

Adolescent Health

The Missing Population in Universal Health Coverage



This paper was funded through a charitable grant made by the AstraZeneca Young Health Programme (YHP) to Plan International UK.

This paper was developed by Susanna Lehtimäki and Nina Schwalbe of Spark Street Consulting with Liam Sollis at Plan International UK. We gratefully acknowledge the contributions of Valentina Baltag, Wole Ameyan, Annemieke Brands, Berit Kieselbach, Yuka Makino, Antonio Montresor, David Ross and Benoit Varenne (World Health Organization), Cristina de Carvalho Eriksson, Willibald Zeck, David Hipgrave and Stefan Peterson (UNICEF), Mychelle Farmer (NCD Child), Susan Sawyer (International Association of Adolescent Health), and Kathleen Spencer Chapman (Plan International UK).

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Executive Summary

The Sustainable Development Goals and global political momentum behind Universal Health Coverage (UHC) offer significant opportunities to build collective global and national action towards achieving universal health coverage for adolescents. This paper sets out the evidence base on adolescent health and makes the case that to achieve Universal Health Coverage, policy makers need to take urgent action in the areas of service delivery, financing and governance.

There are nearly 1.2 billion adolescents (10-19 years old) worldwide. In some countries, adolescents make up as much as a quarter of the population and the number of adolescents is expected to rise through 2050, particularly in low- and middle-income countries (LMICs). Globally, each year there are more than 1.2 million adolescent deaths. While the majority of adolescent health issues are preventable or treatable, adolescents **face multiple barriers in accessing health care and information**¹.

Progress towards UHC requires keeping adolescents healthy as adolescence represents a critical window of opportunity for effective prevention and health promotion with effects throughout the life-course.

Investment in adolescents delivers a “triple dividend” – improving health now, enhancing it throughout the life course and contributing to the health of future generations¹. Healthy adolescents also fuel economic growth by contributing to increased productivity, reduced health expenditure, and the interruption of intergenerational transmission of poor health, poverty and discrimination. For every dollar invested in adolescent health, there is an estimated ten-fold health, social and economic return².

Delivering UHC for adolescents requires addressing the following three priority areas:

Improving service delivery, laws and policies:

In most countries, health systems and services are mainly designed for either young children or adults. Given their specific health and

development needs, **adolescents require responsive anticipatory models of service delivery**. Due to biological and gender-based differences that result in varied health risks and disease incidence, these health services must **always apply an appropriate ‘gender lens.’** Governments need to reach adolescents with high quality, well-coordinated and well-integrated programs in their everyday context. This demands **coordinated multi-sectoral action across a range of service delivery platforms**, and should be complemented by laws guaranteeing that adolescents have access to services.

Increasing financing:

National health strategies and investment plans for UHC must include adolescents, with an emphasis on the most vulnerable and marginalized adolescents and their families to ensure equity. Investing in vertical or single-issue programmes is rarely efficient. Programmes should be **designed to address multiple risk factors and vulnerabilities** and all adolescents should be covered by **mandatory, prepaid, pooled funding with user fees reduced or eliminated**.

Strengthening governance:

Adolescents themselves should be empowered to initiate action and influence decisions that affect their health and development through mechanisms that allow for meaningful participation. This should be bolstered with **disaggregated and regular data** to know the magnitude of disease burden, health needs and barriers to services for this age group.



1. Introduction

Target SDG 3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.

The Sustainable Development Goals and global political momentum behind Universal Health Coverage (UHC) offer significant opportunities to build collective global and national action towards achieving universal health coverage for adolescents. UHC can be a crucial milestone towards ensuring that healthy and empowered young people are the cornerstone of equitable societies and prosperous economies.

While under five mortality halved during the Millennium Development Goals period³, progress in adolescent mortality has stalled⁴

Government commitment to UHC *for all ages*, a core component of the 2030 Agenda for Sustainable Development, means reaching adolescents, as well as other groups. Global intergovernmental processes can ensure that adolescents as a group benefit from the improved health outcomes seen over recent decades among younger children¹, including through adequate levels of resourcing⁵.

UHC's promise to *leave no one behind* calls on governments to both recognize and realize everyone's fundamental right to health, including adolescents⁶.

Healthy adolescents who contribute fully to society are key to sustainable development⁷. In some countries, adolescents make up as much as a quarter of the population, and the number of adolescents is expected to

rise through 2050, particularly in low- and middle-income countries⁸. Investment in this age group can derive a “triple dividend” by improving health now, enhancing it throughout the life course and contributing to the health of future generations¹.

Adolescent demographic data:

- Adolescents make up 16% of the world's population⁹.
- In sub-Saharan Africa, adolescents make up 23% of the region's population⁹.
- More than half of all adolescents live in Asia with 344 million in South Asia and 296 million in East Asia and the Pacific¹⁰.

Investing in adolescent health will also fuel economic growth by contributing to increased productivity, reduced health expenditure, and the interruption of intergenerational transmission of poor health, poverty and discrimination¹. For every dollar invested in adolescent health, there is an estimated ten-fold social and economic return².

Governments have the potential to create transformative outcomes for generations to come, through committing to urgently scale up efforts to respond to the needs of adolescents in all of UHC's three interlinked policy areas – service delivery, financing and governance. This paper sets out a practical agenda for policy makers to guide priority actions to implement this commitment.



About 1.2 billion people, one in six of the world's population, are adolescents aged 10-19 years. Nearly nine out of ten live in low- and middle-income countries (LMICs) where access to health and social services, jobs, and livelihoods are strained⁸. Given that the number of adolescents is expected to rise through 2050, achieving the Sustainable Development Goals (SDGs), including for universal health coverage (UHC) requires addressing the needs of this age group.

UHC, defined as “access of all people to good quality promotive, preventive, curative, rehabilitative, and palliative health services, without financial hardship”¹², provides a critical vehicle through which countries can address the multiple health needs and health rights of adolescents.

