CAPACITY BUILDING FOR IMPROVING PLANNING, IMPLEMENTATION AND MONITORING & EVALUATION OF THE ADOLESCENT HEALTH INTERVENTIONS IN THE WHO AFRICAN REGION

Workshop Report

CAPACITY BUILDING WORKSHOP FOR IMPROVING PLANNING,
IMPLEMENTATION AND MONITORING AND EVALUATION
FOR ADOLESCENT HEALTH INTERVENTIONS IN THE WHO AFRICA REGION
BRAZZAVILLE, CONGO, 8th TO 10th APRIL 2014

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World Health Organization
REGIONAL OFFICE FOR Africa

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INTRODUCTION AND BACKGROUND

Over the past years, the efforts of the World Health Organization (WHO), Regional Office for Africa focused on the development or the review of adolescent and youth health policies and/or strategic plans in the region. In addition, WHO developed guidelines, tools and standards to support Members States in scaling up adolescent-friendly health services. With WHO's support, 23 countries[1] developed national standards for quality health care services aiming at making the adolescent services friendly. In order to promote the access of the young people to health information and involve other relevant sectors like education, 15 countries[2] started to implement school health programmes.

WHO has provided also technical support to 20 countries[3] in the region to introduce HPV vaccine. This vaccine targeting girls aged 9 to 13 years old, is a key element in the holistic approach regarding cervical cancer prevention and control in young people and is recognized as a major opportunity to link HPV vaccination with other adolescent health interventions.

It is against this background that the Director of the Health Promotion Cluster has decided to convene a three day's meeting (8 to 10 April 2014) in Brazzaville, Congo bringing together a group of experts to discuss how to improve the planning, implementation, monitoring and evaluation of adolescent health programmes in the WHO African Region.

WOKSHOP OBJECTIVE

The main objective of the workshop was to discuss and agree strategies to improve; Planning, Implementation, Monitoring and Evaluation of adolescent health in order to accelerate progress toward MDG 5b by achieving universal access to RH – by 2015,

EXPECTED OUTPUTS

- The Mapping Adolescent Programming and Measurement Framework (MAPM) for Adolescent Health is described and agreed for use.
- Types and Sources of Information for planning, implementation, M&E HIV and Adolescent health programs are described.
- Experiences and best practices on planning, implementation, M&E adolescent health programmes are shared.
- Adolescent health indicators for the region are identified, discussed and validated.
- Key adolescent health advocacy messages are developed.

PARTICIPANTS TARGETED

The meeting brought together experts and independent consultants coming from various institutions such as:

[1] Burkina Faso, Congo, Côte d'Ivoire, DR-Congo, Ethiopia, Gabon, Ghana, Guinea Bissau, Kenya, Lesotho, Malawi, Mali, Mozambique, Nigeria, Sao Tome and Principe, Senegal, Sierra Leone, South Africa, Togo, Uganda, Tanzania, Zambia, Zimbabwe.
[2] Burkina Faso, Cameroon, Cape Verde, Côte d'Ivoire, DR-Congo, Erythrea, Ghana, Madagscar, Malawi, Mali,,Sao Tome and Principe, Senegal, Sierra Leone, Togo, Uganda
[3] Benin, Cote d'Ivoire, Gambia, Ghana, Liberia, Mali, Niger, Sierra Leone , Senegal and Togo in West Africa, Burundi and Cameroon in Central Africa, Kenya, Madagascar, Malawi, Mozambique, Rwanda, Tanzania, Uganda and Zimbabwe in East and Southern Africa.

a. Ministries of Health;
b. Ministries of education
c. Teaching institutions;
d. Civil society Organisations;
e. AFRO, IST and WCOs Staff.

METHODOLOGY

The meeting methodology included presentations from key experts and WHO AFRO staff and chaired by select leaders in adolescent health. Each session was discussed extensively and key emerging issues captured as well as recommendations.

WORKSHOP PROCEEDINGS

DAY ONE

Workshop Opening and Introduction

The opening session included a welcome address delivered by the Director of health promotion Cluster at WHO/AFRO. Dr. Tigest KETSELA urged the team to devote energy in addressing adolescent health issues in the African Region with a view to accelerate achievement of MDG 5. The opening remark was followed by self-introductions. These were done by participants highlighting their professional background and current roles they play in adolescent health within WHO or in their respective countries.

The briefing regarding administrative issues and security was delivered by the security adviser. This was followed by presentation of meeting objectives and expected outcomes as listed above and a review of 3-Day Programme and Assigning of Tasks to Rapporteurs, Recap officers and Chairpersons of sessions.

Adolescent health status in the region and available Guidelines and Tools

This session was dedicated to presentation and discussion of the key issues affecting adolescents globally and in Africa. It was mentioned that adolescents are a cohort of people who are neither children nor adults. Adolescents constitute high population in 10 – 19 years. At least 90% of the 1.2 billion adolescents live in developing world and there is a rapid population growth among adolescents in the African Region when other regions of the world seem to have plateaued by 2010. Adolescents are faced with a multitude of health risks leading to mortality. Mental health, substance abuse, HIV, Early marriage, early pregnancy are of particular concern.

