Developing Bold and Transformative Commitments to Adolescents and Youth

EXECUTIVE SUMMARY

WHO ARE ADOLESCENTS, YOUTH, YOUNG PEOPLE, AND ADULTS?

The World Health Organization defines adolescents and youth as follows: adolescents are aged 10–19 and youth are aged 15–24. Young people are those aged 10–24.

Individuals aged 10–14 are considered very young adolescents (VYA) and those aged 15–19 are older adolescents. The evolving capacities and needs of each age group require appropriate and targeted responses.

To meet its goals, FP2030 partners must promote and protect the rights of adolescents and youth (AY) to sexual and reproductive health (SRH) services, including contraception. Strong commitments that prioritize adolescent and youth sexual and reproductive health (AYSRHR) send a clear message about the vital importance of improving adolescent and youth SRH knowledge, fostering their agency and ability to make informed decisions, facilitating their access to high-quality SRH services responsive to their needs, and ensuring a supportive policy and social environment. Actionable commitments will include rights-based and evidence-informed strategies that assist AY to improve their understanding of SRHR, correct myths and misinformation around sexuality and contraception, develop skills that support positive behaviors and decision-making, and emphasize the importance of voluntary choice in the use of contraception.

The World Health Organization's Global Guidance for Accelerating Action for the Health of Adolescents (AA-HA is a key resource for anyone who wants to develop a commitment that includes advancing AYSRHR). This guidance is specifically designed to assist governments in deciding what —and how— to respond to the health needs of adolescents and young people.

In addition to consulting the AA-HA guidance, we recommend countries consider the following three steps in developing their commitments to adolescents and youth:

1. Ensure meaningful partnerships with AY during all commitment development, implementation, monitoring, and evaluation activities.
2. Comprehensively analyze available data on AYSRHR and contraceptive use, including the impact of social and gender norms and the cultural context on AYSRHR outcomes.
3. Consider which evidence-informed approaches and partnerships within the health and other key sectors are most likely to contribute to achieving the commitment.

The FP2030 partnership believes that attention to the WHO AA-HA guidance, as well as these three approaches, will help generate commitments that can achieve real progress in improving the sexual and reproductive health of adolescents and youth.

STEPS TO DEVELOP A STRONG AY COMMITMENT

Each country will have its own preferences and mechanisms for developing FP2030 commitments. However, we suggest the following three approaches to assist countries in developing bold and transformative AYSRH commitments:

1. **Ensure strong and sustainable commitments** by including AY in all activities in commitment development, implementation, monitoring, and evaluation.
2. **Comprehensively analyze available data** on AYSRH and contraceptive use, including the impact of social and gender norms and cultural context on AYSRH outcomes.
3. **Consider which evidence-informed approaches and partnerships** within the health and other key sectors are most likely to contribute to achieving the commitment.

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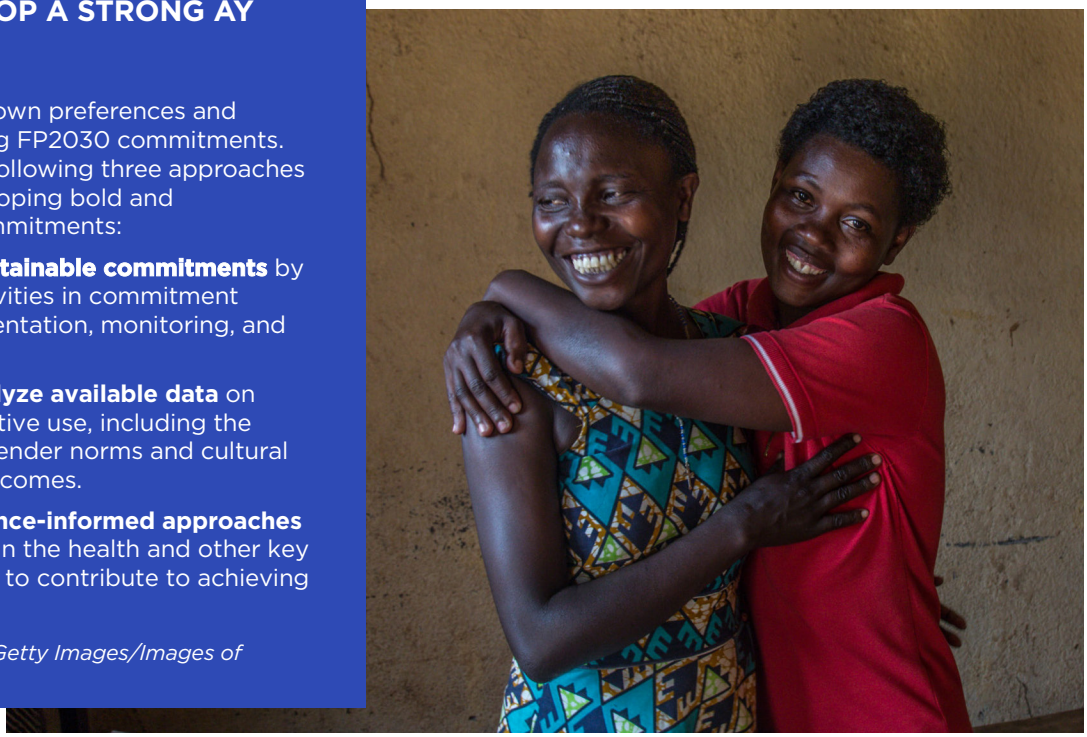


