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Operationalization of the adolescent health component of the Global Strategy for Women's, Children's and Adolescents' Health, 2016–2030

Executive summary

1. Adolescence is one of the most rapid and formative phases in human development; it includes distinct physical, cognitive, social, emotional and sexual development. It demands special attention in national development policies, programmes and plans. Adolescent health and development is an integral part of the Global Strategy for Women's, Children's and Adolescents' Health (2016–2030). They are central to the success of the Sustainable Development Goals (SDGs).

2. Many adolescent diseases and injuries are preventable or treatable, but are often neglected. They require a sustained focus and investment. Such investment brings a triple dividend: benefits for adolescents now, for their future adult lives and for their children. There is a pressing need for increased investment in adolescent health programmes, to improve adolescent health and survival. This is a matter of urgency if we want to curb the epidemic of noncommunicable diseases, to sustain earlier gains in young child health, and ultimately to have thriving and peaceful societies.

3. In the Eastern Mediterranean Region a systemic multisectoral approach is needed to implement strategic plans to reduce adolescent mortality and morbidity. The adolescent mortality rate in the Region in low- and middle-income countries is 115 deaths per 100 000 adolescents – the second highest in the world. The top five causes of mortality among adolescents in these countries are collective violence and legal intervention, road injury, drowning, lower respiratory infections and interpersonal violence. The top five leading causes of adolescent disability-adjusted life years are collective violence and legal intervention, iron-deficiency anemia, road injury, depressive disorders, and childhood behavioural disorders.

4. Adolescent health needs intensify in humanitarian and fragile settings because the burden of malnutrition, disability, unintentional injury, violence, sexual and reproductive health needs, water, sanitation and mental health increases. Therefore, programming in humanitarian and fragile settings must take specific account of adolescents and their health.

5. Member States are urged to translate the commitments made in the Global Strategy for Women, Children and Adolescents' Health 2016–2030 into action by implementing national multisectoral strategic plans for adolescent health. This can be done using the Global Accelerated Action for the Health of Adolescents (AA-HA!): Guidance to Support Country Implementation, which aims to assist governments to decide what they plan to do and how they plan to do it. It is intended as a reference document for national policy-makers and programme managers to assist them in planning, implementing, monitoring and evaluating adolescent health programmes.

Introduction

6. Adolescence (ages 10–19 years) *(1)* is one of the most rapid and formative phases of development in humans; it includes distinct physical, cognitive, social, emotional and sexual development. The capabilities acquired during adolescence underpin well-being throughout life, including the capacity to engage effectively in work and leisure, family life, and the community. Failure to acquire these capabilities during adolescence can have adverse long-term effects on individuals, families and communities *(2)*. Therefore, adolescence requires special attention in national development policies, programmes and plans.

7. The SDGs, which seek to achieve sustainable global economic, social and environmental development by 2030, will not be realized without investment in adolescent health and well-being. Adolescent health and development is an integral part of the Global Strategy for Women's, Children's and Adolescents' Health

(2016–2030). The inclusion of adolescent health in the Global Strategy represents an unprecedented opportunity to increase efforts to ensure that every adolescent has the knowledge, skills and opportunities to lead a healthy and productive life. The United Nations Secretary-General stated: "The updated Global Strategy includes adolescents because they are central to everything we want to achieve, and to the overall success of the 2030 agenda". This statement reflects the widespread awareness that adolescent health merits greater attention *(3)*.

8. There are sound public health reasons for this increased attention to adolescents. Between 2000 and 2012, the adolescent mortality rate declined by only 12%, a relatively small decrease compared to the reduction in maternal and child mortality. In the same period, the rate of adolescent Disability-Adjusted Life Years (DALYs) per 100 000 decreased by only 8%, less than half the 17% decline for all age groups combined. At the same time, the rate of unipolar depression, the top cause of DALYs in adolescents in 2012, increased by 1%. Furthermore, the frequency of health-related behaviours that begin or are consolidated during adolescence, such as tobacco use, eating poor diets, alcohol use, physical inactivity and drug use, which have effect later in life, has declined very little or has even increased *(4)*.

9. Many adolescent diseases and injuries are preventable or treatable, but are often neglected, and they require a sustained focus and investment. Investment brings a triple dividend: benefits for adolescents now, for their future adult lives and for their children. There is a pressing need for increased investment in adolescent health programmes to improve adolescent health and survival. This is a matter of urgency if we want to curb the epidemic of noncommunicable diseases, sustain earlier gains in young child health, and ultimately have healthier societies.