Adolescent Health Strategy for Africa Region: WHO AFRO has supported several African countries to; develop policies and strategies (30), implement evidence based policies (23), and introduction of HPV vaccination either as demo or national.

Entry points to the wider Adolescent Health Agenda include; HIV care, Reproductive and Maternal Health (Delay early pregnancy, Prevent pregnancy deaths and prevent cervical cancer), using the 4S Framework.

Challenges and important considerations were also discussed and are summaries in the text boxes below.

Key Challenges

1. Limited access adolescents and youth friendly services
2. Weak Service Integration
3. Lack of Accurate Data
4. Weak planning & Monitoring
5. Low involvement of stakeholders

Important Considerations

1. Barriers to progress
2. Support to countries to prioritize
3. Building collaborations
4. Improving Monitoring and Evaluation (M&E) for quality improvement

With regard to guidelines and guidance for adolescent health, tools are available on the WHO Website and organized along the themes of: Planning; M&E; Advocacy; sexual and reproductive health. The tools available include: (i) strategic information; (ii) supportive policies; (iii) services (Capacity Building, Quality Improvement, Package of Services; (iv) strengthening and supporting other sectors. Thus, the electronic version of the existing guidelines, guidance and other relevant documents related to adolescent health were distributed to all participants.

Challenges & Opportunities

- Evidence is only one of the policy influencers.
- Barriers exist that are either political or social.
- Policy changes take time and it is always possible to do well in spite of obstructive policies.
- Important to identify tools and make them known to country offices and colleagues.

Mapping Adolescent Programming and Measurement Framework (MAPM) and Strategic Information

The main objectives of Planning, Implementation and M&E are to support substantive accountability, prompt corrective action, ensure informed decision making, promote risk management and enhance organizational and individual learning.

The are several tools available for planning and M&E and which include; District planning tool, Short program revision tool, Programme management cost for child, One health costing tool and the Mapping Adolescent Programming and Management (MAPM) Tool. The MAPM is a tool for designing, implementing, monitoring and evaluating evidence- informed programmes for adolescent health and development. The MAPM can be used to review existing programmes, to plan a new programme based on lessons learned, to identify important risks, to define key indicators for each step in the process and organize their assessment.

Strategic Information is fundamental for the use the MAPM and includes three components: (i) data from studies and periodic surveys; (ii) data from routine information system and (iii) data from epidemiological and behavioral Surveillance. The 4S framework was described as well as what strategic information is, the sources and who uses it. These are Decision makers, Policy makers as key users. Strategic information is essentially used for planning, and designing interventions. Examples were presented e.g preventing early pregnancy and its effects.

Points raised in discussions

- Tool has been translated and is piloted; experience with this is needed to be further clarified.
- Questions were raised on how tool can be made available and request for further familiarity with its use, whether the tool is electronic and it's functionalities
- Can tool be used for strategic planning and its introduction sustainable?
- Is the mapping tool aligned to other WHO mapping tools?
- Communication strategy very important for countries in responding to myths and misconceptions regarding interventions like HPV vaccination etc.
- Training on MAPM requires time and technical assistance may be needed.
- MAPM tool will be made available to all participants and should be disseminated.
- Agencies at country level should work together on common ground however; this meeting was to build capacity to support countries.
- Prioritize boys as well in programming and work on health worker attitudes to adolescent health.
- Call for more engagement and involvement of the youths.

Integrated Approach to HPV Vaccination and lessons learned from HPV Vaccine Introduction

Adolescence provides an opportunity to reduce high health risk behaviors. Opportunities for integration are many but should look at whole intervention package of services for adolescents. School health, vaccination programs, child health programs, cervical cancer, family planning, HIV, pregnancy and childbirth, female genital mutilation and sexual gender based violence. HPV vaccination programs [Demonstration or national introduction] offer great opportunities for integration.

There was advocacy and political commitment at the highest level that supported smooth HPV vaccine introduction. A deliberate design of appropriate and clear communication strategy based on formative studies ensured good advocacy and community mobilization, integration in school health or child health days was a good learning. Getting out of school girls was a challenge resulting on low coverage. Efficiencies can be achieved by utilizing existing platforms, resources and partners.

Questions, answers and comments

- There is clear interest in countries to integrate – but how? There are cost and design considerations.
- Thinking should be within the continuum of adolescent health programming.
- Measuring progress in achieving milestones in desired outcomes through integration is important and should be addressed.
- There are needs to be a paradigm shift in addressing adolescent health – update the Africa Region adolescent health strategy but have country and content specific context for country-level.
- Integration should be addressed through the 4S framework (1. Strategic information; 2. Supportive evidence-informed policies; 3. Supplies and commodities; 4. Strengthening and supporting other sectors).

DAY TWO

Sharing experience and best practice on planning, implementation and M&E

Day two activities started with a recap of Day one. Following this, six countries[4] presented their experiences with regard to planning, implementation, monitoring and evaluation. Globally, the context in terms of planning, implementation, monitoring and evaluation is similar in all countries except in Tanzania and Malawi where significant progress have been noted. The specific situation in each country is as follow :

1. Burundi has no tool for planning, monitoring and evaluation. The country has no specific indicators for routine adolescent sexual and reproductive health (ASRH) and few SRH services are currently offered to adolescents. There is a limited package of ASRH services in health facilities.

