

ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS: THE GFF'S SUPPORT TO ACCELERATE ACTION

Revised as of May 2019

OVERVIEW

The Global Financing Facility (GFF) Partnership presents an opportunity to address the financing gap for adolescent health, to bring promising adolescent interventions to scale, and to support public domestic investment in adolescents to support both scale and sustainability.

To take full advantage of the experience and expertise in GFF partner organizations, a time-bound (Feb-June 2019) technical advisory group (TAG) that includes representation from GFF investors group constituencies (Annex 1) was convened to develop an action plan to support country-led efforts to improve adolescent sexual and reproductive health and rights (ASRHR). This effort is intended to be complementary to ongoing country-led efforts and multi-country initiatives (Annex 2), to inform the work of the GFF Secretariat, and to focus on a set of specific technical challenges for which collective action, coordination, and investment in global goods and learning by members of the GFF Investors Group would benefit both countries and the broader partnership.

This paper proposes three hypotheses for why ASRHR is underfinanced and develops three theories of change to identify activities and themes for GFF focus. These include activities to: (1) close key gaps in the evidence base around the cost of adolescent health interventions; (2) efforts to strengthen health systems and capacity needed to strategically purchase a rights-based package of SRH interventions; and (3) efforts to address bottlenecks to multi-sectoral actions to unlock additional financing that can contribute to improved ASRHR outcomes.

ACTION REQUESTED

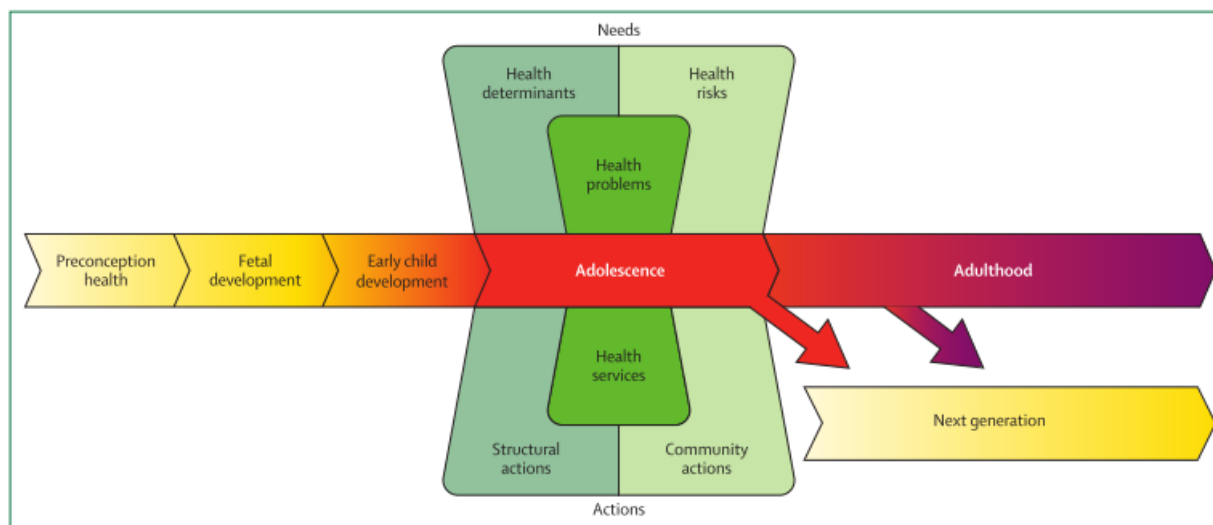
The Investors Group to provide feedback virtually on the action plan to support adolescent sexual and reproductive health and rights in the GFF portfolio with the final report endorsed at the May 30, 2019 Investor's Group Technical Meeting.

Introduction:

The Global Financing Facility (GFF) is a partnership with an innovative approach to financing that supports countries to significantly increase investment in the health of their own people. The vision of the GFF is to end preventable maternal, newborn, child and adolescent deaths and improve the health, nutrition, and well-being of women, adolescents and children by 2030 in support of health and nutrition-related SDGs. This vision is guided by the Global Strategy for Women's, Children's and Adolescents' Health (2016-2030)¹ which explicitly highlights the challenges and opportunities for achieving progress in reproductive, maternal, neonatal, child, and adolescent health and nutrition (RMNCAH-N).

Adolescent sexual and reproductive health and rights (ASRHR) has a critical role to play in improving health outcomes for adolescents themselves but also as a driver for improvements along the life cycle with spillover effects into the next generation (Figure 1). Pregnancy during adolescence carries risk across the life cycle, including halting linear growth of mothers,² risk of pregnancy complications,³ and heightened risk of poverty.⁴ Complications during pregnancy and childbirth are the leading cause of death among adolescent girls in developing countries.⁵ Children born to adolescents are also more likely to have a low birth weight, increased child morbidity and poor nutritional outcomes, including stunting.⁶

Figure 1. Conceptual Framework for Defining Health Needs and Actions in Adolescents and Young Women



1 Every Woman Every Child. The Global Strategy for Women's, Children's and Adolescents' Health (2016-2030) [Internet]. 2016; Available from: http://www.everywomaneverychild.org/wp-content/uploads/2017/10/EWEC_GSUpdate_Full_EN_2017_web-1.pdf

2 Rah J, Christian P, Shamim A, Ummeh A, Labrique A. (2008) Pregnancy and lactation hinder growth and nutritional status of adolescent girls. The Journal of Nutrition, Volume 138, Issue 8, Pages 1505-11.