10. Furthermore, there are compelling economic reasons to invest in adolescent health. Providing opportunities to develop skills and use them productively will ensure that adolescents become a valuable resource with the potential to contribute to their families and communities. Sound investment in interventions targeted at physical, mental, and sexual health in adolescents, as well as education and road safety, would all have considerable economic and social benefits *(5)*.

11. This paper reviews the global and regional burden of adolescent health including the leading causes of death and DALYs among adolescents in the Eastern Mediterranean Region. It highlights the growing emphasis on adolescent health, what has been done to address adolescent health, and what countries need to do to understand and prioritize adolescent health needs within the country context and the tools to assist them.

Global and regional overview of adolescent health and well-being

Global adolescent mortality

12. There are 1.2 billion adolescents in the world today. They represent over a quarter of the global population and their numbers are set to rise to 2 billion by 2032 *(6)*. Globally, about 1.2 million adolescents aged 10–19 years died in 2015, a rate of 101 deaths per 100 000 adolescents. In 2015 in low- and middle-income countries (LMICs) across WHO regions, the highest rate of adolescent mortality was in the African Region (243 deaths per 100 000 adolescents). Adolescent death rates globally are estimated by WHO to have fallen by 17% from 2000 to 2015 *(7)*.

13. The main causes of adolescent deaths were road injury, lower respiratory infections, self-harm, diarrhoeal diseases and drowning. Road injury was the leading cause of death in all male adolescents while for females, the leading cause of death was lower respiratory diseases in younger adolescents (10–14 years) and maternal conditions for older adolescents (15–19 years) *(8)*.

Adolescent health in the Eastern Mediterranean Region

14. Adolescents make up about a fifth of the population of the Eastern Mediterranean Region (129 million) *(9)*. In 2015, the adolescent mortality rate in LMICs in the Region was 115 deaths per 100 000 adolescents, the second highest across WHO regions. In addition, LMICs in the Region had smallest reductions in mortality rates (2%) between 2000 and 2015 *(7)*. The top five causes of death among adolescents were: collective violence and legal intervention, road injury, drowning, lower respiratory infections and interpersonal violence (Table 1) *(8,10)*.

Table 1. Leading causes of death in adolescents (10–19 years) in LMICs in WHO regions and HICs across WHO regions (death rate per 100 000 population)

Rank	African LMICs	American LMICs	Eastern Mediterranean LMICs	European LMICs	South-East Asian LMICs	Western Pacific LMICS	HICs across WHO regions
1	Lower respiratory infections (21.8)	Interpersonal violence (22.6)	Collective violence and legal intervention (23.2)	Self-harm (7.6)	Road injury (10.5)	Road injury (8.0)	Road injury (4.6)
2	Diarrhoeal diseases (19.8)	Road injury (10.9)	Road injury (9.8)	Road injury (5.6)	Self-harm (8.7)	Drowning (4.3)	Self-harm (4.1)
3	Meningitis (18.3)	Self-harm (4.8)	Drowning (5.4)	Drowning (4.0)	Drowning (4.8)	Leukaemia (2.4)	Inter-personal violence (1.8)
4	AIDS[a] (17.2)	Drowning (3.3)	Lower respiratory infections (4.4)	Lower respiratory infections (3.0)	Diarrhoeal diseases (3.8)	Self-harm (2.2)	Congenital anomalies (1.2)
5	Road injury (12.9)	Lower respiratory infections (2.5)	Interpersonal violence (4.0)	Congenital anomalies (2.1)	Tuberculosis (3.5)	Congenital anomalies (1.6)	Leukaemia (0.8)

LMICs = low- and middle-income countries; HICs = high-income countries.

[a]2015 estimates rank AIDS lower than previous estimates because of a reassessment by UNAIDS of inputs into the SPECTRUM model used to produce the estimates. Re-analysis of the 2012 estimates suggested that the high ranking of AIDS as the second cause of adolescent deaths globally was overestimated. Nevertheless, AIDS remains one of the leading causes of adolescent death, particularly in African LMICs.

Source: *(10)*

15. In 2015, the five leading causes of adolescent disability-adjusted life years (DALYs) in LMICs in the Region were collective violence and legal intervention, iron-deficiency anaemia, road injury, depressive disorders and childhood behavioural disorder *(10)* (Table 2). Collective violence and legal intervention was the leading cause of adolescent death and DALYs among all four adolescent groups in the Region. Some causes of DALYs only had a particularly high ranking among males (e.g. road injury and drowning) or females (e.g. anxiety and maternal conditions) or among older adolescents (e.g. depressive disorders) *(7)*.

