Accelerating Adolescent Health Outcomes: The GFF's Agenda under TRANSFORM 2030

Executive Summary

This paper focuses on the areas where the Global Financing Facility (GFF) has a distinctive role: adolescent sexual and reproductive health, including nutrition. The GFF does not attempt to cover the full adolescent-health agenda. It reviews progress and GFF investments to date, identifies opportunities under the TRANSFORM 2030 strategy, and seeks guidance from the Investors Group (IG) on how to take effective approaches to scale.

Adolescent health is central to the GFF's engagement in partner countries. Adolescent birth rates declined in all 36 GFF partner countries between 2015 and 2024, and the pace of decline accelerated (see appendix A for statistics by country). Yet, rates remain high, and demographic momentum has kept annual adolescent births broadly unchanged at about 7.3 million. Adolescent girls — particularly those who are poor, out of school, affected by fragility or conflict, or otherwise marginalized — continue to face intersecting risks from unintended pregnancy, maternal complications, anemia, HIV, and limited economic opportunity.

The GFF has built a strong platform, but delivery and accountability remain uneven. Of 48 GFF co-financed operations active at the end of FY26, 28 had dedicated or mainstreamed adolescent-health content, and attention has increased in recent approvals. Nine of the ten partner countries with both very high adolescent birth rates and severe anemia had an active operation addressing adolescent health. However, nutrition remains underrepresented relative to need, services do not consistently meet adolescent-responsive standards, age- and sex-disaggregated data are limited, and adolescent-specific indicators are not yet routinely linked to results frameworks or routine health information systems.

TRANSFORM 2030 offers a route to country-led delivery at scale. Within the GFF's mandate, the agenda focuses on preventing unintended adolescent pregnancies, improving maternal care for adolescents, and preventing anemia among adolescent girls. The GFF will help countries diagnose delivery barriers; integrate adolescent-responsive services into primary health care and larger operations financed by the International Development Association (IDA) and the International Bank for Reconstruction and Development (IBRD); strengthen results-based financing, commodities, data and implementation learning; and complement health investments through gender-responsive and multisectoral action. The GFF's Sustainable Commodity Access Program can improve access to priority commodities, while a future adolescent-health challenge under the Innovations for Service Delivery Challenge Program could support country-led adaptation and scale-up of proven approaches.

The IG is invited to guide the next phase. Members are asked to advise whether the proposed areas for intensified effort are the right ones, and whether any priorities within the GFF's mandate should be more explicit. They are also asked whether the key barriers and responses have been correctly identified. Members are invited to consider how approaches should be adapted across country contexts — and how partner financing, expertise, and implementation capacity can be aligned.

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1. Why Adolescent Health Matters Now

Adolescent health needs that systems still miss

The world is home to 1.2 billion adolescents, the largest such generation in history. The vast majority of adolescents live in low- and middle-income countries (LMICs), where health systems have historically been designed around the needs of young children and adults of reproductive age, leaving adolescents, especially girls, effectively invisible in primary care. Yet, adolescence is a critical period of physical, cognitive and social development, with different needs for girls and boys across the adolescent years. It is also a period of opportunity. Respecting young people's rights to information, participation and appropriate care — and investing in their health alongside education and employment opportunities — can help countries harness a demographic dividend and advance gender equality.

The health challenges facing adolescent girls in LMICs are well documented, deeply interconnected, and unfortunately very persistent. Each year, approximately 21 million girls between the ages of 15 and 19 years become pregnant in these countries; roughly half of those pregnancies are unintended. The global adolescent birth rate stood at 38.3 births per 1,000 girls aged 15–19 in 2024 — down from 66.3 per 1,000 in 2000, yet remaining unacceptably high, with rates in Sub-Saharan Africa and parts of South Asia far exceeding the global average. In 2024, maternal causes accounted for an estimated 12 percent of deaths among girls aged 15–19 in low-income countries, making them the leading individually identified cause of death in this age group. Recent multi-country evidence from LMICs also found that adolescent mothers aged 10–19 years face higher risks of eclampsia and serious infections than women aged 20–24 years, while very young adolescents are particularly vulnerable to severe maternal complications.

Beyond sexual and reproductive health, adolescent girls in many settings carry a high burden of malnutrition and disease. Recent demographic and health surveys (DHS) show that anemia affects between 15 and 63 percent of girls aged 15–19 in GFF-eligible countries across Africa and Asia, impairing cognitive development, reducing productivity, and elevating risks if they become pregnant. In 2022, approximately 210,000 adolescent girls and young

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women aged 15–24 acquired HIV in Sub-Saharan Africa — accounting for most of the new global infections in this age group. This reflects not only biological vulnerability but also the social and economic conditions that limit girls' ability to make safe choices about their sexual health.

The lifelong ripple effects of adolescent pregnancy

Beyond the physical toll, early pregnancy can have lasting consequences for education and economic opportunity. In many countries, pregnancy remains the single largest driver of girls dropping out of school. UNESCO data indicate that among girls who leave school due to pregnancy, fewer than five percent return, foreclosing their educational futures and sharply curtailing their lifetime economic prospects. Addressing adolescents' unmet need for family planning is a highly cost-effective investment: For every dollar invested in contraceptive services, an estimated US$2.48 in maternal, newborn and pregnancy-related care costs is saved.

Adolescent pregnancy is linked to nutrition, child health, maternal health, education, social protection and economic opportunity. Interrupted education, ill health and reduced opportunities to enter the workforce due to early pregnancy can affect adolescent girls' lifetime earnings and household welfare, while their health, nutrition, and economic status can shape the prospects of their children. A girl who is well nourished and can access quality sexual and reproductive health services has better economic prospects; and if and when she decides to raise children, she and her children are more likely to thrive. Yet, many adolescents, particularly girls, still face social, financial and service-related barriers that keep them from the care they need. Section 4 sets out these barriers and the responses the GFF proposes to address them.