3 Black RE, Victora CG, Walker SP, et al. (2013) Maternal and child undernutrition and overweight in low-income and middle-income countries. Lancet, Volume 382, Issue 9890, Pages 427–51.

4 Patton GC, Sawyer SM, Santelli JS, Ross DA, Afifi R, Allen NB, et al. Our future: a Lancet commission on adolescent health and wellbeing. The Lancet. 2016;387(10036):2423-78.

5 Global patterns of mortality in young people: a systematic analysis of population health data. Patton GC, Coffey C, Sawyer SM, Viner RM, Haller DM, Bose K, Vos T, Ferguson J, Mathers CD. Lancet, 2009, 374:881–892.

6 World Bank. 2010. Reproductive Health Action Plan 2010-2015. World Bank: Washington DC Please consider using this reference: <https://www.ncbi.nlm.nih.gov/pubmed/24641534>

Source: Patton et al., 2016, *The Lancet Commission on adolescent health and wellbeing*.

The conceptual framework above highlights the convergence of health determinants and risks during adolescence and the need to address these with comprehensive structural and community actions with equitable provision and access to coordinated and appropriate adolescent responsive health and community systems that are gender sensitive, equitable, and high quality at the center. Within this broad scope, we present the rationale for financing ASRRH and develop three hypotheses with associated theories of change to generate recommended actions for the GFF partnership to pursue.

Adolescent Sexual and Reproductive Health and Rights in GFF Eligible Countries

Adolescence is a period in which health behaviors are established, patterns of nonfatal disease burden emerge, and risk-taking behaviors are initiated.^{7,8} WHO estimates that nearly 35 percent of the global burden of disease has roots in adolescence.⁹ The 2012 *Lancet Series* on adolescent health illustrated wide variation in the health of adolescents within and between regions. Adolescents in Sub-Saharan Africa were identified as having the poorest health profile, where risk of mortality, early childbirth, and sexually transmitted infection were highest.¹⁰

A large share of the overall health burden among adolescents can be attributed to risks associated with early and forced sexual debut; early marriage; harmful gender norms; poverty; and limited investment in protective actions to address critical antecedents to sexual and reproductive health behaviors such as insufficient access to comprehensive, accurate, and age-appropriate sexuality education; sexual and reproductive health services; lack of SRHR and health literacy/knowledge among adolescents. Sexual violence occurs among girls and boys alike. Globally, over one-in-ten 15–19-year-old girls have experienced forced sexual acts including forced intercourse.¹¹ Consensual and non-consensual unprotected sexual activity introduces a series of risks that include HIV/AIDS and human papilloma virus among other sexually transmitted infections. Young men and boys also experience risk of sexual abuse, however, a global estimate is not available. Research shows that the magnitude of adverse sexual and reproductive health outcomes among boys is high as boys are more likely to die of AIDS-related illnesses.¹²

The ability to obtain and use modern methods of contraception¹³, including condoms for dual protection, is widely recognized as both an important right and one of the most cost-effective public health interventions available.¹⁴ Across GFF eligible countries, average demand for contraception amongst 15-

⁷ Patton GC, Azzopardi P, Kennedy E, Coffey C, Mokdad, A. Global Measure of Health Risks and Disease Burden in Adolescents. In: Bundy DAP, de Silva N, Horton S, Jamison DT, Patton GC, editors. *Disease Control Priorities, Third Edition (Volume 8): Child and Adolescent Health and Development*. Disease Control Priorities. 8. Washington, DC: World Bank; 2017. p. 57-71.

⁸ Azzopardi and others. 2019. Progress in adolescent health and wellbeing: tracking 12 headline indicators for 195 countries and territories, 1990–2016. *Lancet*. [http://dx.doi.org/10.1016/S0140-6736\(18\)32427-9](http://dx.doi.org/10.1016/S0140-6736(18)32427-9)

⁹ WHO. Adolescent health epidemiology. Accessed: https://www.who.int/maternal_child_adolescent/epidemiology/adolescence/en/

¹⁰ Patton, G. C., C. Coffey, C. Cappa, D. Currie, L. Riley, and others. 2012. "Health of the World's Adolescents: A Synthesis of Internationally Comparable Data." *The Lancet* 379 (9826):1665–75.

¹¹ UNICEF. 2014. A statistical snapshot of violence against adolescent girls.