While today's adolescents are healthier than before, progress has been much slower than among younger children, particularly those under five years^{1,4}. Despite the growing recognition of the need to invest in adolescent health^{1,7,13}, many legislative, financial and societal barriers hinder adolescents' access to health services¹. Marked by life-changing transformations, including from childhood dependence on parents and caregivers to adult independence, this period of life requires tailored health and education services, protection and health promotion designed to be aligned with their developmental stage and to meet their needs^{1,14,15}.

Investment in adolescent health and development determines both the present and future health of individuals, as well as that of generations to come. Adolescent pregnancy, often intertwined with child marriage or reduced participation in education, is associated with poorer maternal health outcomes^{16,17} and poor infant health and survival^{18,19,20}. Moreover, an estimated 70 percent of preventable deaths from non-communicable diseases (NCDs) in adults have been linked to health risks and behaviours, including tobacco, alcohol and illicit drug use, physical inactivity, and poor-quality diets, that are commonly established in adolescence²⁰. Health risks and risk behaviours also tend to cluster^{21,22,23,24}, reinforcing the social and health inequities during adolescence and later in life. Moreover, with 1.2 million adolescent deaths annually¹⁵, largely from preventable and treatable causes, adolescents are in need of health services and policies that promote enabling and safe environments, and protect and improve their health and development *during* adolescence.

UHC, with its focus on three interlinked policy areas – service delivery, financing and governance – offers significant opportunities for equitable progress on reducing adolescent mortality and morbidity. It has the potential to influence attitudes and behaviours that will change future risks and improve the resilience of adolescents.



2. Adolescents and Health

2.1 Determinants of Health

Adolescence is a critical period of human development with rapid physical, psychosocial, cognitive and emotional development, and sexual and reproductive maturation. While biology impacts adolescent health and development, social contexts including families, media, schools, and neighbourhoods where adolescents live, learn, and grow also have a great impact on their health and wellbeing^{1,14,15}. Social and cultural norms, particularly regarding gender, as well as ethnicity, sexual orientation, or disability, determine social patterns of behaviour and can both limit and enable everyday choices, needs and expectations^{14,25}.

For example, whereas girls are more likely to be married as children, drop out of school, experience sexual violence and have restricted opportunities including due to early pregnancies²⁶, stereotypical attitudes related to masculinities contribute to boys engaging in more risky behaviours such as harmful substances use, with greater exposure to interpersonal violence and higher rates of injuries²⁷.

During adolescence, independence and autonomy from family increases and peer relations become more significant^{1,14,15}. At the same time, family and parents or caregivers have a great impact on adolescent health. On one hand, family connectedness protects from multiple health

risks^{28,29}. On the other, family circumstances can also cause harm, including through violence and abuse, impairment of identity development (e.g. attitudes towards gender and sexual identity), harmful practices (e.g. child marriage, female genital mutilation/cutting)¹, or parental absence and migration³⁰. Families can also act as a powerful gatekeeper for access to education, health services, and other resources.

The social, emotional and physical environments in which adolescents live and learn have significant influence on their health. From climate change to armed conflict, migration and economic downturns, adolescents are also – and sometimes disproportionately – affected by the risks and opportunities stemming from urbanization and globalization²⁵. New technology and social media provide opportunities for better access to information and services, but can also reinforce vulnerabilities, including exposing adolescents to bullying, sexual abuse, depression or mental health conditions³¹. Adolescents are also vulnerable to the commercial environment, in particular as it relates to food, tobacco and alcohol marketing^{32,33,34,35}. Factors related to physical environment, such as road and playground safety, access to footpaths and parks, water and sanitation and pollutants also influence their health and wellbeing¹⁵.

As a “second sensitive developmental period” after early childhood²⁸, adolescence represents a window of opportunity for effective prevention and health promotion.

Adolescence is defined by WHO as ages 10-19. However, in many countries, delayed role transitions, such as marriage or completion of education, increase the length of dependence and delays separation from home. Thus, it is critical to consider expanding adolescent health services, laws and policies to cover also older youth (i.e. up to 24 years)³⁶.

2.2 Disease burden and health needs

Around the world, health services and policies have largely ignored adolescence¹. An estimated 1.2 million adolescents die each year, largely from preventable causes¹⁵. This age group has failed to experience the improvements other segments of the population have seen. For example, while under five deaths halved during the Millennium Development Goals period³, progress in adolescent mortality stalled⁴. Since 2010, AIDS-related deaths among children have halved, yet have decreased by only five percent among adolescents³⁷. Furthermore, need for contraception is satisfied in only about 42 percent of 15-19-year-old girls, compared to 66 percent of older women³⁸. Young women, especially vulnerable to complications of unsafe abortion and pregnancy, are less well covered by services than older women^{39,40,41}. **Mortality and disability-adjusted life years (DALYs) lost due to road injuries – the leading cause of deaths in adolescence – are not declining**, particularly among adolescents in LMICs as they become more mobile²⁵.

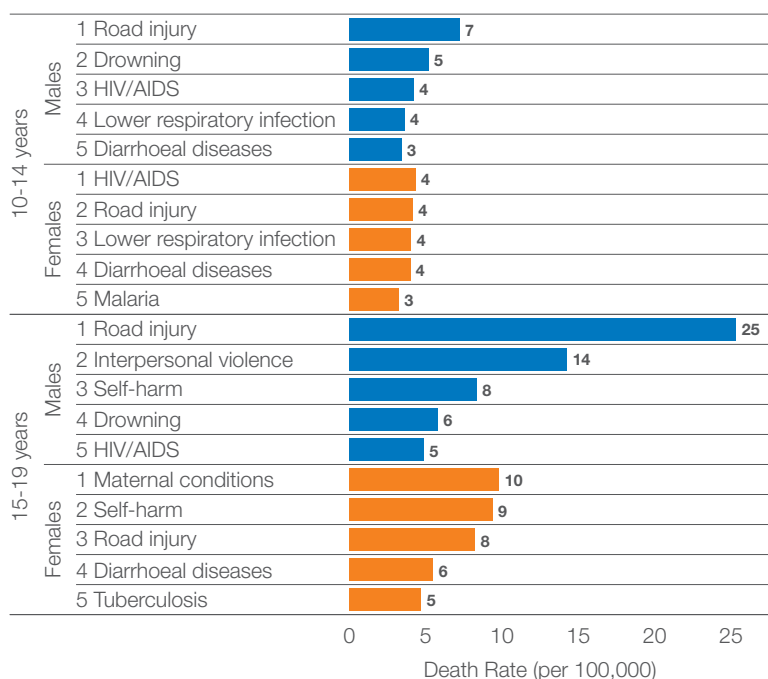
Many health conditions have their onset in adolescence^{15,23}. For example, adolescence represents a period of vulnerability for mental health with nearly 50 percent of mental health conditions occurring by the age of 14 and 75 percent by the age of 24. Often overlooked by health providers, parents, or adolescents themselves due to stigma or lack of knowledge, this critical health issue often goes undetected^{43,44}.

