ strengthened (#)	Output						11	Once in 2016	Admin
57	AYH focal persons assigned per WoHO	Output						All	Once in 2016	Admin
58	AYH focal persons in AY sectors	Output						All	Once in 2016	Admin
59	% of adolescent and youth organizations engaged in AYH programs	Output						100	1 or 2-3 years	Admin / Survey

MOH Leadership and Governance for the Ethiopia NATIONAL ADOLESCENT AND YOUTH HEALTH STRATEGY (2016-2020)

MOH STRUCTURE	KEY ROLES AND RESPONSIBILITIES
FMOH/MCHD	• Develop, lead and coordinate national policy, regulations and strategies on adolescent and youth health and development • Ensure the presence of a formal structure at national, regional and sub-regional levels that is responsible for adolescent and youth health programming and implementation • Ensure effective intra-ministerial convergence among national programs (MCH, communicable and non-communicable diseases including mental health and cancer) • Lead and coordinate detail operational planning and budgeting of the AYH program and its inclusion in the overall annual operational plan of the MOH; and joint technical and managerial supervision of the program • Manage capacity building: – Develop technical resource material (operational frameworks, guidelines, training material for capacity building) for all thematic areas identified in the strategy and train health workers – Facilitate training of service providers on adolescent and youth health and development issues and use existing platforms whenever possible • Ensure that there is adequate capacity in terms of staffing, equipment, and supplies at the health facility level • Strengthen Health Management Information System (HMIS)/monitoring and supportive supervision of AYH program; ensure that the AYH agenda is addressed at all coordination forums (JCF, JCCC, etc.) • Coordinate national partnerships and technically manage the program through chairing the AYH TWG (development and/or implementing partners, youth associations, civil societies, relevant public and private organizations) • Strengthen information, commodities and services including counseling: enhance focus on health education and health promotion at the community and facility levels, provision of commodities, and essential preventive and curative health services • Lead and capacitate the RMNCAYH-N research council to support research and publications; and periodic surveys and evaluations of AYH interventions • Guide and support RHBs and lower levels as they lead the establishment of AYFS services in health facilities within their respective jurisdictions • Actively work with other relevant ministries (Ministry of Education, Ministry of Youth Affairs and Sports, Ministry of Women and Children Affairs, Ministry of Labor and Social Affairs), Ethiopian Youth Federation, and other organizations, and networks to establish the AYH Multi-Sectoral Coordination Forum at national and sub-national levels • Work seamlessly with the new multi-sectoral platform to reinforce sectoral interventions; advocate and mobilize resources for improving AYH and development outcomes • Explore and establish joint monitoring and reporting mechanisms between participating ministries, especially MOE, MOYAS and MOWCA • Lead the development of AYH standards, tools and guidelines

MOH STRUCTURE	KEY ROLES AND RESPONSIBILITIES
Regional Health Bureaus	• Coordinate the planning, implementation, monitoring and evaluation of all adolescent and youth health programs in the region in line with the Adolescent and Youth Health Strategy 2016-2020; and the strategies of related programs such as child and newborn survival, reproductive health, and nutrition • Management of health service delivery, including management of health facilities, personnel and health training institutions in the region • Ensure the devel opment of sound annual operational plans and their inclusion in the overall health sector plan of the region • Conduct strategic communication activities on the new national strategy to sensitize and create awareness about the shift in paradigm in AYH including the current global initiatives to decision makers including the regional administration council, the cabinet, the judiciary, youth leadership, and local communities • Coordinate the inputs of partners and NGOs working on adolescent and youth health in their respective region • Disseminate technical and managerial guidelines on adolescent and youth health • Work with MOH and lower levels to ensure the availability of all essential equipment and supplies to health facilities within the region • Facilitate capacity building and training of health staff on AYH and appropriate staffing of health facilities through equitable deployment including in remote and hard to reach locations • Develop approaches to meet the adolescent and youth health needs of special population groups in their respective region • Collaborate with the regional offices for education, women and children, youth affairs and sport, on activities relevant to adolescent and youth health and development including the establishment and proper functioning of the regional multi-sectoral committee on AYH • Support zone and woreda health offices and relevant sector offices in operational planning and budgeting; and technical and managerial supervision including problem identification and solving, and review of progress in implementing inter- ventions/service delivery • Coordinate and lead (with zones and woredas) the establishment of AYFS services in health facilities and community intervention platforms • Ensure the establishment and operationalization of a structure (including assigning focal persons and allocating budget) to lead and manage the AYH program in the region; support zones, woredas, and health facilities to establish and run strong AYH structures • Establish and lead strong regional AYH TWGs that cater all stakeholders involved in technical AYH program implementation
Woreda Health Offices	• Ensure a focal person for adolescent and youth health is assigned in the office • Coordinate the planning, implementation, supervision and support of all adolescent and youth health activities in the woreda • Ensure that all adolescent and youth health interventions are incorporated in the annual operational plans of the woreda and implemented effectively • Coordinate the inputs of partners and NGOs in the woreda in the area of adolescent and youth health • Improve care seeking behavior through community dialogue and the Health Development Army (HDA) networks • Establish linkage with other sector offices (education; women and children affairs; youth affairs and sports) on activities relevant to adolescent and youth health and development • Organize and conduct clinical supervisions of health workers including supervision of HEWs • Ensure adequate staffing of health facilities with health workers trained and qualified on AYH, as well as availability of spaces and stocks of essential supplies and equipment to ensure the AYFS provision in the facilities • Monitor and review adolescent and youth health activities, including data management, periodic reviews of progress, and problem solving