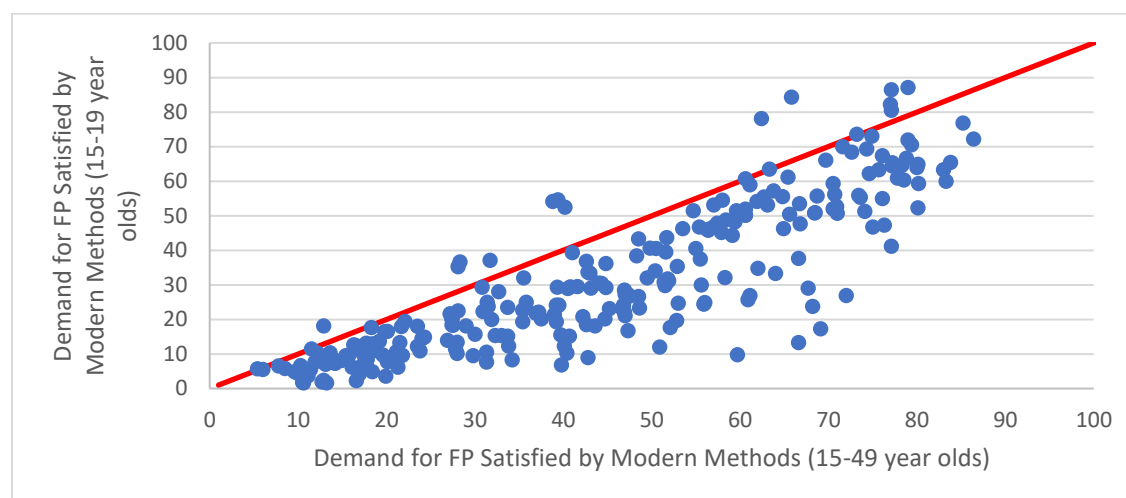
¹² UNAIDS. 2017. Blind Spot: Reaching Out to Men and Boys.

¹³ Hubacher and Trussell (2015) define modern methods of contraceptives to include: sterilization (male and female), intrauterine devices and systems, subdermal implants, oral contraceptives, condoms (male and female), injectables, emergency contraceptive pills, patches, diaphragms and cervical caps, spermicidal agents, vaginal rings, and sponge.

¹⁴ Singh S and Darroch JE, *Adding It Up: Costs and Benefits of Contraceptive Services—Estimates for 2012*, New York: Guttmacher Institute and United Nations Population Fund (UNFPA), 2012

19-year-olds is low.¹⁵ Unmarried adolescents are often not sexually active or exhibit sporadic sexual activity. Many adolescents who are sexually active are married and want to begin childbearing. But in absolute terms, there are large numbers of adolescents in the developing world who need access to contraception. Estimates suggest that 38 million adolescent women aged 15 to 19, including those who are married and unmarried, living in developing countries are sexually active and do not wish to have a child in the next two years. Among these adolescents, 23 million have an unmet need for modern contraception.¹⁶ Adolescents needing contraception are less likely than women on average to see their demand satisfied by modern methods of contraception (see figure 2): dots below the red line suggest that adolescent demand is less likely to be satisfied by modern methods than for women 15-49 years overall.

Figure 2. Demand satisfied by modern methods by age group¹⁷



This market and health system failure includes supply that is unwilling or unresponsive to adolescent demand for contraceptives (e.g. high cost, low quality, provider unwillingness to provide services, inconvenient service placement) and demand-side factors like real or perceived partner resistance, concerns about resumption of fertility, or fear of side-effects. Among adolescent contraceptive users, user error is an important contributor to method failure and subsequent early and unintended pregnancy. Global estimates find that younger users experience up to a ten-fold higher rate of contraceptive failure compared to older users.¹⁸ Unintended pregnancy contributes to an estimated 19 million unsafe abortions each year¹⁹ representing one of the most neglected sexual and reproductive health challenges faced by adolescent girls and women. Most unsafe abortions occur within developing countries (86 percent),²⁰ with

¹⁵ http://www.track20.org/pages/data_analysis/in_depth/youth/opportunities.php

¹⁶ Darroch, Woog, Bankole, and Ashford. 2016. Adding it up: costs and benefits of meeting the contraceptive needs of adolescents. Guttmacher Institute.

¹⁷ All survey data from DHS (LICs and MICs) accessed through StatCompiler.com on 19 March 2019. Each dot represents a country. Dots below the redline suggest that adolescent demand is less likely to be satisfied by modern methods than for women overall.

¹⁸ Bradley, Polis, Bankole, and Croft. Global contraceptive failure rate: Who is most at risk? *Studies in Family Planning*, Vol 50 Issue 1, Pg. 3-24.

¹⁹ Shah and Ahman. Age Patterns of Unsafe Abortion in Developing Country Regions. *Reproductive Health Matters*, Vol. 12, No. 24, Supplement: Abortion Law, Policy and Practice in transition, pp. 9-17

²⁰ Chae, Desai, Crowell, Sedgh, and Singh. 2017. Characteristics of women obtaining induced abortions in selected low- and middle-income countries. *PLoS One*, 12(3).

a quarter of unsafe abortions in Africa occurring among 15-19-year-olds.²¹ Unlike safe abortion, which has very few health consequences, unsafe abortion contributes to an estimated 7.9 percent of all maternal deaths and 9.6% of maternal deaths in Sub-Saharan Africa.²²

Social, gender, and power determinants also play an important role in ASRHR outcomes, as they shape the context in which decisions about sexual debut, education, marriage, and childbearing take place and directly interface with health and education systems that may be underperforming in the delivery of essential services.^{23,24} Gender determinants include, but are not limited to, the legal protections afforded to women and girls, harmful norms and practices that limit women's participation in social and economic activity, employment opportunities for women outside of the home, the threat of gender-based violence, and access to menstrual hygiene and health facilities. This includes the perception of families that there are limited returns to education, perhaps due in part to real concerns about education quality, and where risks of violence for girls and young women are part of lived experience. As a result, child marriage, for example, can emerge as an alternative to human capital investment and contributes to both early childbearing and subsequent limited economic and educational opportunities for girls. Nearly one-in-four adolescent girls aged 15-19 in lower- and middle-income countries (excluding China) is currently married or in union.²⁵