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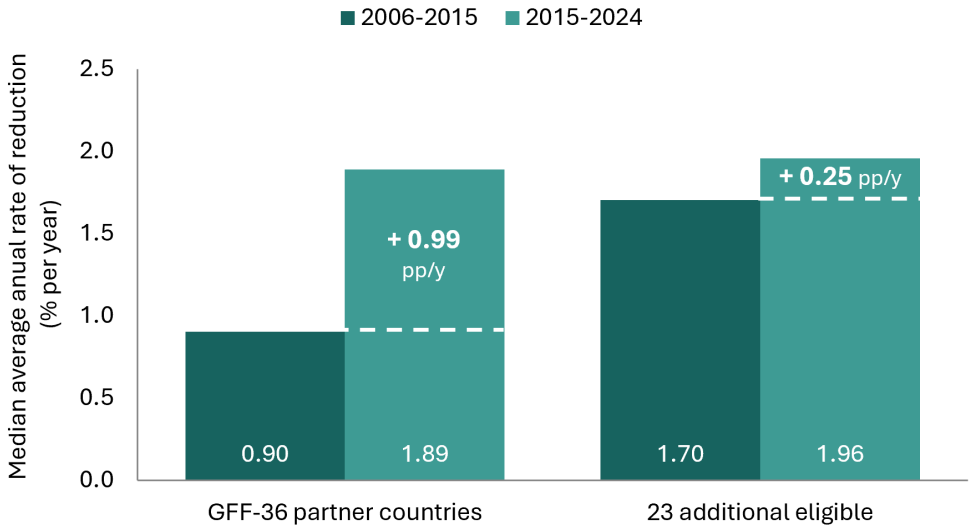
2. Taking Stock: Building on a Decade of Investment

Progress amid population growth

The country-level progress during the period of GFF engagement is remarkable. Adolescent birth rates declined in all 36 GFF partner countries between 2015 and 2024. Across these countries, the median fell from 115.4 to 89.1 births per 1,000 girls aged 15–19. The pace of decline also increased: The median annual rate of reduction rose from 0.90 percent from 2006 to 2015 to 1.89 percent from 2015 to 2024, a gain of 0.99 percentage points.[1] This acceleration was greater than the 0.25 percentage point increase among the 23 additional countries eligible under TRANSFORM 2030 (see figure 1).

Figure 1. Declines in Adolescent Birth Rates Accelerated in GFF Partner Countries

Median annual rate of reduction, by country group and period (% per year)



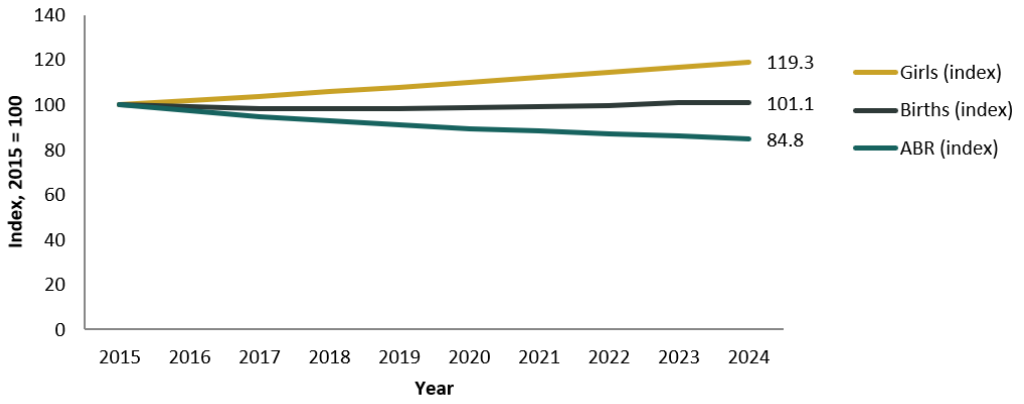
Despite this progress, adolescent birth rates remain high on average in the GFF countries. In 2024, the median rate across the 36 countries was 2.3 times the global rate of 38.3 births per 1,000 girls aged 15–19, and 15 countries continued to record rates above 100 births. Among the 26 GFF countries in Sub-Saharan Africa, 16 had rates above the regional rate of 91.9.

[1] The GFF contributed to this progress, while the results remain attributable to the countries themselves.

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Figure 2. Adolescent Birth Rates Fell, but Population Growth Kept Births Broadly Unchanged

Adolescent population, adolescent birth rate and number of births, 2015–2024 (index: 2015 = 100; girls aged 15–19)



Growth in the adolescent population has limited the extent to which declining birth rates translate into fewer adolescent births. Between 2015 and 2024, the number of girls aged 15–19 across the 36 countries increased by 19 percent, from approximately 85 million to 101 million due to population momentum. Over the same period, the estimated annual number of adolescent births remained broadly unchanged at approximately 7.3 million in both 2015 and 2024 (figure 2). Comparing 2024 with 2015, the estimated number of adolescent births increased in 21 of the 36 partner countries even as their birth rates fell. Nevertheless, these reductions made a substantial difference: approximately 1.65 million additional adolescent births would have occurred in 2024 if countries had retained their 2015 rates. More investments for faster reductions in adolescent birth rates are needed to translate progress into fewer adolescent births and better health and life opportunities for girls and young women.

Making adolescent health investments count where it matters most

Alongside country-led prioritization, GFF co-financing grants and technical assistance are well placed to bring adolescent-health priorities into the design and implementation of larger World Bank operations. From FY17 through FY26, 80 World Bank operations co-financed by the GFF were

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approved, of which 31 percent were tagged for adolescent health.[2] This share increased from 19 percent of operations approved from FY17 to FY22 to 50 percent from FY23 to FY26. A detailed review of project appraisal documents showed that among the 48 GFF co-financed operations active at the end of FY26, 10 had a dedicated adolescent-health focus and 18 mainstreamed adolescent health within broader health, nutrition or RMNCAH programs.[3] Together, these represented 58 percent of the active GFF-financed projects.