DEVELOPING BOLD AND TRANSFORMATIVE COMMITMENTS TO ADOLESCENTS & YOUTH

The SRHR needs of adolescents and youth must be met to achieve the Sustainable Development Goals (SDGs). Improved AY health outcomes generate a triple dividend—for adolescents today, the adults they will become, and the families they may choose to form. Yet poor SRHR outcomes persist, and the rights of AY often remain unrealized. Additionally, while meaningful adolescent and youth engagement (MAYE) in the design, implementation, and evaluation of policies and programs has been acknowledged, most MAYE efforts remain weak and tokenistic.

Bold and transformative commitments are needed to significantly improve AYSRHR and contraceptive use. Commitments should aim to reflect the input and perspectives of AY and strive to fully address the complexity of their AYSRHR needs. FP2030 encourages commitment-makers to go beyond MAYE to create strong, equitable partnerships that share decision-making and mutually build capacities of AY and their allies to implement high-quality AYSRHR programs.

As AY-specific goals in commitments are an opportunity to advance national AY agendas, we suggest all commitment goals be developed through this lens. This means intentionally examining how commitment goals might influence or could be strengthened by addressing AYSRH. For example, a goal to improve the delivery of postpartum family planning (PPFP) could emphasize the needs of first-time mothers who are often overlooked in PPFP programs, despite having higher rates of closely spaced pregnancies.

STEP ONE: ENSURE STRONG AND SUSTAINABLE PARTNERSHIPS WITH ADOLESCENTS AND YOUTH

The effectiveness of efforts to improve AYSRH and contraceptive use depends on how well policies and programs respond to the realities of AY lives. FP2030 therefore recommends that all stages of the commitment process be developed in strong partnership with adolescents and youth—from initial data review and stakeholder consultations to implementation and accountability mechanisms. A strong AY and adult partnership is one in which AY and adults can equally and jointly share power and decision-making to improve programs and policies.

Developing commitments in partnership with AY sends a powerful message that their input, perspectives, and participation are important and valued. Partnerships should attempt to reflect the geographic, social, economic, and cultural diversity of your country's adolescent and youth population, avoid tokenism, and promote diversity and inclusion. This means involving the most vulnerable such as those who are not in school, LGBTI, married and/or parenting, living with disabilities, living in rural areas, or experiencing an emergency, humanitarian crisis, or displacement.

Effective partnership with AY will not happen overnight. Sharing power means mutually respecting and valuing each other's strengths and perspectives, as well as committing to building each other's capacity to work in partnership over the long term.