Education has a particularly important role to play in improving ASRHR and other health outcomes and for building human capital. Increasing the number of years of schooling has health benefits that include reducing child and adolescent morbidity and mortality rates and on changing life-time fertility preferences and practices.²⁶ Encouraging safe behaviors and healthy relationships among younger adolescents (10-14 years) – a critical phase for emotional development and a time when many students remain in school – may foster more equitable gender norms.²⁷ Women with more education tend to marry and bear children later and exercise greater control over their sexual choices and fertility. Nevertheless, there is often a steep drop-off in school enrollment for girls between primary and lower secondary levels (Figure 3), with persistent gender inequality in enrollment, retention, and in learning outcomes.

²¹ Morris and Rushwan. 2015. Adolescent sexual and reproductive health: The global challenges. *International Journal of Gynecology and Obstetrics*, Vol. 131, S40-S42.

²² Say and others. 2014. Global causes of maternal death: a WHO systematic analysis. *Lancet Global Health*, Vol. 2, Issue 6, p. e323-e333.

²³ Malhotra, Amin and Nanda. 2019. Catalyzing gender norm change for adolescent sexual and reproductive health: investing in interventions for structural change. *J of Adol Health*, 64, S13-S15.

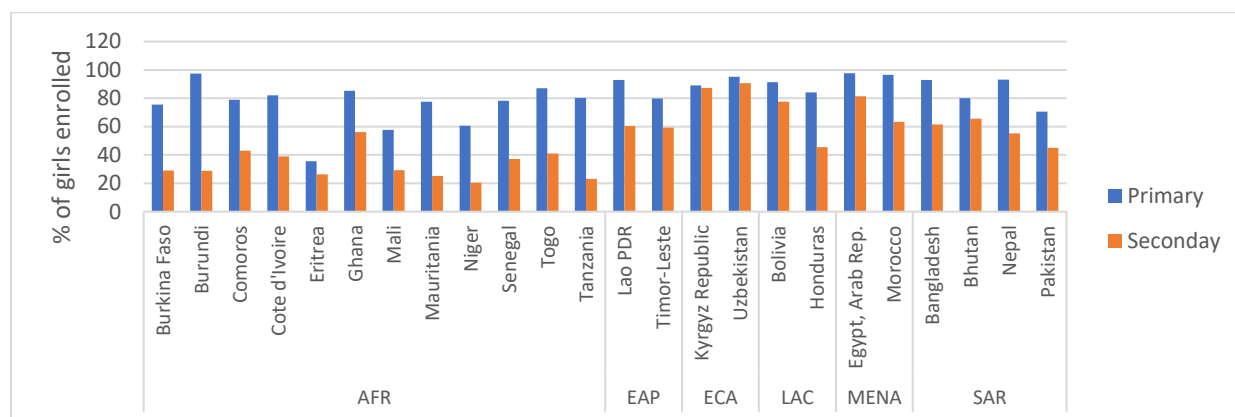
²⁴ Starrs and others. 2018. Accelerate progress – sexual and reproductive health and rights for all: report of the Guttmacher-Lancet Commission. *Lancet*, 391(10140).

²⁵ UNICEF. 2012. Progress for children: a report card on adolescence.

²⁶ Oye, Mari, Lant Pritchett, and Justin Sandefur. 2016. "Girls' Schooling Is Good, Girls' Schooling with Learning Is Better." Education Commission, Center for Global Development, Washington, DC.

²⁷ Kågesten A, Gibbs S, Blum RW, Moreau C, Chandra-Mouli V, Herbert A, et al. (2016) Understanding Factors that Shape Gender Attitudes in Early Adolescence Globally: A Mixed-Methods Systematic Review. *PLoS ONE* 11(6): e0157805.

Figure 3. School Enrollment, Primary and Secondary Rates, Girls, in GFF Eligible Countries with 2017 Data (% net)



Source: World Development Indicators

Financing for Adolescent Health

Expanding financing for ASRHR presents a significant opportunity to contribute to the development of human capital: the aggregated skills and knowledge of a population. The contribution of human capital to national wealth is thought to be around 70 percent in high-income countries but closer to 40 percent in poorer countries.²⁸ There is a vast opportunity to target human capital investments to adolescents ages 10-19 years as 90 percent of the 1.2 billion adolescents worldwide live in developing countries.²⁹ Improving the physical, sexual, and mental health of adolescents aged 10-19 years at the cost of about \$4.60 per person per year could bring a tenfold economic benefit by averting more than 12 million adolescent death and preventing more than 30 million unwanted pregnancies (between 2015 and 2030). Similarly, programs to reduce child marriage costing around \$3.80 per person can bring an almost six-fold return on investment.³⁰

Despite these opportunities and available evidence-based guidance on interventions that can more effectively address adolescent health needs,^{31,32} current levels of financing are neither aligned with the health burden nor with the opportunity. Development assistance for adolescent health has grown dramatically in recent years, but investments have not kept pace with interest; only 2.2 percent of total development assistance for health is allocated for adolescents.³³ Additionally, patterns of healthcare service utilization suggest under-investment of public domestic financing in the delivery of adolescent

²⁸ Lange et al. *The Changing Wealth of Nations 2018: Building a Sustainable Future*. Default Book Series. January 2018.