GFF adolescent-health support is guided by country demand, technical evidence, a range of indicators on adolescent needs, and opportunities to expand service coverage through larger operations. This review shows that the GFF investments are reaching the countries with highest adolescent health needs. To assess whether the active portfolio reaches countries with strong overlapping reproductive health and nutrition burdens, the GFF examined adolescent birth rates, available comparably across countries, alongside anemia prevalence. Ten of the 36 GFF partner countries exceeded 100 births per 1,000 girls aged 15-19 and 40 percent anemia prevalence — the level the World Health Organization (WHO) classifies as a severe public health problem. By the end of FY26, nine had an active GFF co-financed operation with adolescent health content (table 1). The GFF does not limit its investment to these 10 countries but strives to give extra support to these countries due to their high burden.

[2] **Adolescent Health theme tag:** The World Bank's official Level 3 Adolescent Health theme (code 636), defined as covering "activities that improve the health status and well-being of adolescents as well as promote safe behaviors." Projects are counted as AH-tagged where this theme is recorded in World Bank project data.

[3] **Dedicated adolescent-health focus:** Project includes a distinct adolescent-health component or subcomponent, adolescent-specific key activities, or an adolescent-specific DLI, PBC or PDO indicator.
Adolescent health mainstreamed: Project has no distinct adolescent-health component, but explicitly includes adolescents as beneficiaries, embeds adolescent-health activities or intermediary indicators within broader RMNCAH+N interventions, or requires relevant data to be disaggregated by age.

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Table 1. Adolescent SRH and Nutrition Burden and Active GFF Support in 10 High-Burden Partner Countries

Country	Burden		Active GFF-supported adolescent content		
	ABR, 2024 (per 1,000 girls 15-19)	Anemia prevalence (%)	Highest AH focus in operation(s)	Adolescent nutrition in operation(s)	Adolescent specific technical assistance
Liberia	124.7	55.1	Dedicated	-	Yes
Mali	135.9	49.4	Dedicated	-	Yes
Mozambique	151.9	54.4	Dedicated	-	-
Niger	141.6	46.0	Dedicated	Yes	Yes
Chad	132.1	46.5	Mainstreamed	-	Yes
DRC	105.2	40.5	Mainstreamed	Yes	Yes
Guinea	116.8	47.1	Mainstreamed	-	-
Somalia	115.4	46.2	Mainstreamed	Yes	-
United Republic of Tanzania	112.6	45.0	Mainstreamed	Yes	Yes
CAR	161.3	43.4	No explicit AH[a]	-	-

Note: Countries shown meet both thresholds: ABR above 100 births per 1,000 girls aged 15–19 and anemia prevalence of at least 40%. ABR values are 2024 World Bank estimates, based on the United Nations' World Population Prospects (2024 revision). Anemia estimates use adolescent-specific DHS data from 2019 onward; where recent adolescent-specific data are unavailable, WHO's 2023 modeled prevalence among women aged 15–49 is used as a proxy (CAR, Chad, Guinea, Niger and Somalia). Co-financed operations and technical assistance were active at 30 June 2026. AH focus classifications and nutrition content are based on project appraisal documents; where a country has multiple operations, the table shows the highest AH focus level. Technical assistance includes active AH-specific BETFs and ongoing in-kind support. See Appendix B for operation-level details.

a. CAR's GFF co-financed operation, SENI-Plus (P177003), has no explicit adolescent-health focus. However, a separate World Bank project "Maïngo" (P171158) targets adolescent girls through community-based support that explicitly complements SENI-Plus's broader facility-based services. In addition, GFF supported implementation research on Maïngo's mentor-led safe spaces to identify delivery strengths and bottlenecks. In table 1, Maïngo is excluded from the co-financed operation and grant figures; the completed research is excluded from active TA as it concluded in 2025.

Co-financing reaches most of these higher-burden countries, but the scope of interventions does not yet fully reflect their overlapping needs. Across their 11 operations, US$220 million in GFF grants co-financed US$1.87 billion in IDA/IBRD financing, with a proportion of that financing allocated to adolescent health. Project appraisal documents found family planning and community-

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based delivery in seven operations (64 percent), compared with approximately one-third of the full active portfolio. Nutrition interventions, however, appeared in only four (36 percent) — approximately the same share as across the full portfolio — despite the high anemia burden in these countries. Integrated adolescent-responsive services, social and behavior-change activities, and gender, protection and empowerment interventions were also present, though less consistently.

The Democratic Republic of the Congo illustrates how reproductive health and nutritional priorities can be addressed together. Its investment case integrates family planning within the broader reproductive, maternal, newborn, child, and adolescent health and nutrition (RMNCAH-N) package through youth-friendly services at community and clinical levels, postpartum family planning and contraceptive commodity distribution. The GFF co-financed Multisectoral Nutrition and Health project (P168756) also includes iron and folic-acid supplementation and deworming for adolescent girls.

Attention to adolescent health is more often reflected in project measurement in these ten countries, though less consistently in performance-linked operations. Seven of their 11 operations (64 percent) included an adolescent-specific results framework indicator, compared with 21 of 48 (44 percent) across the full active portfolio. Of the three operations in this group using performance-based conditions, two linked an adolescent-specific indicator to disbursement; across the full active GFF portfolio, only five of 22 (23 percent) did so. Adolescent health is therefore increasingly visible in project design, but less consistently embedded in the mechanisms used to track delivery and sustain attention during implementation. It is important to note that country data systems also tend to miss measuring service delivery and responsiveness to adolescents than to other groups.

Using evidence to strengthen investments

The GFF has complemented its grant co-financing lever with analytical work and technical assistance. A global programmatic advisory services and analytics (PASA) program was established in 2019 to provide high-quality analytics and guidance to countries. Mali illustrates how Bank-executed technical assistance can help shape a subsequent GFF co-financed World

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Bank operation. As a GFF high-priority country, Mali faces one of the world's highest adolescent birth rates (135.9 per 1,000 girls aged 15–19), alongside very high prevalence of anemia among adolescent girls (49.4 percent). Under the GFF- and Netherlands-co-financed World Bank project PACSU (Projet pour Accélérer les Progrès vers la Couverture Sanitaire Universelle, P165534), incentives for adolescent family planning were already included in the performance-based financing scheme. Bank-executed analytical work subsequently assessed how adolescent-health activities could be strengthened and provided practical guidance to the government and World Bank team. This work informed the design of the subsequent project, ARISE (Advancing Resilience and Inclusive Health Systems for Everyone, P503776), in two important ways: A stand-alone adolescent-health component was introduced, and the performance-based financing scheme was expanded to include school infirmaries, strengthening adolescents' access to health services.