We suggest the following activities to facilitate partnership with AY and the co-creation of commitments:

- Ensure mutual understanding of and agreement on the importance and value of partnering with AY. Commit to transparency, respect, and fairness among all stakeholders. It may be useful to conduct training for adults on how to work in partnership with AY.
- Create dedicated seats for AY-led organizations and networks on decision-making bodies, such as technical working groups or coalitions at the national and subnational level.
- Support youth-led organizations and networks in identifying their own representatives to participate in decision-making bodies through a transparent selection process.
- Map youth-led organizations and networks working on AYSRHR or other youth development issues in your country.
- Support robust representation and inclusion of diverse AY. The mapping exercise may help to identify new AY partners.
- Reduce barriers to AY participation in decision-making bodies. Address financial or other constraints that have implications for participation, as well as personal safety,and dignity considerations.
- Develop clear terms of reference (TORs) that outline the roles and responsibilities of AY members on decision-making bodies. TORs for AY should be similar as those of other members and should avoid reinforcing habitual power-dynamics, such as expecting AY members to perform administrative tasks like notetaking.
- Support capacity building and skills development for AY members to facilitate their full participation. Consider pairing AY members with a mentor.

COVID-19'S IMPACT ON ADOLESCENTS AND YOUTH

Data compiled by UNFPA suggest that COVID-19 related disruptions and lockdowns will likely increase of the number of unintended pregnancies and gender-based violence, many of which are likely to affect AY, while disruptions in programs to prevent child marriage will lead to an additional 13 million child marriages.

Photo Credit: Liam Blunt, DKT

STEP TWO: CONDUCT AN IN-DEPTH ANALYSIS OF DATA AND THE SOCIO-CULTURAL ENVIRONMENT

Identify Data Sources: A thorough analysis of available data is a critical step in identifying solutions to complex AYSRHR challenges. It is useful to consider the influence of social, cultural, and economic factors, many of which are far removed from health sector programs and services, on the available data. Partnership with AY in the review and analysis of available data is important, as they have unique insights and can share programmatic experiences that help contextualize data. This is especially critical given the real-time effects of COVID-19. In countries with inadequate AY data, governments may wish to commit to actions that improve AY data collection, analysis, and use.

Quantitative data will identify AYSRHR-related morbidities and mortalities that can be addressed by a commitment, while qualitative data will provide an improved understanding of prevailing social norms, cultural beliefs and practices, political will, and other factors that shape the implementation environment and provide greater context. Many countries are likely to have recent analyses of AY health and development that can be built upon.

Analyze the Data: Start by reviewing available data on AY from FP2020, Demographic and Health Surveys (DHS), Performance Monitoring for Action (PMA) , Multiple Indicator Cluster Survey (MICS), Violence Against Children Surveys (VACS), and national/regional/local surveys, censuses, and Health Management Information Systems (HMIS) reports.

As feasible, review local AYSRHR research findings and project reports. Where possible, disaggregate your findings by age bands (e.g., very young adolescents [VYAs] aged 10-14, older adolescents aged 15-19, and young adults aged 20-24), as well as by marital status. Look at the effect of marital status/union and parity on contraceptive use and fertility intentions.

When disaggregating data, also consider the size of the denominator in each disaggregated band. For example, data may show high rates of unmet need among

1. When analyzing data on AY, consider the "n" or the denominator when looking at rates of unmet need for contraception or contraceptive use among different subgroups of AY. Unmet need may appear highest among unmarried adolescents who face multiple barriers to contraceptive services, while appearing quite low among married adolescents who are expected to bear children. A sole reliance on rate may mask the actual numbers of AY who would like to use contraception, if the denominators of each group are not considered.

sexually active AY, with lower rates among married AY. However, in a country where early marriage is common, for example, the total number of married adolescents is likely to be much greater than the total number of sexually active unmarried women, a fact that could skew the interpretation of rates of unmet need. Cross reference data: for example, what is the reported average age of sexual initiation and age of marriage, and what are the different rates of contraceptive use and unmet need? Which methods are used most among AY, and do those methods align with their fertility intentions? Do birth spacing intervals reported by young mothers align with international recommendations? Are young women well-nourished when they begin childbearing? Examine other data that are relevant to AYSRH, such as incidence and prevalence of HIV, sexually transmitted infections, gender-based violence, and nutrition.

As time and resources permit, review available data on factors that have both a direct and indirect effect on AYSRHR, such as education. For example, what are the rates of secondary school enrollment, retention, and completion? What percentage of girls are married before age [18]? What percentage of girls say their first sexual experience is forced or coerced? What are the rates of unemployment for AY, especially for young women, and what types of employment are AY engaged in? How common is transactional sex?