Table 2. Leading causes of adolescent (10–19 years) disability-adjusted life years (DALYs) in LMICs in WHO regions and HICs across WHO regions (DALY per 100 000 population)

Rank	African LMIC	American LMICs	Eastern Mediterranean LMICs	European LMICs	South-East Asian LMICs	Western Pacific LMICS	HICs across WHO regions
1	Lower respiratory infections (1693)	Interpersonal violence (1698)	Collective violence and legal intervention (1981)	Iron-deficiency anaemia (786)	Iron-deficiency anaemia (1179)	Iron-deficiency anaemia (692)	Iron-deficiency anaemia (645)
2	Diarrhoeal diseases (1648)	Road injury (836)	Iron-deficiency anaemia (1024)	Self-harm (578)	Road injury (810)	Road injury (637)	Depressive disorders (633)
3	Meningitis (1462)	Iron-deficiency anaemia (809)	Road injury (757)	Depressive disorders (468)	Self-harm (659)	Skin diseases (498)	Anxiety disorders (478)
4	HIV/AIDS (1421)	Depressive disorders (543)	Depressive disorders (487)	Road injury (445)	Depressive disorders (437)	Anxiety disorders (377)	Childhood behavioural disorders (443)
5	Iron-deficiency anaemia (1098)	Asthma (538)	Childhood behavioural disorders (449)	Childhood behavioural disorders (434)	Skin diseases (419)	Childhood behavioural disorders (347)	Road injury (382)

LMICs = low- and middle-income countries; HICs = high-income countries.

Source: *(10)*

16. Collective violence refers to the instrumental use of violence by members of a group against another group, in order to achieve political, economic or social objectives. It includes coups, rebellions, revolutions, terrorism and war. Legal intervention refers to injuries inflicted by law-enforcement agents while arresting lawbreakers, suppressing disturbances, maintaining order and taking other legal action. The Region is experiencing armed conflict or post-conflict situations, famines and protracted socioeconomic and political instability. Many health burdens increase in such contexts because governance and health infrastructures break down, and protective social and health services become much less accessible *(11)*. Adolescents often face disproportionate risks in emergency and fragile settings, including poor physical and mental health. Collective violence and legal intervention were major concerns in the Region in 2015 as they were the leading cause of adolescent death (around 27 000 deaths) (Table 1) giving an overall death rate of 23 per 100 000 adolescents compared with 3 per 100 000 globally *(8,10)*. They were also the leading cause of adolescent DALYs for all adolescent subgroups (Table 2).

17. Interpersonal violence is the intentional use of physical force or power against another person with a high likelihood of it resulting in injury, death, psychological harm, maldevelopment or deprivation. It includes child maltreatment, youth violence and gender-based violence *(12)*. Youth violence is commonly used to describe interpersonal violence involving 10–29-year-olds and was a main cause of death in LMICs in the Region (fourth overall and tenth for older males) *(10)*.

18. Aside from the main causes shown in the tables, other causes of adolescent death and disability in the Region are of concern.

- Maternal conditions include haemorrhage, sepsis, hypertensive disorders, obstructed labour, complications of abortion, and indirect and late maternal deaths. The rate of maternal mortality among 15–19 year-old girls was high in LMICs in the Region, causing 9 deaths per 100 000 population *(13)*, the second highest after African LMICs.
- Little is known about HIV among young people in the Region, particularly adolescents. It is estimated that in 2015, a quarter (9600 out of 39 000) of the new infections in the Region occurred in the age group 15–24 years and a further 8% (3000 out of 39 000) occurred in those under 15 years of age *(14)*. By the end of 2016, 2389 adolescents (15–24 years) were reported to be diagnosed with HIV in 16 countries of the Region, representing 18% of all people living with HIV reported in that period. Forty per cent of all adolescents diagnosed with HIV in the Region are female. Diarrhoeal disease was one of the top five causes of death among adolescent girls aged 10–14 years in LMICs in the Region *(10)*.
- The nutritional needs of adolescents have been largely neglected, especially in LMICs, where other demographic groups, such as children under 5 or pregnant and lactating women, have been prioritized. This has largely been the case across the Region. The death rate from congenital anomalies in LMICs in the Region was the second highest of WHO Regions (4 per 100 000). Stroke death rates were highest among adolescents in LMICs in the African and Eastern Mediterranean regions in 2015, about 4 per 100 000 population in both regions. Stroke was the third leading cause of death among older adolescent females (15–19 years) in the Region *(12)*. Globally, an estimated 10–20% of children and adolescents are affected by mental health problems, 90% of whom live in a LMIC. Children exposed to conflict and naturally-occurring humanitarian disasters have even higher rates of mental health problems as seen from studies carried out in Afghanistan, Iraq and Palestine. Self-harm, which includes both suicide and accidental death resulting from self-harm without suicidal intent, was the fifth leading cause of death among older adolescent males in LMICs in the Region *(12)*.
- The health-related behaviours that underline the major noncommunicable diseases usually start during adolescence: tobacco and alcohol use, diet and exercise patterns, overweight and obesity. These habits could impact the morbidity and mortality prospects of adolescents later in their adult lives. Available data from the Region indicate that less than 1 in every 4 adolescents meets the recommended guidelines for physical activity – 60 minutes of moderate to vigorous physical activity daily, and the number of adolescents who are overweight or obese is increasing; in many countries of the Region more than half of the adolescents (13–18 years) are overweight.