²⁹ UNICEF. 2012. *Progress for Children: A Report Card on Adolescents*. UNICEF: New York.

³⁰ Sheehan et al. 2017. Building the foundations for sustainable development: a case for global investment in the capabilities of adolescents. *The Lancet*, 390 (10104), pp. 1792-1806

³¹ Child and Adolescent Health and Development. In: Bundy DAP, De Silva N, Horton S, Jamison DT, Patton G, editors. *Disease Control Priorities*. Volume 8. Third ed. Washington, DC: World Bank; 2017.

³² WHO. AA-HA! https://www.who.int/maternal_child_adolescent/topics/adolescence/framework-accelerated-action/en/

³³ Li Z, Li M, Patton GC, Lu C. Global Development Assistance for Adolescent Health From 2003 to 2015. *JAMA Netw Open*. 2018;1(4):e181072. doi:10.1001/jamanetworkopen.2018.1072

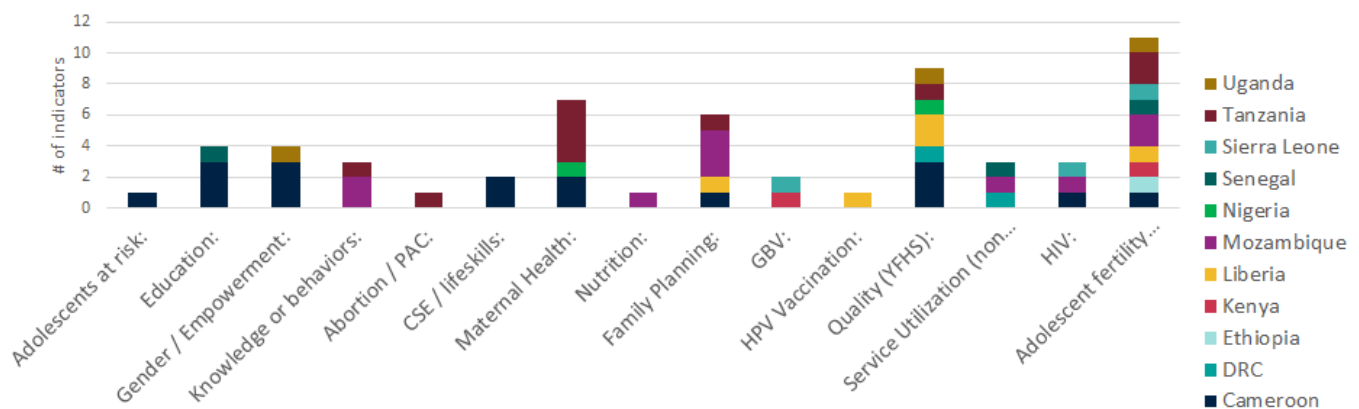
friendly services and ASRHR outcomes, and this investment is coupled with low rates of social service utilization by adolescents (in addition to demand side bottlenecks). For example, contraceptive services delivered in publicly run health facilities tend to serve older, married women, while adolescents and young women use contraceptives less often and are more likely than older users to purchase contraceptive methods from private pharmacies and drug shops and paying out-of-pocket.^{34,35,36}

Investing to Improve ASRHR: GFF Investment Cases

The GFF was launched to help address gaps in financing for the systems and interventions needed to improve RMNCAH-N outcomes. At the global level, the GFF has identified reducing age specific fertility rate for adolescents (15-19 years) as one of eight core outcome goals.³⁷ Other goals including reducing the maternal mortality ratio and increasing birth spacing directly affect adolescents who begin child bearing. Neonatal mortality, under-5 mortality, under-5 stunting, severe wasting, and early child development are other goals that are directly or indirectly mediated by the age and health status of the mother.

Across current GFF countries with final investment cases (11), all have identified at least one adolescent specific indicator³⁸ and 80 percent have identified reductions in adolescent fertility as one of their impact level priorities (Figure 4).³⁹

Figure 4. Adolescent Health Indicators from GFF Results Frameworks.



Cameroon’s investment case, for example, has identified early and unintended pregnancy as a priority and has developed a theory of change (Figure 5a) that includes expanding access to youth friendly health services, interventions focused on access to contraception among adolescents, comprehensive sexuality

³⁴ Weinberger, Michelle and Sean Callahan. 2017. The Private Sector: Key to Achieving Family Planning 2020 Goals. Brief. Bethesda, MD: Sustaining Health Outcomes through the Private Sector Project, Abt Associates.

³⁵ Dennis and others. 2017. Pathways to increased coverage: an analysis of time trends in contraceptive need and use among adolescents and young women in Kenya, Rwanda, Tanzania, and Uganda. *Reproductive Health*, 14(1): 130.

³⁶ Radovich and others. 2018. Who meets the contraceptive needs of young women in Sub-Saharan Africa? *J Adol Health*, 62(3): 273-280.