Assess the Enabling Environment: Commitments may fall short in meeting the needs of AY if they do not consider the influence of the enabling environment. An enabling environment reflects a set of interrelated conditions—legal, political, social, and cultural, among others—that affect the capacity of young people to lead healthy lives and access relevant and necessary services, information, and products.

Consider the full range of factors within and outside the health sector that might affect the achievement of the proposed AY commitment. A rapid landscaping activity can provide a snapshot of the enabling environment and important context to quantitative data. Compiling information on the existence of other programs or initiatives (e.g., costed implementation plans [CIPs], school enrollment efforts, advocacy to end child marriage) may be helpful if there is an opportunity for integration or leverage. A rapid landscaping analysis can also help pinpoint specific geographies or populations where efforts may be most needed.

2. Since CIPs and commitments are mutually reinforcing, it is important that CIPs also include AY in their final products. The Tool for Adolescent Responsive Planning (TARP) created by Pathfinder International's Evidence to Action project is specifically designed to help planners propose evidence-informed programming and allocate adequate resources to meet the needs of AY. See more information about this resource in Appendix B.

CHECKLIST: POTENTIAL QUESTIONS FOR CONDUCTING A LANDSCAPE ANALYSIS

- How well are policies that protect and promote AYSRHR known, disseminated, and implemented to the subnational and even district level, and among AY and key stakeholders? Which policies might have a negative effect on AYSRHR?
- How are sociocultural and gender norms, beliefs, attitudes, and practices manifested in the health sector and the community at large? Are there regional variations?
- How well are violence prevention programs reaching AY boys and girls? How do communities deal with forced/coerced sex, transactional sex, or intergenerational sex?
- How well does the education sector support AY, especially girls, to enroll in and complete secondary school? How well does the education sector coordinate with the health sector for student health?
- How is the country addressing youth unemployment, especially by age and sex? Are certain groups of vulnerable youth being left behind? How well and in what ways do the labor and health sectors collaborate and coordinate?
- To what extent is there functional coordination and collaboration between the health and other sectors (multisectoral programming) that are essential to healthy adolescent development?
- How well are the needs of AY who are displaced or in crisis being addressed? Does current guidance on COVID-19 specifically address AY? To what extent does your country incorporate the needs of AYSRHR in disaster planning or emergency preparedness efforts?
- How is your country investing in youth development and youth-led efforts? Are there efforts to nurture/incubate youth-led organizations and initiatives, including among FP programs and institutions?

STEP THREE: SELECT EVIDENCE-INFORMED INTERVENTIONS

Commitment activities agreed upon in partnership with adolescents and should be forward-looking. In nearly all countries, the population of adolescents and youth will increase over the next 30 years and health programs and services will need to keep pace. Consider how commitments can improve the overall responsiveness of the entire health system to the needs of adolescents and youth, including SRHR and FP services. FP2030 recommends planning for the institutionalization of adolescent responsive approaches and implementation at scale.

To implement evidence-informed strategies and activities that can help you achieve your commitment, we advise the following actions, which are based on a review of evidence by the International Center for Research on Women (ICRW).

Support AY to Make Healthy Choices and Decisions: Commitments should include rights-based and evidence-informed strategies that assist AY to improve their understanding of SRHR, correct myths and misinformation around sexuality and contraception, develop skills that support positive behaviors and decision-making, and emphasize the importance of voluntary choice in the use of contraception. AY are more likely to make a voluntary choice to use contraception:

- When they want to avoid, delay, space, or limit childbearing;
- When they articulate a desire to use contraception; and
- When they acquire the skills and self-efficacy to use contraception.

Additionally, evidence increasingly suggests that supportive social norms can enhance efforts to provide SRH information and services to AY, and facilitate their ability to make healthy choices and decisions about their SRH. Programmatic interventions that help AY to avoid, delay, space, or limit childbearing may be indirect, such as increasing school enrollment and retention through cash transfers, incentives, support for school-related costs, or efforts to lower barriers to school attendance or prevent early marriage. Community-based activities that develop life skills using a trained facilitator and a structured curriculum can help AY gain a stronger sense of life opportunities aside from or in addition to parenthood, which may further help them avoid early marriage and/or early pregnancy.