Among 15-19-year olds, self-harm is one of the main causes of death and DALYs lost¹⁵. Suicide is more common among young people than adults, particularly in LMICs⁴⁵. During adolescence, risk of interpersonal and sexual violence also increases, with a lasting impact on health and wellbeing through health-compromising behaviours, reduced participation in education, restricted access to services and increased risk of mental health problems, heart disease, sexually transmitted infections and HIV⁴⁶.

Gender differences are also critical, as gender-related factors have a decisive influence on health-seeking behaviour, health status and access to health services. Gender plays a particularly important role regarding risk of violence: while girls are at higher risk of sexual violence, risk of violence among boys is more often related to armed conflict, homicide and gang activities. Lesbian, gay, bisexual, transsexual, intersex and queer (LGBTIQ) adolescents and adolescents with disability are at a particularly higher risk for physical, sexual or emotional violence, including from their families⁴⁷.

Like in childhood, **lower respiratory infections, diarrhoeal diseases** and tuberculosis continue to account for a significant disease burden and mortality in adolescence^{15,48}. Furthermore, rapid growth and development result in high nutrient needs with greater rates of anaemia and micronutrient deficiencies in both boys and girls¹⁵. Often coexisting with thinness, **the prevalence of overweight and obesity** in adolescence is rapidly increasing in many LMICs due to the greater access to and marketing of processed foods, as well as decreasing levels of physical activity^{49,50}. In addition, and often overlooked,

Figure 1. Estimated top five causes of adolescent death, by sex and age⁴²



adolescents are affected by a range of oral diseases and conditions that pose significant public health problems^{51,52,53}. Figure 1 shows the major causes of death in adolescents globally.

While the majority of these conditions are preventable or treatable, adolescents **face multiple barriers in accessing health care and information**⁵⁴. On the service user side, out-of-pocket costs including service fees, pharmaceuticals and transportation can be significant barriers as adolescents generally do not prioritise health expenses over other needs, even if they can afford to pay. If they are covered by health insurance, insurance is generally brokered by family¹. Furthermore, support or permission of parents and partners is often required to use health services, including for sensitive issues such as sexual and reproductive health (SRH). Lack of parental support and parental or partner control stemming from socio-cultural and gender norms, and often reinforced by laws and regulations on consent, can further restrict care-seeking. On the provider side, knowledge, attitudes and beliefs about adolescents' health needs and services they can legally provide to adolescents⁵⁵, as well as lack of respect, privacy and confidentiality all serve as barriers to access. As with other age groups, barriers including low health literacy, poverty and marginalization also negatively affect adolescents' access, but likely with stronger impact^{13,56}.

Lack of data is one of the barriers to adolescent health: most countries do not know the magnitude of the disease burden, health needs and barriers to services in this segment of the population. As a result, in many cases the need for adolescent-responsive health services is overlooked by UHC efforts; health care financing arrangements have not been evaluated with respect to adolescents; and there is lack of evidence to determine pockets of vulnerabilities and the most effective ways to ensure equity for adolescents within national plans for UHC^{1,40}.

“Health care should not be a luxury but a necessity. My body, My Right.”

Young person, India
UNICEF Multi-country Consultations on PHC





3. Global Commitments

Adopted in 1989, the UN Convention on the Rights of the Child defines civil, political, economic, social, health and cultural rights of all children up to 18 years. While progress towards prioritizing adolescents has been slow, movement on the right to health for adolescents has accelerated in recent years. The General Comment on adolescence (CRC/C/GC/20)⁶, issued more than 25 years later in 2016, targets **adolescence as a specific life stage that governments need to recognize and in which they need to invest**. The UN Youth Strategy, adopted in 2018, emphasises the agency of young people in the implementation of the SDGs and prioritises their access to quality education and health services⁵⁷. The 2016-2030 UN Secretary General's *Global Strategy for Women's, Children's and Adolescents' Health*, which aims to improve health and wellbeing within the context of the SDGs, recognizes adolescents as central to the overall success of the 2030 Agenda⁷.

The key message of the *Global Strategy* with its *Survive, Thrive and Transform* agenda, affirmed and grounded in evidence from WHO, partners¹⁵, and the *Lancet* Commission on Adolescent Health and Wellbeing¹, among others^{13,58,59}, is that investment in adolescent health, education and engagement creates social, demographic

The distinct needs of adolescents should be recognized throughout the 2030 Agenda, with links to multiple SDGs, including health (SDG3), economic growth and job creation (SDG8), gender equality (SDG5), education (SDG4), nutrition (SDG2), and poverty reduction (SDG1).

and economic benefits for the whole of society including adolescents now, later in their life and for the generations to come¹. It further notes that **the SDGs, including those related to poverty, hunger, education, gender equality, water and sanitation, economic growth, climate change, human settlement and peaceful and inclusive societies, will not be achieved without further investments in policies and programmes for adolescents**. While the SDGs do not have explicit targets for adolescents, they are implicitly encompassed by the UHC targets of “health for all at all ages.” The other health targets, including improving SRH, tackling communicable diseases, and NCDs including mental health conditions, preventing road injuries, and reducing tobacco, alcohol, and illicit drug use, cannot be realized without a specific strategy that attends to adolescents¹⁵.