2. South Africa has ASRH programmes that focus on; HIV preventative strategies: medical male circumcision, condom distribution, HPV vaccine initiative and School health. The problem with programmes is usually; Lack of true inter-sectoral collaboration. The question is: how do we address adults in the process? How do we shift the paradigm from trying the same thing and expecting different results? We need to recognise that adolescents grow up in communities not programmes and it is at the community level that the issue has to be addressed. Do we need to move away from filling the square spaces with round pegs?

[4] Burundi, Burkina Faso, Malawi, Tanzania, Senegal, South Africa,

3. Tanzania has developed a National ARH Strategy, done standardization of adolescent friendly health services and put in place a systematic process to improve their quality and expand their coverage. Monitoring tools for National Standards on Adolescent Friendly SRH services are in place and there has been dissemination coverage of National documents. Budget lines for adolescent RH integrated in MTEF & Council Plans.

4. Malawi has Planning Structures for adolescent health services which include several stakeholders such as: MOH, MOE, SRH technical working group, Youth technical working group etc. Malawi has a functional Health Management Information System with few indicators on ASRH. But age disaggregation is an issue.

5. Senegal is preparing a national strategy for adolescent and youth health. There are implementation activities going on that include; Advocacy – resource mobilization but need proper targeting and follow-up and implementation is focus on out-of-school adolescents and existing community networks and partnerships. Monitoring is through regular reports sent to partners. The reports are made by peer educators.

6. Burkina Faso is planning for adolescent services through its National Health Policy, National Youth Policy and programmes being implemented. Plans are developed on implementation and there are regional strategic plans however meetings to define national activities are yet to be funded.

Challenges

1. Burundi may need to have standard service delivery documents to guide ASRH service provision. There may be need to strengthen leadership in ASRH and collaborative working.

2. In Tanzania the challenges include inadequate dissemination of research findings and national documents to stakeholders at all levels to guide provision of health information, education and services to adolescents and youth and inadequate resources to scale-up provision of adolescent friendly SRH services.

3. Age and sex disaggregation data is a big issue in Malawi.

4. BURKINA FASO is facing challenges in the area of resources, integration of indicators, and disaggregated data in routine manner and strengthening child-parent communication. It is important to ensure that the strategic plan is more focused, communication is to be improved and a National Plan to include themes on early pregnancies and pregnancies in school should be developed /finalized.

Strengthening health sector response to adolescent health and sharing experience and best practice on advocacy

The main reasons for investing in adolescent health and development are to target the benefits therefrom. These include health benefits to reduce death and disease; Economic benefit, to improve productivity; Human rights, to fulfil adolescents' rights. Using strategic entry points, to move the wider adolescent health agenda through HIV, RMNH and cervical cancer is critical. The 4 S approaches should be systematic using strategic information.

In conclusion there is a need to use, at large scale, the 4-S framework with particular emphasis on the two programmatic "entry points" to strengthen the health sector response to adolescent health and development and the need to advocate for increased priority to adolescent health in national health, economic and development policies / strategies as well as the need to strengthen monitoring the adolescent health situation and trends in the region.

As a fundamental element for investing in adolescent health and development, the session on advocacy provided the background reasons for advocacy. There was a presentation done by three countries (Cameroon, Uganda and Benin) that was involved in systematic advocacy and strategic information. The presentation also provided guidance on how to conduct advocacy planning, implementation, monitoring and evaluation. In the above-mentioned countries, planning for advocacy is enshrined within several policy instruments. Several actors including health professional associations, civil society organizations, youth networks and international NGOs support the process of advocacy, education and programming. In Uganda there are a National Health Policy, the National Adolescent Health Policy, and a National Policy on Young People and HIV/AIDS that guide advocacy for adolescent health across several sectors like health and education.

Challenges, strenghts and opportunities

- Advocacy has not translated in to comprehensive services nationally, Weak Monitoring and Evaluation system and few adolescent health specific indicators although this has now been addressed by the review and update of the HMIS to capture key adolescent health indicators.
- One other challenge is that actors are many and need mainstreaming in one fold.
- Strengths and opportunities include stakeholders' commitment and existence of a National strategy and existence of adolescent health in the UN framework and continued commitment by donors.

Proposition of a set of indicators for adolescent health in the African Region

The MDGs have adopted some indicators of the development of young people in low and middle income countries, but with a health focus on SRH. Although there is no standard list of adolescent health indicators, it is against this context that it is important for AFRO countries to have a set of indicators guiding adolescent strategies and programmes development, as well as their implementation, monitoring and evaluation. In order to identify and select a set of indicators that are more specific and tailored to adolescent health, some criteria have been defined. These criteria are adapted to the specific principles associated with heath sector strengthening and to the context of the country. For each of the WHO health building blocks the relevant indicators using rigorous criteria were selected. The health domains covered by the proposed indicators are:

- Sexual and Reproductive Health;
- HIV infection;
- Injuries, including Road and other injuries;
- Mental Health including Self Harm;
- Interpersonal Violence;
- Nutritional Status, including underweight, overweight and obesity;
- Other NCD Indicators: Alcohol use, Tobacco use, Physical Activity;
- Illicit Substance Use;
- Protective Factors;
- Policy and Programme level Indicators.