Key Collaborators

COLLABORATOR	KEY ROLES AND RESPONSIBILITIES
Ministry of Education	• Implement AACSE in-line with the Education Sector Policy Support utilization of ICT and other innovative approaches, such as modeling youth champions in delivery of AYH information • Enhance implementation of the promoting girls' education initiative • Facilitate provision of information to parents on AYH within the school set-up • Support implementation and scale up of school health and nutrition programs as per the school health and nutrition strategy • Collaborate with MOH for expanding adolescent and youth-friendly health and nutrition information and services in all university clinics and strengthening health referral system • Support the implementation of equitable school health policies that promote skills-based health education and ensure safe and healthy school environment for promotion of psychosocial and physical wellbeing that include sufficient safe water and sanitation facilities as well as sound, welcoming and secure physical structures (buildings, paths and latrines) • Strengthen life skill training manual implementation for primary and secondary school
Ministry of Youth Affairs and Sports	• Make the health and development of adolescents and youth a political priority • Support policy advocacy, resource mobilization, and generation of data/information • Integrate AYH into youth empowerment programs • Support mainstreaming youth in all AYH and related programs • Enact and ensure enforcement of laws that protect adolescents and youth with regards to alcohol, drugs, and tobacco • Enact and ensure enforcement of laws that protect adolescents and youth with regards to alcohol, drugs and tobacco • Create awareness on harmful effects of alcohol, drugs and tobacco • Ensure greater livelihood opportunities for adolescents and youth in line with existing laws • Create sports and recreational outlets and mobilize adolescents and youth to engage in leisure-time (sports and recreational) activities • Provide age-sex disaggregated data for alcohol, drugs, and tobacco use for decision making • Provide organizational capacity building support to youth organizations and enhance their meaningful participation in programming of AYH related policies, strategies, and plans
Ministry of Women's and Children's Affairs	• Protect adolescents and youth against harmful cultural practices, child marriages, child labor, and trafficking • Ensure implementation of the Prohibition of FGM Act, the revised criminal law on child marriage, and other AYH related acts • Lead and coordinate the implementation, monitoring and evaluation of the national strategy and action plan on HTPs against women and children, including advocacy on elimination of GBV and monitoring anti-FGM interventions • Collaborate with law enforcement bodies and relevant AYH sensitive sectors and ensure the effective enforcement of laws and administration of justice to protect adolescents and youth – Complaints on violations of the rights of adolescents and youth are received – Violations of the rights of adolescents and youth are properly investigated – Implementation of AYH commitments and obligations are monitored • Provide age-sex disaggregated data on FGM and GBV for decision making • Support promotion of adolescent nutrition and influence HTP and social norms affecting adolescent nutrition