To support the implementation of the Global Strategy, **Global Accelerated Action for the Health of Adolescents – AA-HA!**¹⁵ provides policy-makers with guidance on how to **prioritize, plan, implement, monitor and evaluate adolescent health programmes**. As adolescent health needs, disease burden and risk factor profiles vary across the developmental span of adolescence, as well as across countries and regions, governments must prioritize their policy and programme actions accordingly.



4. Designing UHC for Healthy Adolescents

With its target of “health for all at all ages,” UHC provides a critical vehicle through which countries can build on global commitments to enhance the health and development of adolescents, supporting them to realize their right to health without suffering financial hardship⁶. While implementing UHC can impact positively on adolescents’ health and wellbeing, it also has positive effects on society at large, including by enhancing economic growth, productivity and active engagement⁶⁰.

This section highlights how Governments can design UHC in the interest of adolescents.

4.1 Service Delivery

Primary health care (PHC), as defined within the renewed Alma-Ata Declaration⁶¹, **is the backbone of UHC and adolescent-responsive health systems**. With its people-centred approach and family and community orientation, it takes into account the broader context affecting adolescents’ lives, fosters equity, mutual trust and continuity⁶², and provides opportunities to link to other services, such as those related to education, social services, child protection and water and sanitation¹³. Depending on the country context, including adolescent disease burden and key health risks, PHC needs to contribute to tackling the full spectrum of health issues: from SRH, to mental health, unintentional and intentional injuries, violence, communicable diseases, NCDs and health-compromising behaviors (Box 1).

Box 1. Based on existing global evidence, the following measures have shown to be effective in enhancing adolescent health:

- **Injury prevention:** Clinical assessment and management of injuries; identification, health education, response and care for survivors of intimate partner violence and sexual assault²³; laws and use of helmet and seat belt; alcohol laws; traffic and vehicle safety measures¹⁵; drowning prevention measures⁶³; sports-related injury prevention⁶⁴; prevention of youth violence⁶⁵; policies and interventions to prevent violence against children⁶⁶.
- **Mental health and wellbeing:** Promotion of mental health and wellbeing; responsive caregiving and stimulation; parenting skills; prevention of bullying, including at school¹⁵; interventions for eating disorders; pharmacotherapy; psychological and cognitive therapies for depression and anxiety; interventions to prevent suicide and suicidal behaviours⁶⁷; care for adolescents with developmental delays and emotional and behavioural issues; stress management²³; modification of school environments by whole-of-school approaches^{68,69}.
- **Sexual and reproductive health :** Interventions to prevent unintended early pregnancies including access to contraception; comprehensive sexuality education; interventions to modify sexual risk behaviors; treatment and management of sexually transmitted infections; ending female genital mutilation/cutting⁷⁰; identification, health education and care for survivors of intimate partner violence and sexual assault²³; prevention of HIV transmissions, including PMTCT and voluntary medical male circumcision in countries with generalized HIV epidemics; comprehensive care of HIV¹⁵.
- **Maternal health:** pre-pregnancy, pregnancy, birth and post-pregnancy care adjusted to adolescent needs¹⁵.
- **Nutrition:** Interventions to promote healthy nutrition; prevention and management of obesity, micronutrient supplementation; nutrition in pregnant adolescents⁷¹.
- **Substance abuse:** Tobacco, alcohol and drug abuse prevention and rehabilitation interventions⁷².
- **Communicable diseases:** Prevention, detection and treatment of communicable diseases, including tuberculosis⁷³, schistosomiasis and soil transmitted helminthiasis^{74,75}; prevention and integrated management of childhood illnesses, including pneumonia, diarrhoea and malaria; case management of meningitis¹⁵; immunization, including against human papilloma virus, measles, mumps, and rubella, varicella, tetanus, diphtheria and pertussis, and meningococcal vaccines⁷⁶.
- **Oral health:** Atraumatic restorative treatment, extraction and fluoride tooth brushing⁷⁷; interventions to modify the consumption of sugars, tobacco and alcohol⁵¹.

Making adolescent services an integral part of UHC and comprehensive national health systems, including in all relevant health policies, strategies and programmes, requires a shift from past practices of building parallel services through project-based initiatives. Given the specific health and developmental needs distinct to adolescence, health systems need to be **responsive to adolescent needs**²³. For all age groups but particularly adolescents, health care providers need to deliver services in a way that develops and inspires trust and confidence in the system and services, reduces stigma and discrimination, and ensures that adolescents' expectations and needs are responded to⁷⁸. **While on one hand respecting adolescent autonomy is crucial, meaningful involvement of parents or other trusted adults may also be required**, particularly among younger adolescents, as access to services or treatment often requires guardian consent or support (e.g. financial, emotional)⁷⁹.

Biological and gender-based differences between adolescent girls and boys result in differences in health risks, disease incidence and health service needs. As gender-related factors have a significant influence on both the supply and access to health services, governments should apply a 'gender lens' when designing adolescent-responsive UHC services.

Along with diagnostics, treatment and care, adolescent health services need to emphasise prevention and health promotion. 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 modifiable⁸⁰. In recent years, adolescent health programmes have mainly focused on delivering SRH services and information, and while there remains a great deal more to do, other health concerns have largely remained neglected. Instead of investing in vertical disease-specific programmes, it is more effective to address multiple interrelated health outcomes and associated behaviours through integrated policies and programmes¹⁵.

Adolescent-responsive workforce

Progress towards UHC will require enhancing professional education on adolescence and adolescent-responsive health care. Health systems, with services mainly designed for either young children or adults, particularly in many LMICs, lack both the workforce^{20,79} and standards⁵⁶ to meet the specific needs of adolescents. Unlike maternal health with obstetricians, gynecologists and midwives, or child health, where nurses, general practitioners and pediatricians have specialist training, in too many LMICs pediatrics stops relatively early in adolescence, leaving a gap in professional leadership. Similarly, while many countries have family doctors whose remit spans the life-course, their training is also often deficient in terms of adolescent health and development^{54,81}. Where adolescents require care for chronic health conditions (e.g. HIV), a sudden transition from paediatric to adult health care services can lead to adolescents' health needs "falling between the cracks"⁸².