Given the covered health area, the final set of 36 indicators to capture the core functions were selected and classified into the following categories:

- Mortality
- Morbidity
- Health condition
- Health Behavior
- Service Provision
- Coverage of intervention
- Determinants
- Input & output

DAY THREE

Validation of key messages for advocacy and set of indicators for adolescent health

The day three began with a recap of day 2 activities followed by a presentation on the 16 country global school health survey that is being done. The web links have been provided to the team on how to access the data and country fact sheets already published. Following the presentation on global school health survey, the participants were divided in two groups. The

main objective of the group work were to discuss and select relevant a set of 20 indicators to be used by countries among which 10 core indicators will be identified and develop key advocacy messages for adolescent health. Participants then worked in 2 groups (French and English) reviewing and deciding which one of the 36 draft indicators is relevant and would be adopted. The Anglophone group consisted of delegates from 8 countries[5] and the francophone group consisted of representatives coming from 9 countries[6]. After studying and analyzing the 36 indicators, the groups proposed a set of 24 indicators and selected 10 core indicators each. The groups also worked on key sensitization and advocacy messages for the ten selected indicators.

At the plenary session, the set of indicators selected by each group were then discussed at length and very important lessons were learnt by all participants as we shared ideas and trade in experiences. The process finally led to build the consensus on a set of 10 core indicators out of the list of 24 indicators that have been selected based on their relevance (See the 24 validated indicators in the Appendix 3, the ten core indicators are in blue color). The ten core indicators on which all participants reached a consensus are the following:

1. Adolescent mortality all causes,
2. Adolescent mortality due to HIV related illnesses,
3. Maternal mortality ratio,
4. Adolescents living with HIV,
5. Adolescent birth rate,
6. First sex before age 15,
7. Condom use at last sex,
8. Contraceptive prevalence rate,
9. HPV vaccination rate,
10. Health service utilization by adolescents.

Workshop recommendations

In order to move forward and better support countries in investing in adolescent health and improving planning, implementation, monitoring and evaluation, the participants made the following recommendations:

1. Adolescent health interventions should be implemented through a strategic framework supported by the ministry of health. The 4S WHO framework should be used to support this work.

2. Capacity building in planning, implementation and M&E for adolescent health at country level is required to build expertise among national and sub national level adolescent health focal persons.

3. Advocacy for adolescent health is paramount to increase the level of interest and support from leadership of the country. Note- (The recommendation on adolescent

[5] South Africa, Ethiopia, Malawi, Tanzania, Uganda, Ghana, Kenya & Cameroun.
[6] Benin, Burkina Faso, Burundi, Congo, Cote d'Ivoire, Guinea, Niger, Senegal, Togo.

health from the independent Expert review group can be used to strengthen the message).

4. The current monitoring focuses on implementation of activities in adolescent health. Therefore, monitoring policy development, inputs and outputs and impact to assess progress. Indicators and standards for adolescent friendly health services can be used for this purpose.

5. Adolescent health focal points at national and district levels should be involved in the, planning, training and implementation of the Global school health survey in conjunction of with Ministries of Health. They should include in the survey other relevant indicators to help track progress in adolescent health in the country.

6. Using the framework of the continuum of care, adolescent health focal points at national and district level should always be present when maternal and child health planning, proposal development, funding allocation to ensure that adolescent health interventions are embedded in maternal and child health interventions and support is provided to in-country Adolescent Health Working Groups.

7. Other opportunities to improve implementation of adolescent health interventions such as HPV vaccination, HIV interventions, and prevention of non-communicable diseases should be used at every opportunity to support implementation of adolescent health interventions.

8. A database of adolescent health experts for the African Region should be developed, updated and made available.

9. Adolescent health should be placed high on the health agenda for the African Union, and a Day for the African Adolescent should complement the Day of the African Child. This one looks good but many countries are celebrating child health Day/week or maternal and child health Day or week with different themes every year in addition to the African Child Day, Safe-motherhood etc. Therefore, it will be good to factor in adolescent issues during the ongoing celebrations in order not to overcrowd the calendar.

Conclusion

The workshop was a great opportunity to provide background information on adolescent health in the African Region. In addition, the deliberations of the 3-day meeting highlighted the importance of improving planning, implementation, monitoring and evaluation of adolescent health programmes and interventions in the region. That is why in her closing remarks, the HPR cluster Director called on the teams to keep their commitment by helping the countries in developing and monitoring adolescent health programs. She recommended the use of the adolescent health platform put in place in Brazzaville, for technical discussions, experience sharing and future actions to the benefice of member states.