³⁷ https://www.globalfinancingfacility.org/sites/gff_new/files/documents/GFF-Results-Monitoring-Framework.pdf

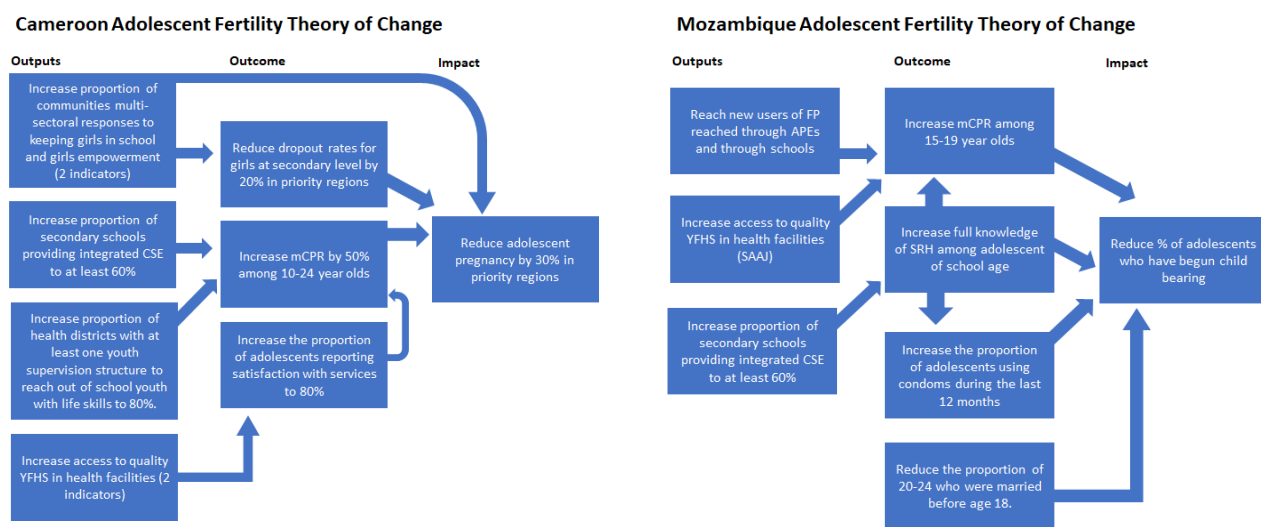
³⁸ ASRH indicators are included in many global monitoring frameworks (for example, SGDs, Global Strategy). However, indicator definitions vary across frameworks. The “Global Action for Measurement of Adolescent health” group has ongoing work to harmonize and prioritize indicators.

³⁹ https://www.globalfinancingfacility.org/sites/gff_new/files/documents/ME_frameworks_for_GFF_countries.xlsx

education and life skills education in and out of schools, education sector investments to improve girl’s attendance and learning outcomes, and community-based empowerment initiatives.

Similarly, Mozambique’s investment case builds on the experience of *Programa Geração Biz*, a multi-sectoral and multi-partner effort aimed at addressing ASRH issues in the country (HIV incidence, early and unwanted pregnancy, adolescent maternal mortality ratio) that started in the late 1990s.⁴⁰ The investment case theory of change (Figure 5b) focuses attention on adolescent knowledge and behavioral indicators as well as expanding access to modern contraceptives and other essential SRH services through their youth friendly health service delivery strategies.

Figure 5. ASRHR Theory of Change for Cameroon (a) and Mozambique (b)⁴¹



However, these investment case theories of change are in some respects exceptional. Most investment cases completed to date focus on responses that use existing health service delivery strategies rather than interventions that recognize and respond to the unique demand-side, informational, and service delivery needs of adolescents. Additionally, few have identified opportunities for multi-sectoral investments to address underlying social and gender determinants that target girls, boys, and broader communities. While this is understandable given health sector leadership on broader SRHR, this may miss opportunities to direct non-health-sector resources (e.g. education, WASH, social protection, judiciary) towards improving SRHR outcomes that deliver broader societal benefits.

Strengthening ASRHR Theories of Change and Scaling Financing

A technical advisory group that includes representation from GFF investor group constituencies (see Annex 1) was convened by the GFF Secretariat to inform the development of an action plan aimed at identifying the most important contributions the GFF can make towards addressing the financing gap for ASRHR. The action plan is organized around three hypotheses that explain the current state of under-