While there are some efforts to develop specific curricula and training standards, most medical schools do not deliver training on adolescent-responsive health care⁸¹. The training should enhance competencies in clinical care, health promotion and interpersonal communication and in assessing adolescents' capacity for autonomous decision-making, with a broad understanding of developmental and contextual aspects, including adolescents' stage of development, the role of parents or guardians⁸³ and laws and policies that promote, protect and fulfil adolescents' rights to health care^{54,81,84}. In this regard, **investment is needed to create a cadre of adolescent health specialists at the national level.** Currently, unlike for maternal and child health, there is no professional leadership at the national level for adolescent health and medicine in most LMICs^{54,84}.

The Republic of Moldova's addressing of adolescent health and development in state medical university curricula

Since 2001, a network of youth-friendly health centres (YFHC) has been established and gradually expanded to provide adolescents and young people with the services they need. To ensure that services are being provided according to national quality standards, it was crucial to address providers' competences, such as age-appropriate communication, confidentiality and integrated health risk assessment, among others. In 2014, a postgraduate training course for service providers (in-service training as part of ongoing education) was developed, approved and integrated into the university curriculum for ongoing medical education. Having a dedicated course on adolescent health in continuous professional education was an important achievement, and a key to sustainability.

It was soon realized that improving the structure, content and quality of the adolescent health component of pre-service curricula is also very important to ensure that every medical graduate is adolescent-competent at the level of basic competencies. Between 2014–2016, adolescent health and development issues have been incorporated in postgraduate training in three ways:

- In residency training of family doctors (18 hours – 3 hours theory and 15 hours practical seminars).
- In residency training of paediatricians (45 hours – 6 hours theory and 39 hours practical seminars).
- In residency training of obstetricians and gynaecologists (140 hours – 70 hours theory and 70 hours practica seminars).

With these successful efforts, the country has ensured that adolescent health and development training is now available in both pre-service and in-service education. Therefore, a progression across this spectrum of education is possible to ensure lifelong learning.

AA-HA! guidance¹⁵

“Meeting the needs of [...] adolescents will require creativity, experimentation and innovation to develop service delivery models that reach everybody; are responsive to gender, age and disability; culturally appropriate; and underpinned by a commitment to nondiscrimination.”

UHC2030



Enabling policies

Laws are equally important in guaranteeing that adolescents have adequate access to services. In some cases, laws can work against the best interest of the adolescent. For example, in countries where the age of consent to sex is 18 years, health workers' ability to provide minors with SRH, including maternal health services, can be restricted, exposing adolescents to multiple health risks, reducing health seeking and putting health professionals in a challenging position⁵⁵.

While adolescents are in need of protective policies, their ability to consent for their own care cannot be undermined. Given current laws, many **countries will need to rethink how adolescence is dealt with in current legal frameworks**. While some laws may be too restrictive, for example around confidentiality and provision of services and health information without a guardian's consent¹⁵, for others, a minimum age requirement can function to address social determinants and protect from harm (e.g. minimum age for marriage, legal driving or purchase of tobacco or alcohol; or laws restricting marketing and sales of unhealthy food)^{6,15}.

Furthermore, there is a need for national implementation and enforcement of existing international agreements, including the International Framework for Tobacco Control, as well as development and enforcement of new types of **international agreements, in particular to tackle transnational influences**, like internet advertising, internet gambling and pornographic violence⁸⁵.

Service delivery platforms

Multiple service delivery platforms can be utilized for primary care provision, outreach and referrals. **Given the spectrum of changing life circumstances and new experiences that may pose risks to health, adolescents need anticipatory models of care that can effectively detect and address these risks within an adolescent's everyday context**. To this end, developing adolescent-specific services, such as school health, e-health, mobile health, or using universal platforms, such as community-based systems delivered by a range of health service workers, including health professionals, peers, lay counsellors, and others, can expand health coverage for adolescents^{15,23,54,68}. Furthermore, population-based interventions, such as human papilloma virus (HPV) vaccination, are an opportunity to co-deliver other types of interventions for adolescents⁸⁶.

When deploying multiple service delivery platforms, it is important that they reach adolescents at scale, with good quality services that are well-coordinated and complementary. Evidence shows that too often interventions are fragmented and one-off and thus ineffective to tackle underlying causes of ill-health, including those associated with social norms and standards⁸⁷. At global, regional and country levels, there is also a need for the documentation of best practices with a view to harnessing the benefits and cascading them to scale.

Multi-sectoral approaches

While the health sector may lead the overall response to health, addressing broad determinants of adolescent health and wellbeing requires multi-sectoral action. Perhaps the most important of these is the **education sector**.

“I want future primary health care to be as near as a click away from me.”

Young person, Mongolia
UNICEF Multi-country Consultations on PHC



Rwanda's comprehensive school health policy

School-aged children in Rwanda face many challenges related to poor health, poverty and environmental hazards, such as inadequate water and sanitation facilities, limited school infrastructure, communicable and NCDs, and gender-based violence. Other important health issues relate to sexuality, SRH, HIV prevention, trauma, violence, substance abuse and mental health problems. These factors impact on attendance at schools and on learners' abilities to concentrate on school lessons, leading to poor retention rates and learning outcomes. In order to overcome such barriers, the Government of Rwanda has developed a comprehensive national school health policy as an integrated set of planned and sequential efforts designed to promote the students' physical, social, psychological and educational development. The school health policy recommends policy actions in eight key areas:

- health promotion and disease prevention and control
- HIV, AIDS and other STIs
- sexual and reproductive health and rights
- environmental health
- school nutrition
- physical education
- mental health and related needs
- gender and gender-based violence issues.

The policy takes a whole-school approach, with interventions directed at improving the school curriculum; physical infrastructure; access to school-based health services; school ethos; school policies; and linkages with the community. It recommends a school health minimum package, including health promotion and education; referral and follow-up of minor health issues; safe water and sanitation provision; deworming; and school nutrition. Nine ministries implement the policy, each with its specific areas of responsibility.