ANNEX

Appendix 1 – Meeting Agenda

TIME	SESSIONS	Facilitators
Day 1 Tuesday, April, 8 2014		
SESSION 1: Workshop Opening and introductions Chairperson: HPR Rapporteurs:		
8:00 - 9:00	Reception and registration	Secretariat
9:00- 10:00	Opening of the meeting: • Welcome address – HPR • Self- introduction of Participants • Meeting objectives and expected outcomes – ADH • Admin/security briefing– RSUM	
10: 00 - 10:15	Group photo	
10:15 - 10:45	Coffee/Tea break	Secretariat
10:45 - 11:00	Presentation of the agenda	ADH
SESSION 2: Updates on adolescent health status in the region Chairperson: Rapporteurs:		
11:10 - 11:30	Overview on adolescent health status in the African region	ADH
11:30 - 12:00	Presentation of guidelines and other relevant documents pertaining to adolescent health;	CAN
12:00 - 12:30	Mapping Adolescent Programming and Measurement (MAPM) framework can be used to structure the planning, monitoring and evaluation of adolescent health programmes	ADH
12:30 - 13:00	Discussions	
13:00 - 14:00	Lunch break	Secretariat
14:00 - 15:00	• Description of the types and sources of information needed to plan, implement, monitor and evaluate HIV and reproductive programmes for adolescents. • Discussion	ADH
15:00 - 15:30	Lessons learnt from the introduction of HPV vaccine in the African Region	Tevi Carol
15:30 - 16:00	Integrated approach to HPV vaccination	ADH
16:00 - 16:30	Coffee/Tea break	Secretariat
16:30 - 17:00	Discussions	Participants
Day 2 Wenesday, April 9, 2014		
SESSION 3: Sharing experience and best practice on planning, implementation and M&E Chairperson: Rapporteurs:		
8:30 - 9: 00	Recap of day 1	
9:00 - 10:00	• Sharing experiences and best practices regarding	Countries (CA)

	planning, implementation, monitoring and evaluation of adolescent health interventions • Discussions	
10:00 - 10:30	Coffee/Tea break	Secretariat
10:30 - 11:20	• Sharing experiences and best practices regarding planning, implementation, monitoring and evaluation of adolescent health interventions • Discussions	Countries (ESA)
11:20 - 12:10	• Sharing experiences and best practices regarding planning, implementation, monitoring and evaluation of adolescent health interventions • Discussions	Countries (WA)
12:10 - 13:00	• Strengthening health sector response to adolescent health and development • Discussions	CAN
13:00 - 14:00	Lunch break	Secretariat
14:00 - 16:00	Sharing experiences and best practices on planning, implementation and monitoring of advocacy activity for adolescent health.	Countries (CA)
	Sharing experiences and best practices on planning, implementation and monitoring of advocacy activity for adolescent health.	Countries (ESA)
	Sharing experiences and best practices on planning, implementation and monitoring of advocacy activity for adolescent health.	Countries (WA)
	Discussions	Participants
16:00 - 16:30	Coffee/Tea break	Secretariat
16:30 - 17:30	• Presentation of proposed set of indicators for monitoring adolescent health • Discussions	ADH
Day 3 Thurday, April 10, 2014		
SESSION 4: Validation of key messages for advocacy and set of indicators for adolescent health Chairperson: Rapporteurs:		
8:30 - 9: 00	Recap of day 2	
9:00 - 10:00	Group work : • Indicators for adolescent health • Key advocacy message development	Participants
10:00 - 10:30	Coffee/Tea break	Secretariat
10:30 - 13:00	Group work : • Indicators for adolescent health • Key advocacy message development	
13:00 - 14:00	Lunch break	Secretariat
14:00 - 15:30	Plenary presentation, discussions and validation of a set of indicators for adolescent health and key advocacy messages.	Participants
15:30 - 16:00	Coffee/Tea break	Secretariat
16:00 - 16:30	Closing ceremony	HPR Cluster Director

Appendix 2 – Workshop Participants

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Appendix 3 – A set of Indicators validated for the Adolescent Health in the African Region

N°	Indicator	Rationale	Definition	Data sources	Recommendations
Mortality: due to all causes					
1	**Mortality- all causes**	An important measure of population health and a major component of disease burden.	The estimated proportion of adolescents aged 10-14 and 15-19 years, that have died in a specified year due to all causes of mortality. Expressed per 100,000 adolescents aged 10-14 and 15-19 years olds. The mortality rates are further disaggregated by sex. **Numerator:** Number of all deaths among adolescents aged 10-14 and 15-19 years, in a specified year. (Further disaggregated by sex). **Denominator:** Per 100,000 Adolescents ages 10-14 and 15-19 years. (Further disaggregation by sex).	Global Mortality Database (GMD), Census, DHS, MICS, civil status and vital registration	These age groups need to be taken into account in the DHS
N°	**Indicator**	**Rationale**	**Definition**	**Data sources**	
Mortality: due to Road Traffic Injuries					
2	**Mortality due to Road Traffic Accidents (RTA)**	This is estimated to be the leading cause of death globally, for 10-19 year olds in 2012.	The estimated proportion of adolescents aged 10-14 and 15-19 years who have died in a specified year due to road traffic accidents. Expressed per 100,000 adolescents aged 10-14 and 15-19 years olds. The mortality rates are further disaggregated by sex.	Global Mortality Database (GMD), Census, DHS, HMIS, vital statistic registers	To consider the road data provided by safety services (police),