19. The leading health risk factors for younger adolescents (10–14 year olds) globally include unsafe water, unsafe sanitation and inadequate hand washing. The leading risk factors in the older age group are risk behaviours such as tobacco, alcohol and illicit drug use.

20. Limited reliable data, scarcity of financial resources, low competence of the health workforce in adolescent health, and insufficient coordination and alignment among concerned stakeholders are problems in the Region. Without these being addressed, implementation of adolescent health interventions will be hindered.

21. According to a recent study, investment of US$ 5.2 per capita each year across 75 low-income and middle-income countries in programmes aimed at adolescents to improve physical, mental, sexual, and reproductive health and to reduce road traffic injuries will show economic and social benefits at 10 times their costs by saving 12·5 million lives, preventing more than 30 million unplanned pregnancies, and averting widespread disability *(2)*.

WHO response to the adolescent health burden

22. The sustainable development agenda 2030 *(15)* and the updated United Nations Global Strategy for Women's, Children's and Adolescents' Health 2016–2030 with its link to the global financing faculty provide a unique opportunity for accelerated action on the health of adolescents. The global strategy highlights the health and social challenges that adolescents face and lists the evidence-informed health and social interventions needed to address them at different levels and by different sectors. It also outlines what is needed at national and international levels *(3)*.

23. In May 2016, the Sixty-ninth World Health Assembly adopted resolution WHA69.2 in which Member States committed to implementation of the Global Strategy for Women's, Children's and Adolescents' Health in accordance with their national plans and strengthening of accountability and follow up. It requested the Director-General to provide adequate technical support, continue to collaborate in order to advocate and leverage multistakeholder assistance for aligned and effective implementation of national plans, and report regularly on progress *(5)*.

24. In response to a request from Member States at the Sixty-eighth World Health Assembly in May 2015, the Secretariat, in collaboration with WHO's other partners in the H6 Partnership, UNESCO and an external advisory group, prepared guidance on implementing global accelerated action for adolescent health – the Global Accelerated Action for the Health Of Adolescents (AA-HA!): Guidance to Support Country Implementation.

25. Adolescent and youth health is a strategic priority of the Regional Director for the Eastern Mediterranean for 2017–2021. The focus is on the essential central role of adolescents and youth in health promotion and disease prevention. The enabling requirements are Health in All Policies, partnership, role of civil society, social and environmental determinants of health and monitoring and evaluation.

26. In October 2015, the Sixty-second session of the Regional Committee for Eastern Mediterranean adopted resolution EM/RC62/R.1, which urged Member States to develop or update national reproductive, maternal, neonatal, child health strategic plans in accordance with the United Nations global strategy on women's, children's and adolescents' health.

27. In March 2017, the Regional Office conducted a joint WHO/UNAIDS/UNFPA/UNICEF regional meeting on the Global Accelerated Action for Health of Adolescent AA-HA! implementation guidance. The key objectives were to introduce and use the AA-HA! guidance in developing/updating national adolescent strategies and plans, and determine action areas for programming in adolescent health of Member States, United Nations organizations and other relevant stakeholders.

28. Many Member States of the Region are developing/updating their national policies and strategic plans for adolescent health and some have requested technical support of the Regional Office in using the AA-HA! Guidance (Egypt, Morocco, Sudan and the United Arab Emirates).