AA-HA! guidance¹⁵

Policies to increase school enrolment and retention, for example, abolishing school fees or additional costs related to uniforms and meals, are effective interventions that help to keep adolescents in school, with demonstrated health benefits¹. Education of girls is associated with a decrease in early and unintended adolescent pregnancy and child marriage. Further, it provides a platform for health education, including menstrual health management and comprehensive sexuality education, as well as individual skills building and school-based preventive interventions, including growth monitoring, dental and sight screening and immunization⁵⁴. School environments (physical

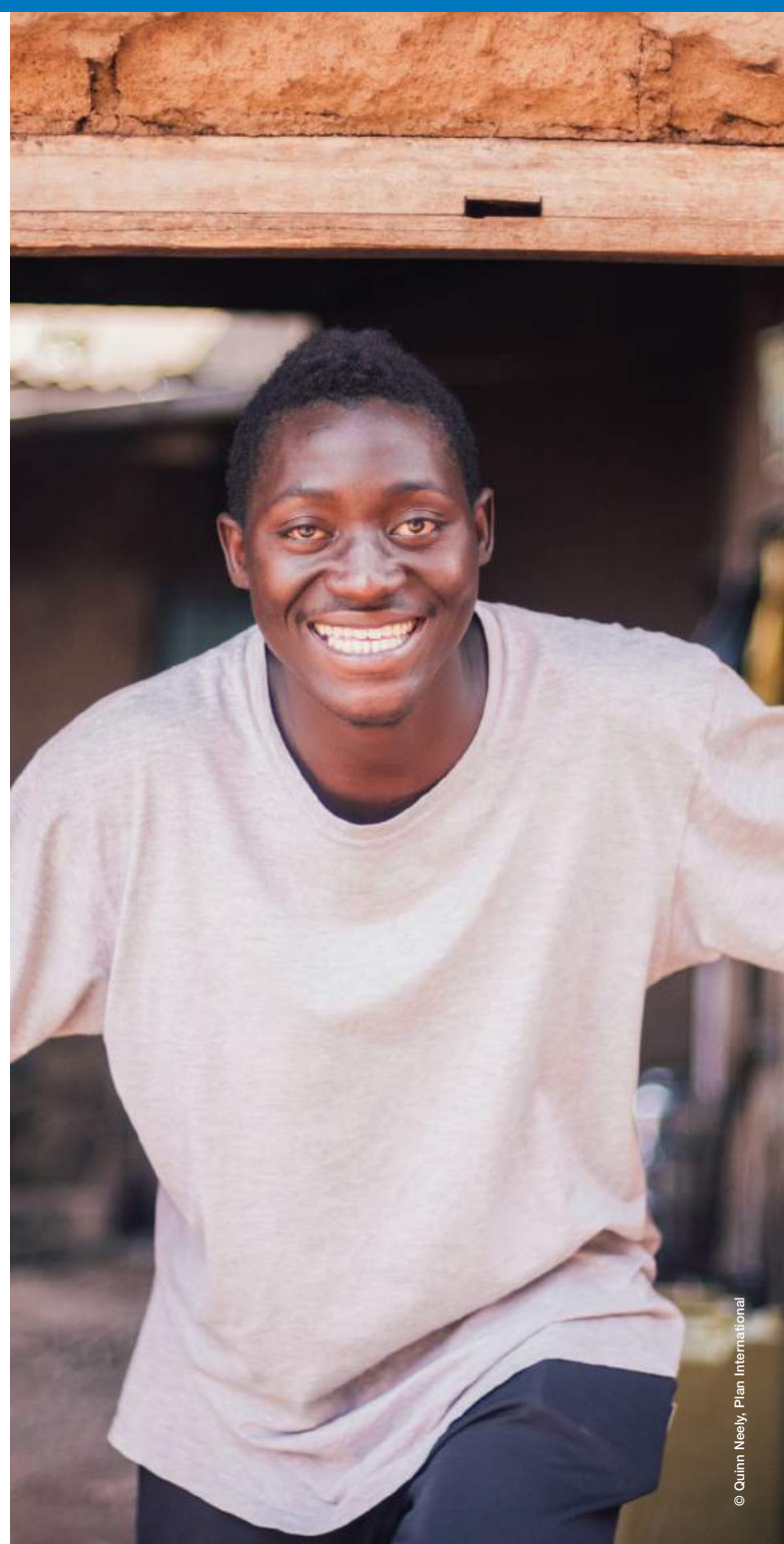
and social) are an important factor associated with a range of adolescent health outcomes, including those related to sexual health, substance use, mental health and wellbeing, physical activity, nutrition and violence and bullying prevention¹. Evidence from different income settings shows that whole-of-school interventions that comprehensively modify school environments, for example, through school policies, social and emotional education, dialogue, and student participation, are effective in promoting health and reducing health risks among students^{68,69}. Further, schools can offer a platform to reach families and communities and help to enhance parenting or caregiver skills or their health literacy¹⁵.

Measures to enhance UHC include **social protection programmes**, such as cash transfers that incentivize health-promoting behaviours, care seeking and school participation⁸⁸. More broadly, **economic and social policies** that tackle the unequal distribution of power, wealth and resources in society can also yield positive outcomes for adolescents. Examples include policies that improve opportunities for education, provide skills building and employment, especially for girls, or regulate tobacco, alcohol and unhealthy foods and beverages sales and marketing⁸⁹. Improvements in **transportation, including in road safety, can contribute to** UHC for adolescents by improving access to services and schools. **Water and sanitation and the environment** play a fundamental role by offering access to clean water, sanitation and reducing exposure to harmful pollutants. **Urban planning** also affects health through interventions such as traffic lights in front of schools, or spaces for physical activity and recreation²³.