			Numerator: Number of RTA deaths among adolescents aged 10-14 and 15-19 years, in a specified year. (Further disaggregated by sex). **Denominator:** Per 100,000 **adolescents** aged 10-14 and 15-19 years. (Further disaggregated by sex).		
N°	**Indicator**	**Rationale**	**Definition**	**Data sources**	
Mortality: due to HIV					
3	**Mortality due to HIV related illnesses**	This is estimated to be the second cause of death globally, for 10-19 year olds in 2012. In 2013, UNAIDS estimates showed that it is only for the Adolescent Age-group that HIV-related deaths have increased, by three-fold, while a decrease has been observed in all other age groups.	The estimated number of adolescents aged 10-14 and 15-19 years, that have died in a specified year due to HIV Expressed per 100,000 adolescents aged 10-14 and 15-19 years olds. The mortality rates are further disaggregated by sex. **Numerator:** Number of HIV deaths among adolescents aged 10-14 and 15-19 years, in a specified year. (Further disaggregated by sex). **Denominator:** Per 100,000 adolescents aged 10-14 and 15-19 years. (Further disaggregated by sex).	UNAIDS, Census, DHS, MICS, HMIS, country reports, vital statistics registers	
N°	**Indicator**	**Rationale**	**Definition**	**Data sources**	
Maternal mortality					

4	**Maternal mortality ratio**	An important measure of maternal health. Maternal deaths are responsible for about one in eight deaths of women globally.	Maternal mortality ratio is the estimated ratio of female deaths for 15-19 year olds during pregnancy, child birth, or within the first 42 days following pregnancy termination irrespective of the location of the pregnancy as a function of 100,000 live births for a given period. There are direct and indirect causes. This includes within 42 days of terminated pregnancy, regardless of duration and site of pregnancy. This excludes (1) accidental or incidental causes in pregnancy and childbirth. Expressed per 100,000 live births **Numerator:** Number of maternal deaths for 10-19 year olds. **Denominator:** Per 100,000 live **Ratio:** Number of maternal deaths per 100,000 live births.	Census, DHS, MICS, civil status registration, HMIS (maternal deaths surveillance)	This can be disaggregated into 10-14 years and 15-19 years by countries
N°	**Indicator**	**Rationale**	**Definition**	**Data sources**	
Morbidity: Adolescents living with HIV					
5	**Adolescents living with HIV**	The number of adolescents living with HIV is important to document in order to inform testing, treatment	The proportion of adolescents aged 10-14 and 15-19 years who is living with HIV. The numbers are further disaggregated by sex.	UNAIDS, HIS, DHS, MICS, HMIS, country reports.	

		and prevention strategies. The number indicates the response of the health system to the HIV epidemic.	**Numerator:** Number of adolescents aged 10-14, 15-19 years, who live with the HIV. (Further disaggregated by sex). **Denominator:** Total number of adolescents aged 10-14, and 15-19, (Further disaggregated by sex).		
N°	**Indicator**	**Rationale**	**Definition**	**Data sources**	
Morbidity: Tuberculosis prevalence					
6	**Tuberculosis prevalence among adolescents**	The number of adolescents, infected with Mycobacterium tuberculosis is important as TB can an opportunistic infection related to HIV/AIDSs. It also gives an indication of the social situation in a country.	The proportion of adolescents aged 10-14 and 15-19, infected with Mycobacterium tuberculosis. The numbers are further disaggregated by sex. **Numerator:** Number of 10-19 year who are infected with Mycobacterium tuberculosis. **Denominator:** Total number of 10-19 year in the cachment area.	HMIS, Clinic Records from surveillance sites, TB registers	
N°	**Indicator**	**Rationale**	**Definition**	**Data sources**	
Health Condition: Adolescent Pregnancy					
7	**Adolescent birth rate**	Almost 11% of all births are to adolescent girls 15-19 year. There are complex socio-economic, educational, cultural and service availability factors that influence this, but adolescent pregnancies can compromise the health and development of the mother and child.	The proportion of female adolescents aged 15-19 years who are pregnant. **Numerator:** Number of female adolescents aged 15-19 year who are pregnant or have been pregnant **Denominator:** Total number of female adolescents aged 15-19 years old.	DHS, MICS, birth registers, TOP registers	This can be disaggregated into 10-14 years and 15-19 years by countries

N°	**Indicator**	**Rationale**	**Definition**	**Data sources**	
Health Condition: Underweight					
8	**Prevalence of Underweight**	Being underweight in early adolescence is associated with diarrhoea, malaria, pneumonia and maternal mortality. This risk factor commonly becomes established in childhood, but is associated with adverse consequences during the adolescent years.	The proportion of adolescents aged 13-15 years considered underweight. The standard measurement to be considered underweight is: > 1 SD below weight and height for age and sex, using WHO growth reference for adolescents. **Numerator:** Number of adolescents aged 13-15 years old considered underweight (Further disaggregated by sex). **Denominator:** Total adolescent respondents aged 13-15 years. (Further disaggregated by sex).	GSHS	This can be disaggregated into 10-14 years and 15-19 years by countries
N°	**Indicator**	**Rationale**	**Definition**	**Data sources**	
Health Condition: Obesity					
9	**Prevalence of Obesity**	A known risk factor for later life hypertension, diabetes, range of cancers, infertility and cardiovascular disease. Increase in rates in all countries. Studies have found that much obesity begins during the adolescent and young adult years. Obesity has also been identified as one of the	The proportion of adolescents aged 13-15 years considered obese. The standard measurement to be considered obese is: > 2 SDs above weight and height for age and sex, using WHO growth reference for adolescents. **Numerator:** Number of adolescents aged 13-15 years old considered obese (Further disaggregated by sex). **Denominator:** Total adolescent respondents aged	GSHS	This can be disaggregated into 10-14 years and 15-19 years by countries