This PASA also led to the creation of the Adolescent Health Learning, Action and Benchmarking initiative (AdLAB) in 2022, with US$5 million in initial funding, supported by the Foundation Botnar. AdLAB is a collaboration between the GFF and the World Bank's Development Economics Research Group (DEC) and bridges the gap between adolescent-health commitments and implementation by embedding country-led research in national programs and World Bank operations. Working with governments, local researchers and adolescents, it strengthens adolescent-responsive services, measurement and accountability, and generates evidence for scale-up.

Together we are stronger: Using partnerships to accelerate results

The GFF's approach to adolescent health is grounded in partnership, and this is reflected in both its governance and its country-level implementation. At the global policy level, the GFF participates in the United Nations (UN) H6+ Technical Working Group on Adolescent Health and Well-Being, which brings agencies and partners together to develop shared guidance and promote coordinated policies, programs, and measurement frameworks to improve adolescent health outcomes. These global partnerships translate directly into country-level action. The GFF is, for example, working with the United Nations

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Population Fund (UNFPA) to support digital measurement of the quality of health care services for adolescents in Madagascar, using guidance and tools originally developed by WHO, a model that connects global normative work with the real-time data systems to improve and sustain adolescent-responsive care. The advocacy around adolescent health at country and global and country level driven by the Partnership for Maternal, Newborn and Child Health (PMNCH) is also creating a more enabling environment for the financing and technical assistance provided by the GFF.

Youth representatives come together with representatives from UN agencies and other global stakeholders through a steering committee, ensuring that the evidence and tools generated by AdLAB are shaped by a broad coalition of expertise and lived experience.

The boxes below examine how the GFF supported Liberia and Madagascar in identifying gaps in and improving access to adolescent sexual and reproductive health (ASRH) services.

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Liberia: From Evidence to Scale in Adolescent Sexual and Reproductive Health

Learning from Evidence: In 2019, with support from the GFF, the Ministry of Health conducted a study in Grand Bassa County to understand why adolescent girls were not accessing sexual and reproductive health services. The findings were striking: 69 percent of sexually active females reported a prior pregnancy, 67 percent of which were unintended, and none of the eight health facilities assessed met basic standards for adolescent-responsive care. Pervasive stigma, commodity stock-outs, and providers untrained in confidential; nonjudgmental care kept young people, particularly girls, away from services that were nominally available to them. This evidence informed the subsequent pilot's rationale and design requirements.

Testing Implementation through Pilot: Drawing on the 2019 evidence, the GFF supported an ASRH pilot in Grand Bassa under the World Bank's Health System Strengthening Project (HSSP), establishing youth-friendly corners in health facilities and school health clubs across all eight districts. A 2024 qualitative case study found that where enabling conditions were met — trained providers, confidential spaces, and community engagement — adolescents showed increased health-seeking and positive shifts in gender norms. However, critical gaps remained: commodity stock-outs, inconsistent provider attitudes, overstretched staffing, and no domestic financing to sustain activities after HSSP closed.

Informing Policy, Practice, and Scale-Up: The Grand Bassa pilot directly informed the design of the adolescent health component under the World Bank and GFF co-funded Institutional Foundations to Improve Services for Health (IFISH) project, that scaled ASRH programming to other counties. GFF is co-financing IFISH and providing technical assistance, which is supporting additional implementation research in a broader set of counties which is designed to generate real-time evidence that can course-correct implementation before scale-up activities compounds problems rather than solutions. The Liberia case illustrates what GFF's model of sustained, adaptive investment can enable: a connected sequence of evidence, learning, and scale that builds government capacity and ownership at each stage.

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Madagascar: Making Health Services More Responsive for Adolescent Girls

Identifying gaps in youth-friendly services: With support of the GFF and the World Bank, Madagascar has adopted an adolescent health strategy and established youth-friendly health centers (Centres de Santé Amis des Jeunes) to help adolescents better access health services. However, designating a facility as youth-friendly after providing it with equipment, communication materials, and training does not guarantee that every girl receives the care she needs. Analyses of existing data and policies supported by the GFF, the World Bank, and government partners found encouraging progress: certified facilities generally had better service availability, more trained providers, and stronger infrastructure. At the same time, the analyses identified important gaps in the consistency and quality of care, as well as limited opportunities for adolescents to provide feedback.

Giving girls a stronger voice in their care: GFF-provided technical assistance is now testing practical ways to ask adolescent clients about their experiences and combine their feedback with information on facility readiness and provider practices. This gives health workers and district managers a clearer picture of adolescent girls' experiences when seeking care, including whether services are available, responsive to their needs, respectful, and of high quality. Regular discussions of the findings allow facility teams to identify gaps, incorporate direct feedback from adolescent clients, and take action to improve their care.

Turning learning into better services: This work is helping shift attention from whether adolescent services exist on paper to whether they work for girls in practice. Facilities and district managers now have more useful information on service quality and adolescent experiences, while girls have a stronger voice in shaping the care they receive. The findings can inform government quality-improvement efforts and broader World Bank-supported investments in primary health care. By testing practical approaches within existing health systems, Madagascar is also generating lessons that can help other countries make youth-friendly services more responsive, effective, and accountable.

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3. A New Chapter under TRANSFORM 2030

Published in 2025, TRANSFORM 2030 sets the GFF's strategic direction for 2026–2030 through three objectives: (1) mobilizing more and smarter country-led health financing; (2) accelerating service quality and access to proven commodities and innovations; and (3) fostering health-system sustainability, sovereignty and resilience. Building on the foundation described above, the strategy provides a route towards country-led investments and wider service coverage. The GFF's distinctive role remains in adolescent sexual and reproductive health and rights and nutrition. Within this scope, three priorities guide the discussion: preventing unintended adolescent pregnancies, improving maternal care for adolescents, and preventing anemia among adolescents.