Finally, the **media and telecommunications** sectors have a critical role to play. Through the internet, mobile phones, and social networks, young people aged 15-24 years are the “most connected” age group in the population, with over 40 percent online in Africa and 70 percent globally⁹⁰. On one hand these technologies, shown to be particularly popular and effective among this age group, can enhance adolescents’ access to information and education and promote social inclusion, with the potential to enhance demand and care seeking^{78,91}. At the same time, these technologies can expose adolescents to bullying, harassment, and abuse and inadvertently enhance existing inequities. Thus, increased control and monitoring of these platforms, quality assurance of information, enhanced knowledge of parents or caregivers and professionals, and legislation with criminalization and clear definitions of online abuse and exploitation need to be in place⁹².

“As young people, we are always on social media. It is the best way to talk to and reach to us.”

Young person, Rwanda
UNICEF Multi-country Consultations on PHC



Bhutan's project to enhance skills and capacities of parents of adolescents

In 1999, the Government of Bhutan introduced an educational project to enhance the skills and capacities of parents of adolescents – recognizing that parents are the primary gatekeepers and a key source of information and support for adolescents. Objectives of the project included raising parents' awareness of issues facing today's adolescents; educating them about adolescents' special needs; enhancing their capacity to communicate comfortably with their children in general and specifically on sensitive topics; and strengthening their capacity to address issues confronting their adolescent children at home.

The Bhutanese parenting project functions through secondary school teachers who help coordinate meetings with the parents and provide other logistical and programmatic support. In total, 320 local teachers underwent specialized training, and subsequently led sessions with approximately 40 000 parents of adolescents in their schools. The parent intervention focused on understanding the physical and psychosocial changes of adolescence, and on parenting skills, drug use and factors affecting adolescent sexual and reproductive health.

Afterwards, parents were expected to take more active roles in the lives of their adolescents, and to be able to communicate with their children concerning important issues such as substance use and reproductive health. In addition, parents were encouraged to establish parent support groups as a means of providing advice and assistance to one another. These groups became self-functioning after the initial phase, but the Ministry of Education continued to provide them with new information and support, e.g. to organize broader talks for parents and adolescents. A qualitative evaluation of the project suggested that parent participants developed better attitudes toward their children, improved their parenting skills and reported increased communication with their children, including communication on sensitive topics such as reproductive health.

AA-HA! guidance¹⁵

4.2 Health Financing

Investment opportunity

For every dollar invested in selected adolescent health interventions, there is an estimated ten-fold health, social and economic return². Further, with a “triple dividend of benefits,” investments in UHC have the potential to enhance health outcomes throughout the life course: for adolescents now, during their adult lives and for future generations¹.

Estimates suggest that investing US\$5.20 per capita per year in specific adolescent health interventions across 75 LMICs could save approximately 12.5 million lives and prevent over 30 million unwanted pregnancies by 2030. Furthermore, investing US\$3.80 per capita per year in best-practice programmes to end child marriage and US\$22.60 in secondary school enrolment and quality of education

could generate benefits of six and 12 times the cost, respectively, while resulting in broad and long-lasting health, social and economic benefits to adolescents and communities as a whole². However, even though adolescents carry 11 percent of the global disease burden, they received only 1.6 percent of development assistance for health through 2015⁵.

Financing integrated programmes

In the past, countries and donors primarily invested in vertical adolescent programmes, for example, targeting SRH or HIV/AIDS. While some of these programmes have been successful with regard to their specific focus area, they failed to address adolescent health and wellbeing more broadly. Moreover, some targeted only a small proportion of adolescents, often not serving the adolescents most at risk or in need of services,

used platforms (e.g. youth centres) that have not been found to be cost-effective, or implemented interventions in a fragmented or uncoordinated way⁸⁷. Evidence is now clear that rather than investing in vertical approaches, programmes are more effective if designed to address multiple risk factors and bundles of vulnerabilities. They should be costed as part of a comprehensive national package of adolescent health interventions, based on situation and barrier analysis¹⁵.

Governments should include a focus on adolescents in national health strategies and investment plans for UHC¹⁵. Investment must reach beyond service delivery to also include routine monitoring of health patterns across adolescence, strengthening of national institutions and building human resources in adolescent health⁶⁰.

While **donor funding can accelerate investment in adolescent health, domestic public funding constitutes the main financing source for UHC**. Given that many countries are transitioning from a proportionally greater share of external assistance towards domestic financing, thorough assessment, transition planning and dialogue to scale and sustain services are required⁹³.

All adolescents should be covered by mandatory, prepaid, pooled funding for the health services they need. Financial barriers are a significant hindrance to care among adolescents and young adults in many countries due to their limited access to financial resources^{14,94}. User-fee elimination policies introduced within the broader health financing reforms also have potential to enhance access to care^{95,96,97}. As such, governments should reduce or eliminate payments for adolescents at the point of use¹⁵ while also developing systems adaptable to the differing circumstances of adolescents still living with their families and those living independently.

In addition to adequate financing, achieving UHC requires an emphasis on the most vulnerable and marginalized adolescents and their families. If poorly planned and monitored, increasing spending may result in widening disparities among adolescents (e.g. by gender, sexual orientation, age, socioeconomic status, migrant/rural/urban, disabilities) rather than narrowing them⁹⁵.

“Spending funds well is critical for mobilizing additional resources and improving health system performance.”

UHC2030

“We don’t have universal health care here. Even though I have insurance, it only pays 20%. When I hurt my foot, I waited more than a year to get help because I couldn’t pay the doctor.”

Young refugee, Jordan
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4.3 Governance

Adolescent Participation

Mechanisms for meaningful adolescent participation are missing in many settings.

Achieving UHC for adolescents requires that adolescents themselves are empowered to initiate action and influence decisions that affect their health and development through meaningful participation. Adolescents are often not organized for advocacy, and decision-making is rarely informed by adolescent rights.

Embedded in the UN Convention of the Rights of the Child, adolescent participation is a human right and governments must ensure adolescents, including those from vulnerable, marginalized and excluded groups, are involved in development, implementation and monitoring of policies and programmes at all levels of society⁶. While developing mechanisms for participation, adolescents, service providers and policy-makers should be provided with skills and capacities that encourage dialogue and ensure that adolescent voices are genuinely heard.