Social and behavior change (SBC) programs can promote positive attitudes towards contraception, help AY understand the benefits of contraception, correct common myths and misperceptions around contraceptive methods, and create greater community support for AY contraceptive use. The most successful SBC programs are designed to transform harmful gender norms, or to alleviate cultural pressures for young women to demonstrate fertility.

ENCOURAGING IRRESPONSIBLE BEHAVIOR?

Some cite concerns that exposing AY to information on sexuality and contraception will "encourage" them to "experiment" with sexual activity, but this perception has proven false.

Evaluations of CSE and community-based programs that focus on transforming gender norms consistently show that such programs protect AY. AY who participate in these types of activities are more likely to delay sexual activity and to use protection/ contraception at first sex.

Comprehensive sexuality education (CSE) is an important SBC program that has been shown to improve AY knowledge of and attitudes towards contraception, including improved AY self-efficacy to use contraception, if implemented with attention to those factors that make it effective.[3,4] Multiple media channels such as traditional media, the internet, social media, and mobile phones also are popular platforms for informing AY about SRHR and contraception.

In addition to helping AY acquire information and develop skills, agency, and confidence, SBC efforts can support AY in seeking needed services. SBC programs can develop closer links to SRHR and FP services through voucher distribution or effective referral networks. It is important to ensure, however, that available services and service providers are receptive to seeing AY clients.

Increasingly, programmatic experience suggests that it is important to reach young people before they become sexually active. A 2017 report from the Guttmacher Institute found that targeted programming for VYAs helps ensure adolescents are better prepared when they do decide to engage in sexual activity. ICRW's evidence review also reports that peer-led programs can help young people develop critical communication and negotiation skills that increase agency, although there is little evidence that peer education programs result in increased use of contraception.

Provide Responsive Contraceptive Services: Commitments should recommend strategies to ensure that high-quality, adolescent-responsive contraceptive services are available and easily accessible. Diverse approaches and programmatic models have been documented, and this information can be used by

3. International technical guidance on sexuality education: an evidence-informed approach, UNESCO et al. (2018)
4. Sexuality education: emerging trends in evidence and practice, Haberland & Rogow. (2015)

commitment-makers to better target the right model to the right group of AY. Popular approaches, such as youth corners and youth centers, have not been found to improve uptake of SRHR and contraceptive services, and are difficult to scale, although they may have other benefits.[5]

To increase the availability of and access to quality health services, commitments might include the following:

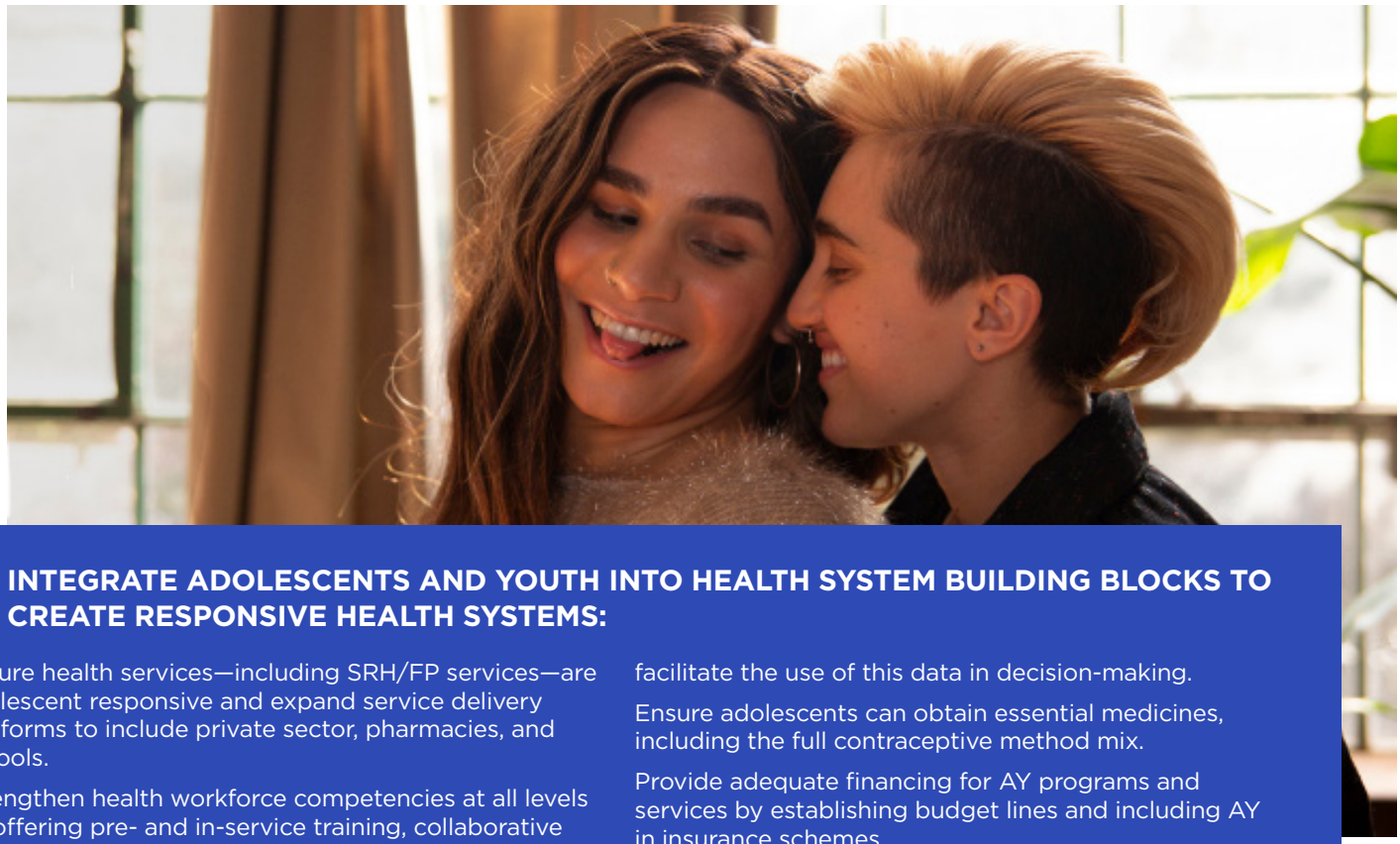
- Community-based distribution and outreach, vouchers, and social franchising have been shown to reduce some of the physical and financial barriers to contraceptive methods experienced by some groups of AY, but not all.
- High-quality provider training can improve the quality and responsiveness of services. While provider training in "youth-friendly service delivery" has been a common response to AY complaints that SRHR services are hostile and unwelcoming, better pedagogical approaches need to be implemented alongside in-service training. This includes the development of pre-service curricula in AY and AYSRH, on-the-job training, learning collaboratives, and supportive supervision. Importantly, it is insufficient to train individual providers to be "friendly;" rather the entire health facility staff needs to be responsive to and supportive of AY seeking SRHR and FP services.

Increasingly, experts recommend that AY service delivery efforts apply a whole system approach, using the WHO Health System Building Blocks[6] and the AA-HA Framework.[7] Commitment-makers may wish to consider support for more systematic and strategic investments in improving the overall health system to create a more adolescent responsive health system.

Address the Enabling Environment: WHO recommends using the socio-ecological model to identify the right strategies and activities to improve AYSRHR. The suggested landscaping activity will help determine types of activities that should be implemented at each level of the socio-ecological model—societal, community, relationship, and

5. What Does Not Work in Adolescent Sexual and Reproductive Health: A Review of Evidence on Interventions Commonly Accepted as Best Practices, Chandra-Mouli, Lane & Wong. (2015)

6. Everybody's Business: Strengthening Health Systems to Improve Health Outcomes. WHO's Framework for Action, World Health Organization. (2007)
7. Global Accelerated Action for the Health of Adolescents (AA-HA): Guidance to Support Country Implementation, the World Health Organization. (2017)



INTEGRATE ADOLESCENTS AND YOUTH INTO HEALTH SYSTEM BUILDING BLOCKS TO CREATE RESPONSIVE HEALTH SYSTEMS:

Ensure health services—including SRH/FP services—are adolescent responsive and expand service delivery platforms to include private sector, pharmacies, and schools.