		NCD indicators to be monitored for adolescents.	13-15 years. (Further disaggregated by sex).		
N°	**Indicator**	**Rationale**	**Definition**	**Data sources**	
Health Behaviours*:* First Sex Before Age 15					
10	**First sex before age 15**	Early initiation of sexual activity for adolescent girls increases their risk of getting pregnant during adolescence; an indicator for cervical cancer/HPV infection, STIs, HIV prevalence, a reflection og gender empowerement in a community.	The proportion of adolescents aged 15-19 who have had sexual intercourse before age 15. (Further disaggregated by sex). **Numerator:** Number of adolescents 15-19 year old adolescents who have had sexual intercourse before age 15. **Denominator:** Total number of adolescent respondents 15-19 years old (Further disaggregated by sex).	DHS	
N°	**Indicator**	**Rationale**	**Definition**	**Data sources**	
Health Behaviours*:* Condom Use at last higher-risk sex					
11	**Condom Use at last - sex**	This is an essential protective behaviour for dual protection against HIV and unwanted pregnancies	The Proportion of adolescents aged 15-19 - in the last 12 months who report condom use in their last intercourse. (Further disaggregated by sex). **Numerator:** Number of adolescents aged 15-19 years old adolescents reporting condom use during last (vaginal or anal) intercourse. **Denominator:** Total number of adolescent respondents 15-19 years old who have had at least one sexual partner in the last twelve months (Further disaggregated by sex).	DHS, behavior survey	This can be disaggregated into 10-14 years and 15-19 years by countries

N°	Indicator	Rationale	Definition	Data sources	
Health Behaviours: HIV Testing and Counselling					
12	**HIV Testing and Counselling**	Access to and use of HIV Testing and counselling is needed to know one's HIV Status and get treatment as well as prevent further transmission.	The proportion of sexually active adolescents who had an HIV test in the last 12 months and know the results **Numerator:** Number of adolescents aged 15-19 years who have had an HIV test in the last 12 months and know the results. (Further disaggregated by sex). **Denominator:** Total number of adolescent aged 15-19 years old who have had sex in the last 12 months. (Further disaggregated by sex).	HIS, DHS, MICS	
N°	**Indicator**	**Rationale**	**Definition**	**Data sources**	
Health Behaviours*:* Tobacco Use					
13	**Tobacco Use**	A known major contributor to premature mortality and disability and one of the NCD indicators to be monitored for adolescents	The proportion of adolescents aged 13-15 and 16-19 years who have smoked one or more cigarettes in the past 30 days **Numerator:** Number of adolescents aged 10-15 or 16-19 years old who have smoked at least one cigarette or more in the past 30 days. (Further disaggregation by sex). **Denominator:** Total number of adolescent respondents aged 13-15 or 16 - 19 years. (Further disaggregation by sex).	GSHS, Global youth tobacco survey	This can be disaggregated into 10-15 years and 16-19 years by countries
N°	**Indicator**	**Rationale**	**Definition**	**Data sources**	
Health Behaviours*:* Alcohol Use					
14					

	Alcohol Use	A known major contributor to premature mortality and disability and one of the NCD indicators to be monitored for adolescents	The proportion of adolescents aged 13-15 and 16-19 years who had one alcoholic drink at least on one or more days during the past 30 days. Numerator: Number of adolescents aged 13-15 and 16-19 years old who had one alcoholic drink at least on one or more days during the past 30 days. (Further disaggregation by sex). Denominator: Total number of adolescent respondents aged 13-15 and 16-19 years. (Further disaggregation by sex).	GSHS, HBSC	This can be disaggregated into 10-15 years and 16-19 years by countries
N°	**Indicator**	**Rationale**	**Definition**	**Data sources**	
Service provision: Contraceptive prevalence rate					
15	**Contraceptive prevalence rate**	It is an important indicator of health, population, development and women's empowerment. It also serves as a proxy measure of access to reproductive health services that are essential for meeting many of the MDGs, especially the child mortality, maternal health, HIV/AIDS, and gender related goals.	Contraceptive prevalence rate is the proportion of women of reproductive age who are using (or whose partner is using) a contraceptive method at a given point in time. **Numerator:** Number of adolescents aged 15-19 years who use modern contraceptives **Denominator:** Estimated number of adolescent aged 15-19 years in the catchment area.	HIS, DHS, MICS	This can be disaggregated into 10-14 years and 15-19 years by countries
N°	**Indicator**	**Rationale**	**Definition**	**Data sources**	
Service provision: Unmet needs for family planning					