Engagement and meaningful participation of adolescents as well as their families in policy formulation, decision-making and monitoring is a way to make services and policies more effective while also strengthening social accountability.

Countries should set up mechanisms for adolescents to participate in the national process to plan steps towards UHC, to ensure health platforms are inclusive and, where appropriate, prioritize adolescent health. This engagement should occur during the formative stages of planning to move more rapidly towards UHC so that adolescents can share decision-making roles during the design, implementation, monitoring and evaluation of progress towards UHC.

Information and communication technology and tools enable reaching out for feedback from a large number of adolescents with different backgrounds, while also equipping them with capacities to seek and use information^{78,98}.

Multi-stakeholder collaboration

While at the country level the Ministry of Health is likely to lead and coordinate work on adolescent health, as described above, multiple other ministries and government bodies are required to contribute to health promotion and protection. In addition, a range

Transformative accountability for adolescents

In its 2017 report the Every Woman Every Child Independent Accountability Panel emphasised that accountability to adolescents is fragile and needs to be strengthened. They called on all stakeholders to make adolescents more visible, specifically by:

1. Locking in Accountability to Achieve the Global Strategy and the SDGs
2. Making Adolescents Visible and Measuring What Matters
3. Fostering a Whole-of-Government Accountability to Adolescents
4. Making Universal Health Coverage Work for Adolescents
5. Boosting Accountability for Investments, including for Adolescents' Health and Well-Being
6. Unleashing the Power of Young People, Move Away from Tokenism⁹⁹

of non-state actors, including non- and for-profit and faith-based organizations provide services for adolescents and consequently, have an important role in efforts to achieve UHC. Involvement of civil society organizations, including adolescent and youth organizations, health rights movements and others promoting inclusion can help to raise the concerns of the most disadvantaged and vulnerable adolescents^{7,15,60}. Through these networks, adolescents can also become stronger voices to counter harmful practices, such as violence (female genital mutilation/cutting) or harmful industries, such as tobacco, alcohol and some of the practices of the food and beverage industries.

Research and data

Compared to maternal and child health with decades of well-established research, monitoring and evaluation, adolescent health **lacks research capacity and funding**, particularly in LMICs. While monitoring progress towards UHC is critical, the **lack of a globally agreed set of adolescent health indicators is a significant challenge** at both global and country level¹⁰⁰.

Finally, as most countries **lack data on adolescent health**, there are critical gaps in understanding adolescent health needs. Global household and school surveys, such as Multiple Indicator Cluster Surveys (MICS), Demographic and Health Surveys (DHS), and Global School-Based Student Health Surveys (GSHS) provide some nationally representative data for many countries, but national health management information systems (HMIS) must also integrate adolescence into indicators that track health service coverage, quality and financing¹⁵. Data should be disaggregated by sex and age between younger (10-14 years) and older adolescents (15-19 years) and young adults (20-24 years)¹⁴.

“I would like to tell the ministers of health and other high-level delegates [...] to involve young people in health care decision-making in their country.”

Young person, Nigeria
UNICEF Multi-country Consultations on PHC

“Good data provides a basis for better health.”

UHC2030





5. Recommendations and Looking Ahead

Governments should maximise the opportunities afforded to them through international political processes on UHC and build political momentum for adolescent health. Through the power of UHC they can make sure no adolescent is left behind.

In order to deliver on every adolescent's right to health and achieve sustainable growth and development across the life course and for future generations, the following priority actions must be integral to the UHC agenda and health for all:

- **Governments should ensure that the specific needs of adolescents are recognized through international political processes and their related outcome documents.**

Strengthen Service Delivery across the Sectors and Platforms

- **Prioritize adolescents in UHC benefit packages.** Develop comprehensive, evidence-based adolescent health programmes and services responding to disease burden and needs, tackling a full spectrum of adolescent health issues from sexual and reproductive health to injuries prevention.
- **Invest in the education of health workers,** the public health workforce and other professionals, including leadership models, to improve the quality of and demand for adolescent services.
- **Implement legal frameworks** that adopt a human rights approach and guarantee access to services in the best interest of adolescents, including those most marginalized and vulnerable.
- **Develop and implement national quality standards** for adolescent-responsive health care services that are both technically sound and attractive to adolescents themselves.
- **Improve efficiency by co-delivering or bundling health services** and information for adolescents and deploying interventions across multiple platforms such as health facilities, schools, e-health, mobile health, and community-based initiatives.
- **Engage** and act beyond the health sector, addressing the broader structural, environmental, and social determinants of adolescent health as a path for prevention.



Enhance Financing

- **Acknowledge the economic benefit of investment in adolescent health** so that it is included in health spending considerations.
- **Assess the impact of out-of-pocket payments** on adolescents and remove user-fees or reduce costs accordingly.
- **Cover all adolescents with mandatory, prepaid, pooled funding** for the health services that comprehensively address adolescent health needs.
- **Increase spending on adolescent health**, while strengthening the costing and budgeting of programs.
- **Include adolescent specific focus in UHC investment plans** so that investments reach beyond service delivery and include comprehensive provisions for adolescent health.
- **Ensure that financing and service delivery are designed so to ‘leave no one behind’** by prioritizing the needs of the most vulnerable and marginalized adolescents, reducing disparities driven by gender, sexual orientation, age, socioeconomic status, migrant status or disability.

Improve Governance through Accountability, Research, Monitoring and Evaluation

- **Engage adolescents** in national and sub-national policy, legislation and programme processes through formal and informal mechanisms. Deploy technology and increase capacities for a shared role in design, implementation, monitoring and evaluation.
- **Report regularly on adolescent health indicators**, with disaggregation by sex and age (10-14/15-19/20-24 years).
- **Drive evidence-based programming, policy and resource allocation** by identifying priority health needs of different adolescent groups.
- **Monitor adolescent health and service coverage, quality and spending** through existing national data systems and surveys (e.g., national HMIS, DHS, MICS, STEPS on NCD risk factors).
- **Strengthen research and policy capacity** to increase understanding of health determinants, disease burden, and evidence-based action specific to adolescent health.

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