Mobilize more and smarter country-led health financing

TRANSFORM 2030 clarifies how the GFF's position within the World Bank Group can translate adolescent-health priorities into larger and more sustainable investments. The GFF will lead implementation of the IDA21 commitment to expand access to sexual and reproductive health services and continue to contribute its RMNCAH-N and gender expertise to country partnership frameworks, universal health care (UHC) compacts, and the design and implementation of IDA- and IBRD-financed operations. GFF grants, technical assistance and staff expertise can help countries prioritize adolescent health within these larger financing platforms. Results-based instruments — including programs-for-results and disbursement-linked indicators — offer an opportunity to strengthen accountability for delivery and, ultimately, the share of adolescents reached.

The FY26 portfolio review found that 26 of the 28 active GFF co-financed operations with dedicated or mainstreamed adolescent-health content (93 percent) were led by the World Bank's Health, Nutrition and Population unit; and one each was led by the Education and Social Protection and Jobs units. This reflects the GFF's health mandate but also points to opportunities to complement health-led investments more intentionally through other World Bank sectors. In collaboration with teams working on gender, education, social protection and governance, the GFF can support nutrition and family

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planning information and services in schools, connect social protection with health-benefit packages, address gender-related policy barriers, and help adolescent girls remain healthy, stay in school, and participate in economic life.

Accelerate quality of care and scale access to proven commodities and innovations

TRANSFORM 2030's differentiated country model creates scope to tailor GFF support to country needs and opportunities. Adolescent birth rates and anemia can help identify overlapping reproductive-health and nutrition burdens, while country demand, service gaps and implementation capacity determine the response. The ten countries highlighted in section 2 warrant sustained attention; they are not an adolescent-health eligibility list, and the ambition is to continue expanding effective service coverage well beyond them.

Priority areas for action

Preventing unintended adolescent pregnancies. TRANSFORM 2030 commits the GFF to expanding adolescent-responsive sexual and reproductive health services, including integrated school- and community-based packages that provide information and services. This means addressing both access to a choice of modern contraceptive methods and the barriers that prevent adolescents — especially those out of school or otherwise marginalized — from using them. The GFF's role is to help countries integrate these approaches into primary health care and larger investments, drawing on its IDA21 commitment. WHO/Human Reproductive Programme (HRP), UNFPA and other partners provide important technical and normative expertise for this work.

Improving maternal care for adolescents. Adolescents who become pregnant need care that responds to their age and circumstances, from antenatal nutrition and anemia assessment to respectful childbirth and postnatal care. This is also an investment in their children: Babies of adolescent mothers face higher risks of preterm birth and low birthweight, while better maternal nutrition and care can support healthier growth

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through infancy and early childhood. Strengthening this care would make the RMNCAH-N continuum more responsive to young mothers and their children.

Preventing anemia among adolescents. Anemia prevention needs to reach adolescents at risk before and irrespective of pregnancy. The portfolio review identified nutrition interventions in only four of the 11 operations in the higher-burden countries, despite the high anemia prevalence that helped identify them. TRANSFORM 2030 commits the GFF to integrating gender-responsive nutrition into primary health care and maintaining at least 30 percent of country investments for nutrition. Applying those commitments through school, community and primary care platforms, alongside other responses tailored to the causes of anemia in each setting, will help address this portfolio gap.

These priorities define where the GFF will intensify its support, not the limits of its adolescent health work; countries may prioritize other adolescent needs within the reproductive, maternal, newborn, child and adolescent health and nutrition continuum, such as HPV vaccination (see box below), HIV prevention or mental health linked to maternal care, where these reflect national priorities and evidence.

All three priorities come down to the challenge that adolescents are not reached by existing services. Implementation research can identify barriers to care, test practical adaptations and establish which approaches are ready for wider use. The GFF can then bring those lessons into the design and implementation of larger country investments.

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HPV Vaccination as Part of Adolescent Health

HPV vaccination is delivered primarily to girls aged 9 to 14 years, but its principal health benefit — preventing cervical cancer — is usually realized later in life. It therefore belongs in an adolescent-responsive delivery agenda and the wider cervical cancer elimination agenda, illustrating the value of investment across the life course. In 2022, an estimated 660,000 women were newly diagnosed with cervical cancer and 350,000 died from the disease, with low- and middle-income countries accounting for approximately 94 percent of deaths. At the March 2024 Cervical Cancer Elimination Forum, the GFF and World Bank jointly committed US$400 million for HPV- and cervical cancer-related programs, covering screening, vaccination and treatment.

The GFF will collaborate with Gavi, the Global Fund, UNFPA, Unitaid and WHO to scale these efforts. Its comparative role is to complement partners responsible for vaccine procurement and introduction by supporting integration into national systems, sustainable financing, service-delivery readiness, community engagement, equity and links with broader adolescent-health platforms.

New routes to sustainable delivery at scale

Two challenge programs in TRANSFORM 2030 offer additional routes to scale. Launched in April 2026, the Sustainable Commodity Access Program (S-CAP) aims to strengthen domestic financing, procurement and last-mile delivery for priority family planning and maternal, newborn and child health commodities, with family planning expected to account for most commodity financing. Although not adolescent-specific, more reliable contraceptive supplies support pregnancy prevention; eligible nutrition commodities, including iron–folic acid supplements, can support care for pregnant adolescents. The strategy's innovation objective signals a deliberate approach to adapting and scaling proven service-delivery solutions. The proposed Innovations for Service Delivery Challenge Program (ICP) would

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provide additional grants and technical support for country-led adaptation and scale-up of proven approaches to more accessible, higher-quality care. Its first proposed Safer Births Challenge will be considered by the Trust Fund Committee in November 2026. A future adolescent-health challenge could follow where countries identify a delivery bottleneck, a proven approach ready for adaptation, and a credible route to scale through national systems and larger financing.