Strengthen health workforce competencies at all levels by offering pre- and in-service training, collaborative learning and supportive supervision in adolescent development and responsive service delivery approaches.

Ensure HMIS can capture and report essential data on AY through better disaggregation of data by age and facilitate the use of this data in decision-making.

Ensure adolescents can obtain essential medicines, including the full contraceptive method mix.

Provide adequate financing for AY programs and services by establishing budget lines and including AY in insurance schemes.

Facilitate leadership and governance through improved partnership with AY, collaborating with AY led organizations, and strengthening AY accountability efforts.

Photo Credit: The Gender Spectrum Collection

individual. Commitment-makers may wish to support activities:

- At the societal level, as many countries have strong policies and laws on their books, but policies are often not enacted and laws are not enforced. Advocacy is needed with Ministries of Health, Finance, Education, and Justice, among others, to encourage the allocation of resources to implement AY-focused policies and enforce laws.
- Within communities as supportive norms exhibited by teachers, religious leaders and community members can encourage AY to initiate and maintain healthy AYSRHR and FP choices and behaviors.
- Within relationships, since parents, partners, family members, and peers are highly influential to AYSRHR and FP behaviors and decision-making.

Small group discussion programs for stakeholders and gatekeepers that are curriculum-based and conducted by trained facilitators can help these important influencers understand, normalize, and support the development of AY agency, skills, and healthy behaviors, and help put an end to traditional practices that are harmful to AY health and wellbeing.

Monitor and Evaluate: While data can help decision makers better understand AYSRHR and FP priorities and develop targeted programs, as explained above, no single indicator can fully capture the status of AYSRHR. Since its establishment in 2012, FP2020 has annually reported on a set of Core Indicators for all 69 FP2020 focus countries, including the adolescent birth rate. Commitment-making countries have worked with Track20 on reviewing data and progress annually and reporting the indicators to FP2020 for the progress report. This process of annual review and reporting will continue in the FP2030 partnership. Assessing data on AYSRHR during this annual process is critical for assessing the effectiveness of chosen approaches.

While the adolescent birth rate is an indicator under the SDGs, Every Woman Every Child, and FP2020, more data is needed on AYSRHR and FP to determine programmatic priorities and monitor progress. FP2020's Performance, Monitoring, and Evidence (PME) Working Group has been reviewing the set of core indicators from FP2020 and is finalizing an updated measurement framework and set of core indicators for FP2030. In 2018, after consultation with partners, including FP2020 youth focal points and the PME Working Group, FP2020 began aggregating a set of supplemental AYSRHR indicators on demographics, key life events, and contraceptive practices among AY. Vital for assessing progress, these supplemental AYSRHR indicators will become a part of regular reporting in the FP2030 measurement framework.

Monitoring progress toward meeting AYSRHR and FP needs remains a challenge even with annual reporting of adolescent birth rate and supplemental indicators. Current data sources and global indicators are designed to capture data for all women of reproductive age. Detecting statistically significant change in AYSRHR indicators may be difficult with the small number of adolescent girls who report being sexually active. Thus, commitments monitoring should also draw upon other data sources that may be available from service statistics and special surveys. HMIS from public and private sector partners may be used to assess client volume or services distributed to those younger than 20 years old.[8] Special surveys may be used to focus on AYSRHR issues and may capture more diverse information than large-scale national surveys, but they should be interpreted with caution as they may not be nationally representative.

8. Service partners who have experience collecting age data among adolescents have suggested caution in collecting detailed age data for every client. Two issues include poor data quality and ethical and privacy concerns regarding asking a young client's age. Monitoring contraceptive services provided to adolescents, while protecting provider and client privacy, may be as simple as noting whether a client is under the age of 20.

ADDITIONAL RESOURCES

1. IYAFP's Meaningful Adolescent and Youth Engagement Checklist
2. Adolescent Responsive Contraceptive Services: A High Impact Practices Enhancement
3. Youth Engagement Training, Youth Power Action
4. Global Health Observatory, WHO
5. Track 20

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