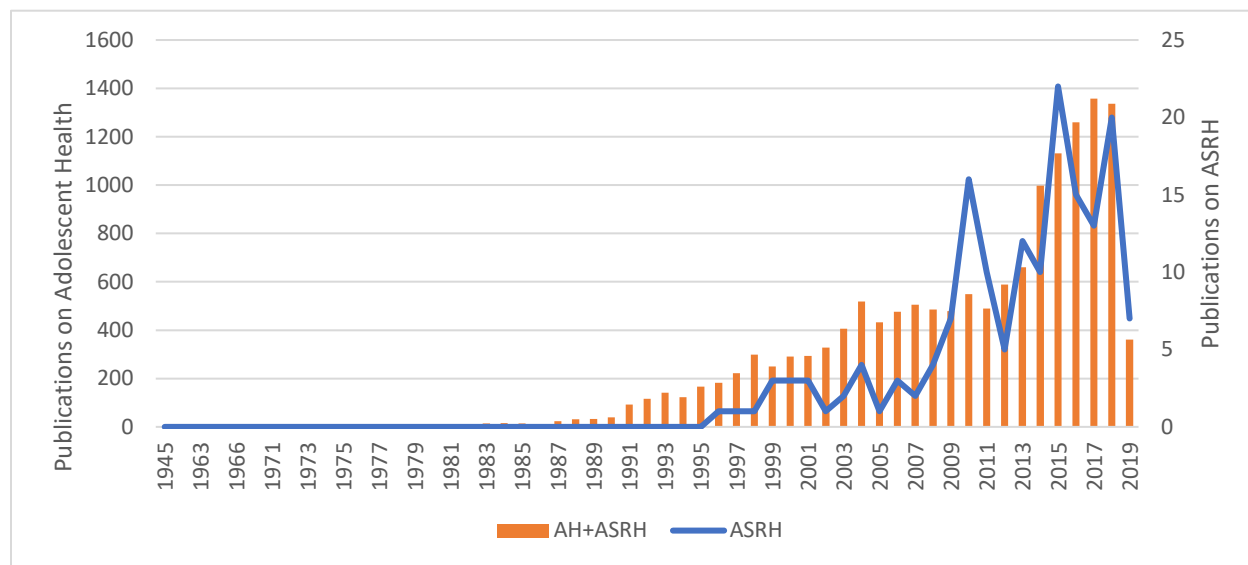
⁴⁰ <https://reproductive-health-journal.biomedcentral.com/articles/10.1186/1742-4755-12-12>

⁴¹ Figures are stylized by the authors based on investment case results frameworks for [Cameroon](#) and [Mozambique](#).

investment with an associated theory of change for each hypothesis (See Annex 3). These, and their rationale, are presented below.

Hypothesis 1: Evidence for ASRHR interventions has improved dramatically in recent years but key gaps limit choice of intervention, implementations in new contexts, and scale.

Figure 7. Publications on Adolescent Health and ASRH Based on PubMed Key Word Search



While there has been a dramatic increase in the attention paid to adolescent health and SRH in the past twenty years (Figure 7), the availability of high-quality evidence has remained relatively sparse. An analysis conducted by Bundy, Schultz and others (2017)⁴² found that of the published literature describing health in ages 0-19 less than one-percent focused on 15-19-year age group. A 2016 adolescent SRH evidence gap analysis by 3ie found the evidence base on costing and cost-effectiveness to inform policy and planning almost entirely absent.⁴³ This gap means that there is virtually no comparative cost-effectiveness analysis for ASRHR interventions in the public domain. This creates challenges for prioritization of ASRH interventions in investments cases when countries are balancing limited fiscal space and other priorities.

⁴² Bundy DAP, de Silva N, Horton S, Patton GC, Schultz L, Jamison DT, et al. Investment in child and adolescent health and development: key messages from Disease Control Priorities, 3rd Edition. The Lancet. 2017;391(10121):687–99.

⁴³ Rankin, K., Jarvis-Thiébault, J., Pfeifer, N., Engelbert, M., Perng, J., Yoon, S., & Heard, A. (2016). *Adolescent sexual and reproductive health: an evidence gap map*. International Initiative for Impact Evaluation.

Priority areas of focus to respond to hypothesis 1:

- 1.1 Pilot the adolescent health module in Equist in GFF expansion countries to inform package design.
- 1.2 Undertake cost analysis for proven intervention to improve ASRH outcomes in 5 GFF supported countries.
- 1.3 Review existing evidence base to gain an understanding of the breadth of available evidence (mixed methods) and gaps.
- 1.4 Develop user-friendly evidence synthesis on interventions that address priority ASRHR outcomes (i.e. early and unintended pregnancy) to highlight promising approaches and reinforce messages on low-evidence interventions.

Hypothesis 2. Many health and social service systems lack the financing instruments to use resources in ways that respond to ASRHR needs.

Many innovative programs focused on adolescent sexual and reproductive health are financed bilaterally. One of the largest programs is the President’s Emergency Plan for AIDS Relief (PEPFAR) DREAMS program, which has a comprehensive theory of change that invests across several platforms to address access to SRHR services and many of the social determinants that elevate risk of HIV infection for adolescent girls and young women. Since 2015, PEPFAR has invested more than \$800 million across ten countries in East and Southern Africa.⁴⁴ This investment will yield benefits for adolescent girls and young women in these countries and further expand our knowledge base around adolescent SRHR information and service delivery strategies. However, nearly all the purchasing uses United States government contracting systems. Using public domestic financing to purchase the same or similar interventions would require capacities and systems that are under-developed in many countries. In the short-term, limited fiscal space makes this a less acute problem. But over the next decade and beyond, government expenditure will be the largest driver of health expenditure growth in all regions of the world.⁴⁵ If governments lack the purchasing instruments and systems needed to finance adolescent health interventions, the potential scale of those interventions will be limited.

Additionally, for many adolescent health interventions, the systems needed to support strategic purchasing, like information and quality assurance systems, don’t adequately capture data on or from adolescents. While some of these issues can be changed with adjustments to system design (e.g. age disaggregation), many present more complex structural challenges. For example, adolescents may prefer to use pharmacies, drug shops, and informal sector outlets that not captured in national data systems.