COLLABORATOR	KEY ROLES AND RESPONSIBILITIES
Media and Communications	• Position the health of adolescents and youth as a priority item on the news agenda • Lead and coordinate in developing social media and digital platforms to give adolescents and youth a voice and to support utilization of ICT in delivery of AYH information • Regulate media content on adolescent and youth health and nutrition information • Implement mass media campaigns to advocate and create public awareness on matters related to AYH work with MOH and others to publish more evidence-based stories about the health of adolescents and youth, coverage gaps and young people who miss out on needed services • Communicate responsibly and accurately on public health issues using information received from academia and the government in a careful and considered way
The Private and Business Sector	• Support government policies aimed at universal health coverage, better nutrition and healthier foods • Identify and address with partners the external consequences of business actions that might harm the health and nutrition of adolescents and youth • Support efforts to improve access to good-quality health services and life-saving commodities • Explore new drugs, technologies and interventions to improve emerging health challenges and bring the most promising innovations to market • Use business expertise to create and scale up interventions that promote adolescent and youth health, such as essential interventions and education on sanitation and hygiene and access to improved nutrition
CSOs, CBOs, FBOs	• Support provision of AYH information and services to adolescents and youth and communities • Advocate for increased attention to, and investment in, adolescents' and youth's health • Strengthen community and youth capabilities to implement the most appropri- ate and affordable interventions and to participate meaningfully in the governance of services • Forge multi-sector partnerships for adolescents' and youth's health; build community and stakeholder support for AYH policies and programs • Support efforts to close gaps in data about marginalized and vulnerable adolescents and youth • Support research and policy formulation and dissemination on AYH • Support sustainable programs seeking to empower adolescents and youth • Meaningfully involve adolescents and youth in policy formulation, program design, implementation, research, and M&E • Advocate and mobilize resources for policy implementation • Design and implement innovations to enhance special efforts that empower adolescent girls and boys who are especially vulnerable • Track progress and hold itself and all other stakeholders accountable for commitments • Support promotion of adolescent nutrition and influence HTP and social norms affecting adolescent nutrition
Youth Organizations, Associations, and Networks	• Participate meaningfully in research, policy, and planning, and program implementation • Champion adolescent AYH interests through existing relevant structures at all levels • Design, develop, implement, and evaluate innovative AYH interventions at all levels • Generate demand for health programs and support their implementation • Actively support positive changes to social norms and attitudes that impede progress • Advocate for adolescent and youth health and hold governments and duty-bearers to account • Create and support special provisions to foster participation and inclusion of adolescent girls • Discipline members who violate code of conduct on matters relating to AYH • Undertake research on AYH and knowledge sharing

COLLABORATOR	KEY ROLES AND RESPONSIBILITIES
Academic and Research Institutions	• Enhance AYH content in medical and allied health sciences curricula at pre-service level • Advocate for targeted research and increased budgets for research and innovation • Build institutional research capacity in low- and middle-income countries • Conduct continuous research on AYH and generate, translate and disseminate evidence and best practices to inform decisions for effective and equity-oriented AYH policies and programs • Strengthen networks of academics and researchers to promote knowledge exchange
Bilateral Development Partners and Philanthropic Institutions	• Mobilize additional resources for adolescent and youth health, including through innovative financing, to complement domestic investments, and align these resources with country plans and priorities • Deliver effective technical support for country-identified adolescent and youth health priorities, while enhancing local capacities to develop, finance, implement, and monitor evidence-based national plans and programs that support adolescent and youth health • Invest in innovation and research, including implementation research, to better meet country needs through effective health interventions, tools, and delivery mechanisms • Enhance cross-sector collaboration in line with best practice; integrate health, nutrition, water and sanitation interventions, and strengthen links with sectors, such as education and gender equity
Multilateral Organizations and UN Agencies	• Mobilize resources to fill funding gaps at country level, including through innovative financing mechanisms, and invest in public health and goods that improve adolescents' and youth' health • Provide technical support to develop and cost national plans and to implement them by working with a full range of stakeholders • Define evidence-based norms, regulations and guidelines to underpin efforts to improve the health of adolescents and youth • Support the creation of dedicated safe spaces for adolescents and youth, e.g. support the GOE's efforts to implement Citizens' Charters • Support and participate in systems that track progress and identify gaps to strengthen action and accountability for AYH

Annex D Power Point presentations

D.1 The global overview of adolescent health

D.2 An overview of the AA-HA! guidance

D.3 Selecting indicators, setting targets and monitoring and evaluation of adolescent health programmes

D.4 Adolescent participation, governance and financing adolescent health programmes

D.5 Other WHO tools to support implementation of adolescent health programmes

Pending their publication on the WHO website, these presentations could be made available upon request to Valentina Baltag baltagv@who.int.

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