29. The Regional Office is collaborating closely with the Arab League to strengthen the adolescent health component of national strategic plans for mothers, children and adolescents.

30. The AA-HA! guidance aims to support policy-makers and programme managers on how to plan, implement and monitor a response to the health needs of adolescents within their national plans in line with the three key objectives of the Global Strategy: survive, thrive and transform.

31. The AA-HA! guidance provides a systematic approach for understanding adolescent health needs, prioritizing these in the country context, and planning, monitoring and evaluating adolescent health programmes. It provides the key steps in: understanding a country's epidemiological profile; undertaking a landscape analysis to clarify what has already been done, and by whom; conducting a consultative process for setting priorities; and planning, implementing, monitoring and evaluating national adolescent health programmes. It ends with key research priorities.

32. Led by WHO, this guidance document was developed in consultation with adolescents and young people, Member States, United Nations agencies and civil society organizations and other partners. It is endorsed by the Every Woman Every Child (EWEC) initiative, the Partnership for Maternal, Newborn & Child Health (PMNCH), UNAIDS, UNESCO, UNFPA, UNICEF, UN Women, WHO, and the World Bank.

Conclusion

33. The adolescent mortality rate in the Eastern Mediterranean is the second highest globally after the African region with the lowest progress in reducing mortality rate since 2000 (only 2%). There are wide variations between Member States in burden and risks, so the particularities of each country need to be taken into account in order to improve adolescent health. Member States need to evaluate the drivers of disease and injury among adolescents to support implementation of appropriate strategic plans to improve the health of adolescents.

34. Funds are limited so governments should prioritize their actions according to the health and injury burden and risk factors among their adolescent population to achieve the targets of the SDGs. The health and other sectors need to include adolescents' needs in all aspects of their work. An Adolescent Health in All Policies approach should be used in policy formulation, implementation, monitoring and evaluation.

35. Coordinated investments in adolescent health provide high economic and social returns and are among the best investments that can be made by the community to achieve the United Nations SDGs and the Global Strategy for Women's, Children's and Adolescents' Health 2016–2030.

36. Policies play a key role in protecting adolescent health, and health sector efforts must go beyond interventions directed at individual adolescents. While it remains important to ensure that adolescents have knowledge, skills, and access to health services, interventions that support parents and make schools health-promoting are needed.

37. Adolescent health in emergencies needs to be addressed with policies and practices that meet adolescents' needs and respect their rights, best interests, safety, autonomy and self-determination.

38. Many countries in the Region have either taken steps to implement comprehensive adolescent health programmes or are planning to do so. Much remains to be done, however. National governments have the necessary evidence and tools to address adolescent health challenges effectively, as outlined in the AA-HA! guidance. Governments also have strong economic, public health and human rights arguments to do so. Through this, they will attain the triple dividend of benefits for adolescents now, for their future adult lives, and for the next generation.

Recommendations to Member States

39. Identify adolescent health priorities within the country, because the nature, scale and impact of adolescent health needs are unique to each country. Ensure that every adolescent has access to the 27 adolescent health interventions recommended by the Global Strategy for Women's, Children's and

Adolescents' Health and positive adolescent development interventions, especially in humanitarian and fragile settings.

40. Establish strong leadership at the highest level of government to support implementation of policies and programmes for adolescent health. To accelerate progress, consider institutionalizing national adolescent health programmes aiming at collaboration between different sectors of the government, working closely with communities, civil society, young people and the private sector.

41. Ensure financing for adolescent health priorities in national health plans and implement laws and policies that address adolescents' health and protection. Ensure age- and sex-disaggregated data are provided in health management and information systems.

42. Develop a primary care workforce competent to handle adolescent health by implementing WHO core competencies for adolescent health in pre-service and continuing professional education to ensure quality delivery of basic package of health services for all adolescents, and scale up service delivery platforms, including school health, that maximize coverage.

43. Strengthen country data collection disaggregated by age and sex by use of appropriate tools and systems to measure unmet needs so as to ensure adequate planning of services to attain adolescent-responsive health systems.

44. Establish, or update, school health programmes to address health priorities (e.g. injuries, violence reproductive health, and communicable and noncommunicable diseases) integrated within the overall approach to promote adolescent health services.

45. Ensure accountability and monitoring and evaluation mechanisms in national programmes as an integral part of programme planning; include this in the initial programme plan so that an adequate budget is allocated.

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