Foster health-system sustainability, sovereignty and resilience

Sustained adolescent-health gains depend on country capacity to track who is reached, maintain quality and adjust services as needs change. TRANSFORM 2030 places greater emphasis on timely data use and learning. The GFF's frequent assessments and systems tools for resilience (FASTR) initiative supports countries in using routine service-delivery data, facility and household assessments, and client feedback to identify bottlenecks and adapt implementation. Its findings can also inform planning and budget decisions and help protect essential services during shocks. Strengthening community health workers, midwives and local expertise offers further opportunities to make adolescent-responsive care more accessible and resilient, especially in underserved areas.

The new results framework retains adolescent birth rate as an impact indicator and adds anemia prevalence among adolescent girls and women; family planning uptake and HPV vaccination feature among its outcome measures. These will be complemented by better information on service coverage, quality and adolescents' experience of care, addressing the measurement gap identified in the portfolio review. The new GFF initiative Evidence to Action (E2A) can support lesson-learning across countries to inform future investments and replication. The focus will move beyond counting operations with adolescent-health content to tracking whether more adolescents receive effective services.

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Cross-cutting enablers: Gender, evidence and partnerships

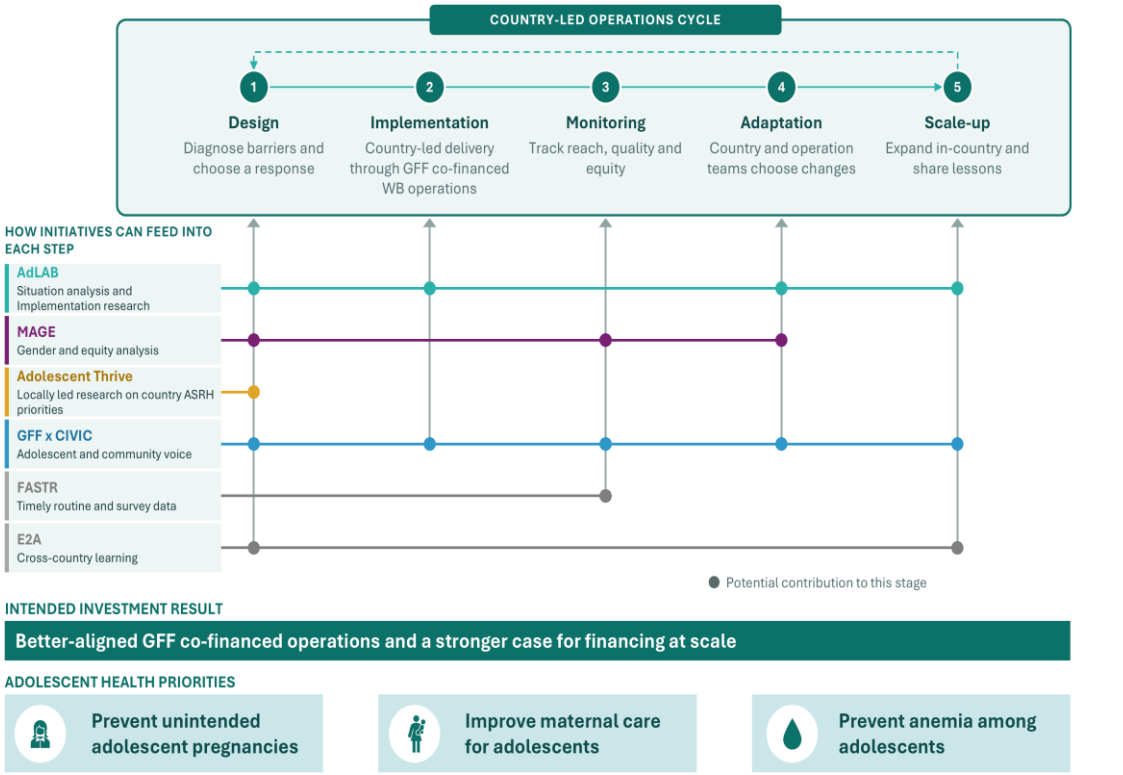
Gender equity and adolescent girls' empowerment cut across all three objectives. Under TRANSFORM 2030, the GFF is conducting rapid gender diagnostics in partner countries and using the findings to inform investment cases, monitoring, and program adaptation. For adolescents, this brings particular attention to girls who are married, out of school, affected by fragility or conflict, or facing financial barriers to care. Health financing and social protection reforms can also help ensure they are included in essential services and benefits packages.

The GFF's adolescent-health partnerships provide complementary evidence, measurement and community perspectives for this country-led work. AdLAB, with the World Bank's DEC research group, supports situational analysis and implementation research; the Monitoring and Action for Gender and Equity (MAGE) project, with Johns Hopkins University, strengthens gender and equity analysis; the GFF–IDRC Adolescent Thrive partnership, led by the African Population and Health Research Center (APHRC), builds locally led research capacity and context-specific evidence; and the adolescent-health component of the GFF–CIVIC platform brings civil society, youth perspectives, and community-led solutions to scale. The GFF coordinates the research and analytical support through the different initiatives, with GFF–CIVIC linked through country platforms and operation teams. These are not separate delivery channels; their value lies in informing country decisions and strengthening GFF–World Bank co-financed operations.

Figure 3 shows how these contributions can inform GFF grants and technical support linked to IDA- and IBRD-financed operations. In particular, analytical work and technical assistance financed through Bank-executed trust funds can strengthen the design, targeting and monitoring of recipient-executed trust fund (RETF) grants that co-finance country operations.

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Figure 3. How Partnerships Strengthen GFF Co-Financed IDA/IBRD Operations



Countries lead the design and delivery of IDA/IBRD operations co-financed by GFF RETF grants. The initiatives contribute evidence, data and adolescent perspectives at selected stages. Together, these financing, delivery and learning mechanisms offer a pathway from better-aligned investments to wider adolescent service coverage.

4. Key Challenges and Discussion Points for the IG

Translating prioritization into results requires addressing why adolescents, particularly girls, do not use services even where they are nominally available. The barriers operate at three levels that reinforce one another.