16	**Unmet need rate for family planning**	Adolescents with unmet need are those who are want to delay childbearing but are not using any method of contraception.	Unmet need for family planning is defined as the percentage of women of reproductive age, either married or in a union, who have an unmet need for family planning. **Numerator:** Number of adolescents aged 15-19 years – who have an unmet need for family planning. **Denominator:** Total number of adolescent aged 15-19 years	HIS, DHS, MICS	
N°	**Indicator**	**Rationale**	**Definition**	**Data sources**	
Service provision: Human Papilloma Virus vaccination rate					
17	**HPV vaccination rate**	Cervical cancer is the fourth most common cancer affecting women worldwide, after breast, colorectal, and lung cancers; it is most notable in the lower-resource countries of sub-Saharan Africa.	The Human Papilloma Virus (HPV) vaccination rate is the proportion of girls aged 9- 13 years in the target area who complete their HPV vaccination. **Numerator:** Number of girls aged 9-13 years who complete the HPV vaccination. **Denominator:** Total number of girls aged 9-13 years living in the catchment area.	HMIS	
N°	**Indicator**	**Rationale**	**Definition**	**Data sources**	
Service provision: Adolescent ART enrollment rate					
18	**ART enrollment rate**	Highly active antiretroviral therapy (HAART) results in survival benefits for HIV-infected adolescents.	The ART enrollment rate is the proportion of adolescents aged 10-14 and 15-19 years who receive antiretroviral treatment for AIDS. **Numerator:** Number of adolescents aged 10-19	HIS, Clinic Records from ART sites	This can be disaggregated into 10-14 years and 15-19 years by countries

			years who are enrolled in ART. **Denominator:** Total number of adolescent aged 10-19 years living with HIV in need of treatment.		
N°	**Indicator**	**Rationale**	**Definition**	**Data sources**	
Coverage of interventions: Skilled Attendant at Birth					
19	**Skilled Birth Attendance**	Historical and epidemiological data provide evidence to support the emphasis on skilled attendance for reducing MMR as well as IMR.	The proportion of live births to an adolescent (15-19 years) in a given time period, attended by skilled health personnel. **Numerator:** Number of adolescents (15-19 years) who reported having been attended by skilled health personnel at the time of delivery **Denominator:** Total number of adolescent respondents (15-19 years) who reported a live birth in a given time period	DHS	This can be disaggregated into 10-14 years and 15-19 years by countries
N°	**Indicator**	**Rationale**	**Definition**	**Data sources**	
Coverage of interventions: Health Service Utilization by Adolescents					
20	**Health Service Utilization by adolescents**	This provides important data on the delivery of a package of quality health services for adolescents and their utilization of specific interventions. It also provides information on the health conditions for which adolescents seek services and which groups among them are being served.	The proportion of adolescents aged 10-14 and 15-19 years who utilized a specified package of health services in the last 12 months. **Numerator:** Number of adolescents who used the specified package of health services provided in the last 12 months. (Further disaggregation by sex). **Denominator:** Total number of adolescents who responded to the survey (Further disaggregation by sex).	Population based surveys; Health Facility Surveys, HMIS	These age groups need to be taken into account in the DHS

N°	**Indicator**	**Rationale**	**Definition**	**Data sources**	
Determinants of Health: Early marriage prevalence					
21	**Early marriage prevelence rate**	Nine out of the ten countries with the highest rates of child marriage are in the African region.	The proportion of girls between the ages of 15 and 19 years of age who are either married or in union. **Numerator:** Number of adolescents aged 15-19 years who are either married or in union. **Denominator:** Total number of adolescent respondents, aged 15-19 years**.**	Census, DSH	This can be disaggregated into 10-14 years and 15-19 years by countries
N°	**Indicator**	**Rationale**	**Definition**	**Data sources**	
Inputs and Outputs					
22	**Functional National Adolescent Health Programme**	A programme outlines the actions taken to implement policy intentions for improving adolescent health	An index including: a) an approved national plan of action on adolescent health, b) designated funds in the national budget to support the national action plan, c) has a record of implemented activities in the last year **INDEX:** (Cumulative Score out of 10)**:** availability of a) a plan of action approved by national authorities b) allocated funds within the national budget to support activities for adolescents c) a record of the past year's adolescent-related activities.	HMIS	
23	**National Standards**	National standards hold countries accountable in ensuring that quality health services are	An index including: a) a clearly defined package of health services b) specification of the age group to which those will be delivered, including the mention of	HMIS	

		available for adolescent populations.	specific target populations, c) Specification health workers capacity building needs including required levels of performance, d) defined managerial responsibilities at various levels of care, e) officially adopted/endorsed by the Ministry of Health **INDEX:** (Cumulative Score out of 10)**:** Defined National standards with a) a clearly defined package of health services b) specification of the age group to which those will be delivered, including the mention of specific target populations, c) Specification health workers capacity building needs including required levels of performance, d) defined managerial responsibilities at various levels of care, e) officially adopted/endorsed by the Ministry of Health.		
24	**Trained Health Service Provider on adolescent health**	A provider trained on service provision to adolescents has been one of the factors associated with increased use of health services by adolescents	The proportion of facilities that have health service providers trained in the provision of adolescent health services in the last two years. **Numerator:** Number of facilities with at least one health service provider trained in the provision of adolescent health services in the last two years. **Denominator:** Total number of facilities surveyed.	SARA, HMIS Programme national sante des adolescents	