At the policy and financing level, consent requirements, where they apply, and child marriage limit girls' ability to make decisions about their own health. Where contraception, maternity care and anemia prevention and treatment

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are not covered by benefit packages, the cost of care deters adolescents from using them.

Within health services, fear of disclosure and judgmental care discourage adolescents from seeking contraception, and stock-outs of contraceptives and iron–folic acid mean services may fail them when they do come.

Pregnant adolescents often make their first antenatal care contact late and face weak referral systems. Even where their coverage is comparable to that of older women, care may not address their needs. Girls who are not pregnant have few routine contacts with preventive services, which limits opportunities to prevent anemia. Across all three priorities, limited age-disaggregated data make it difficult to see which adolescents are being missed and to improve care.

In communities and schools, stigma around adolescent sexuality and pregnancy discourages girls from seeking care. Out-of-school and marginalized girls are missed by both facility-based services and school programs. Weak links between schools and health services mean lost opportunities for health education, anemia prevention and referral, and early pregnancy can end girls' schooling. Adolescents also have little say in how services are designed and monitored.

Because these barriers reinforce one another, action at one level alone rarely changes outcomes. Table 2 sets out responses grouped by the same three levels, drawing on WHO guidance and implementation evidence. They are not a blueprint: Responses need to be selected and adapted to each country's context, developed with adolescents and communities, and matched to the GFF's role, whether through co-financing, technical assistance, policy dialogue or a potential adolescent-health challenge.

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Table 2. Barriers to Adolescents' Use of Services and Proposed Priority Responses

Barrier	Proposed response	How the GFF could support
Policies that restrict access (consent requirements, child marriage)	Support governments to review policies and regulations that limit adolescents' access to services, alongside partners working on child marriage.	Policy dialogue and analytics, together with UN and civil society partners.
Costs of care	Include priority adolescent services (contraception, maternity care, anemia prevention and treatment) in benefit packages, with financial protection.	Health financing dialogue and technical assistance under the financing objective.
Fear of disclosure and judgmental care	Apply adolescent-responsive quality standards: confidential consultations, ensure informed choice of contraceptive methods, provider competencies, supportive supervision, and routine improvement using adolescents' own feedback on their care. Pilot digital care options.	Co-financed operations, including adolescent quality indicators in results frameworks and performance-based financing; technical assistance.
Contraceptive and iron–folic acid stock-outs	Secure last-mile supply of contraceptives (including emergency contraception) and iron–folic acid	S-CAP; partnership with UNFPA.
Late first antenatal visit and weak continuity of care	Ensure an adolescent care pathway from early antenatal care through respectful delivery care to postnatal follow-up, with nutrition and anemia screening and postnatal contraception.	Co-financed operations; technical assistance on protocols.
Few routine contacts for anemia prevention	Weekly iron–folic acid for girls who are not pregnant, delivered through health services, schools and an out-of-school channel; deworming where endemic.	Co-financed operations; links with nutrition and education operations.
Adolescents invisible in data	Add age bands (10–14, 15–19) and sex into health information systems, dashboards and results frameworks, then use the data to review gaps in care.	Co-financed operations; technical assistance; FASTR for monitoring.
Out-of-school and marginalized girls are missed by facility-based services	Paid, trained and supervised community health workers providing adolescent counseling, referral and follow-up, supported by digital job aids.	Co-financed operations.
Weak links between schools and health services	School-linked health services combining age-appropriate health education, menstrual hygiene, iron–folic acid, assessment and referral, with support for pregnant and parenting girls to stay in or return to school.	Co-financed operations and dialogue with education counterparts; World Bank education operations.
Adolescents have little voice in how services are designed	Gather adolescent feedback on services (for example through U-Report) and involve youth organizations and civil society in monitoring; pilot confidential teleconsultation.	Support civil society, especially youth led engagement.

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IG members are invited to provide guidance on the following questions:

1) Are the proposed areas for intensified effort the right priorities? Are there other adolescent-health needs within the GFF's mandate that should be addressed more explicitly?

2) Do the identified barriers and proposed responses capture the most important constraints? Are any significant barriers or responses missing?

3) How should the proposed interventions be adapted to different country contexts? How can partners align financing, technical expertise, and implementation support to take effective approaches to scale?

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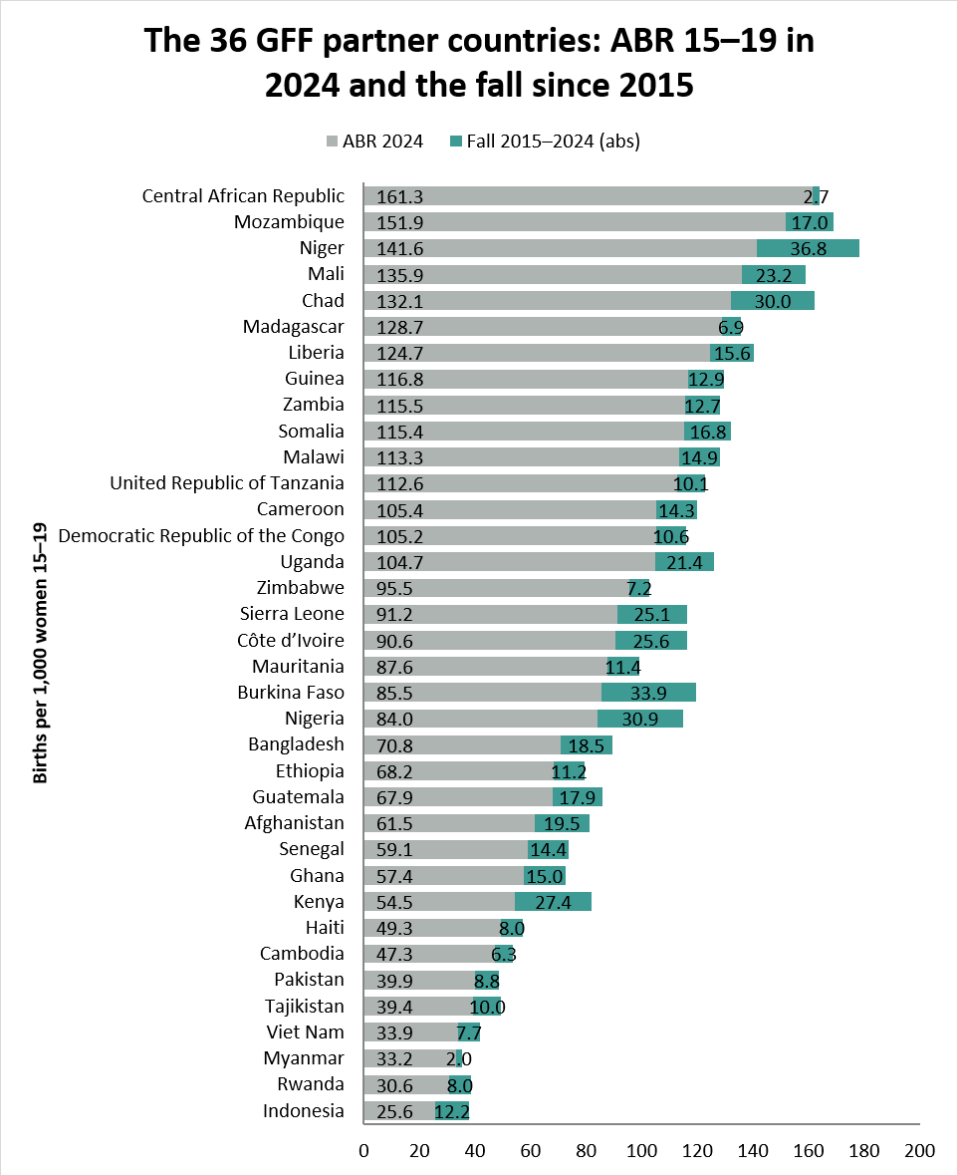
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Appendix A: Adolescent Birth-Rate Levels and Declines Across the 36 GFF Partner Countries



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Appendix B: Adolescent Health Portfolio Across GFF Partner Countries

GFF co-financed operations active at FY2026, adolescent-health technical assistance and initiative presence per country

Country	GFF co-financed operations			AH-specific technical assistance			GFF initiatives			
	# Active operations	Active operations with AH content (level o focus)	Total GFF grants US$ million	BETFs	BETF budget US$ 000	In-kind	AdLAB	IDRC	MAGE	CIVIC
Afghanistan	1		54.0	–	–					
Bangladesh	1	1 (mainstreamed)	25.0	–	–				✓	
Benin	1	1 (mainstreamed)	20.0	–	–					
Burkina Faso	1		17.0	–	–	✓				
Cambodia	2		25.0	–	–		✓			
Cameroon	1		10.0	–	–					
◆ **Central African Republic**	1		12.0	–	–					
◆ **Chad**	1	1 (mainstreamed)	16.5	1	62	✓	✓		✓	
Côte d'Ivoire	3	3 (1 mainstreamed; 2 levels of focus not specified)	50.0	–	–	✓		✓	✓	✓
◆ **Democratic Republic of the Congo**	1	1 (mainstreamed)	26.3	1	50	✓	✓			
Ethiopia	3	3 (2 dedicated; 1 mainstreamed)	60.1	–	–			✓	✓	✓
Ghana	1	1 (dedicated)	31.0	–	–	✓	✓	✓	✓	–
Guatemala	1		9.0	–	–					
◆ **Guinea**	2	2 (1 mainstreamed)	26.0	–	–				✓	
Haiti	1		15.0	–	–					
Honduras	1	1 (dedicated)	15.0	–	–					
Indonesia	1	1 (dedicated)	17.0	–	–					
Kenya	2		24.0	–	–	✓				
◆ **Liberia**	1	1 (dedicated)	11.0	–	–	✓	✓			
Madagascar	3	3 (2 mainstreamed; 1 level of focus not specified)	45.0	2	100	✓	✓		✓	✓
Malawi	1	1 (mainstreamed)	10.0	–	–		✓	✓		
◆ **Mali**	1	1 (dedicated)	25.0	–	–	✓			✓	
Mauritania	1	1 (dedicated)	15.0	1	150	✓	✓			✓
◆ **Mozambique**	1	1 (dedicated)	20.0	–	–				✓	

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Myanmar	1		10.0	–	–	✓				
◆ Niger	1	1 (dedicated)	25.0	–	–	✓				✓
Nigeria	1	1 (mainstreamed)	70.0	1	400	✓	✓	✓		✓
Pakistan	1		72.0	–	–					
Rwanda	2	2 (mainstreamed)	20.0	–	–					
Senegal	1	1 (mainstreamed)	20.0	–	–			✓		✓
Sierra Leone	1	1 (mainstreamed)	20.0	1	20					
◆ Somalia	1	1 (mainstreamed)	25.0	–	–					✓
Tajikistan	3		18.0	–	–	✓	✓			
Uganda	1		9.0	1	50	✓				✓
◆ United Republic of Tanzania	1	1 (mainstreamed)	33.5	1	75	✓	✓	✓		✓
Viet Nam	–		–	–	–					
Zambia	1	1 (mainstreamed)	7.0	–	–			✓	✓	✓
Zimbabwe	–		–	–	–	✓	✓			✓
TOTAL	**48**	**28 (10 dedicated; 18 mainstreamed)**	**908.4 of which 584.4 in operations with AH content**	**9**	**907**	**17**	**12**	**8**	**10**	**12**

Note. ◆ marks the ten countries with high overlapping burden (adolescent birth rate >100 and anemia prevalence ≥40%, using the paper's 2019-onward DHS rule or WHO proxy). Operations are GFF co-financed WB operations through RETF with a closing date after 30 June 2026. GFF grants are total GFF contributions to those operations, not amounts earmarked for AH. The AH-content total combines dedicated and mainstreamed operations. BETF counts and budgets cover AH-specific TA recorded and active through 30 June 2026. Initiative columns show country presence, not necessarily active implementation at the FY26 cutoff. In the TOTAL row, in-kind and initiative figures count countries, not operations.

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