Finally, we lack quality and rights metrics for many adolescent health interventions including some of the most often implemented.⁴⁶ While interventions may have demonstrated promise through rigorous evaluation, implementation at scale requires a measurement agenda that ensures fidelity and accountability.

⁴⁴ PEPFAR DREAM Annual Report, 2018: <https://www.pepfar.gov/documents/organization/287807.pdf>

⁴⁵ Dalal K. Future and potential spending on health 2015-40: development assistance for health, and government, prepaid private, and out-of-pocket health spending in 184 countries (2017). *The Lancet*; Last accessed on 17th April 2017.

⁴⁶ Mazur A, Brindis CD, Decker MJ. Assessing youth-friendly sexual and reproductive health services: a systematic review. *BMC Health Serv Res.* 2018;18:216.

Priority areas of focus in GFF participating/supported countries to respond to hypothesis 2:

- 2.1 Conduct capacity assessments and investment recommendations for routine data systems (e.g. HMIS, CRVS) to ensure they produce actionable information on ASRHR for use by policy makers.
- 2.2 Test novel strategies for measuring ASRHR service quality using validated metrics in the context of public purchasing systems (service contracts, RBF, insurance payments).
- 2.3 Landscaping of promising ASRHR platforms (health facilities, community interventions, school health, media campaigns, mHealth) in 5 countries and develop country specific plans to connect platforms to public financing instruments.
- 2.4 Support policy-maker, CSO, and academic institutional capacity to meaningfully engage adolescents, use adolescent health data, and evaluate adolescent health interventions.

Hypothesis 3: There is a need for multi-sectoral responses and accountability to maximize potential financing and impact for ASRHR outcomes.

There is substantial evidence to suggest that sectors outside of health have a critical role to play in improving ASRHR outcomes. Additionally, given limited fiscal space in any single sector, maximizing the role of each relevant sector (e.g. education, social protection, WASH) to contribute to improved ASRHR outcomes will speed progress to national goals for ASRHR as well as expand the overall financing envelope.

Despite these opportunities, investment in the institutions needed to innovate on multi-sectoral strategies and lead multi-sectoral action is limited and often results to failure during implementation.⁴⁷ While there is still much to learn from evaluation and implementation experience, the need to cultivate champions and leadership across sectors around common goals is critical.⁴⁸

Priority areas of focus to respond to hypothesis 3:

- 3.1 Support analytical work to ensure that WBG Human Capital Project is making links between ASRHR and Human Capital in dialogue with Ministers of Finance.
- 3.2 Strengthen Multi-Stakeholder Country Platforms on including meaningful engagement of youth in the IC development process.
- 3.3 Provide new GFF countries with analytic support to best identify individual and social determinants of health for ASRHR outcomes to ensure early inter-sector engagement.
- 3.4 Develop stronger linkages between education and GFF global initiatives in countries receiving financing from Global Partnership for Education and the GFF.

⁴⁷ *BMJ* 2015;351:h4213

⁴⁸ Rasanathan K, Bennett S, Atkins V, Beschel R, Carrasquilla G, Charles J, et al. (2017) Governing multisectoral action for health in low- and middle-income countries. *PLoS Med* 14(4): e1002285.

Next Steps:

After the 8th Investors Group meeting, the GFF Secretariat will convene an in-person discussion of the ASRHR TAG to develop the joint action plan centered around the theories of change described in this paper (Annex 3). This will be an opportunity for organizations to identify ways they can contribute to this joint plan and will be opportunity to discuss process and output level indicators for monitoring implementation.

Conclusion:

Adolescents is a stage of growth, evolving capacities, and new opportunities. Sexual and reproductive health and rights is at the very heart of the transition into adulthood and plays a vital role in adolescence and throughout life in terms of identity, health, wellbeing, and personal fulfillment.

However, adolescents, and particularly girls, face unique sexual and reproductive health risks and challenges in accessing health and social services needed to mitigate those risks. Investment in ASRHR supply and demand interventions are therefore critical for ensuring that adolescents thrive and reach their full potential.

While current levels of investment for adolescent sexual and reproductive health do not match the health burden that this group faces, there are key opportunities that have been identified for the GFF partnership to accelerate progress and support country leadership in this technical area. These include activities to close gaps in the evidence base around the cost of adolescent health interventions at scale, efforts to strengthen systems and capacity needed for governments to purchase a rights-based package of SRH interventions (including investments in quality assurance, data management and use, and other critical capacities), and to address challenges to unlocking non-health sector resources and multi-sectoral actions to contribute to improved adolescent SRHR outcomes.

Supporting families, communities, as well as health and social service systems to be more responsive to the needs of adolescents is critical to supporting adolescents themselves to realize their sexual and reproductive health and rights. These efforts have the potential to improve health outcomes along the life cycle and are a pillar on which to build individual, household, and national human capital wealth.

ANNEX 1: List of Technical Advisory Group Members

The TAG is coordinated by Brendan Hayes as the SRHR Technical Lead at the GFF Secretariat. Brendan Hayes is joined by the following colleagues who support the adolescent health agenda at the GFF: Supriya Madhavan (Senior Health Specialist, Demographer), Julie Ruel Bergeron (Nutrition Specialist), Genesis Samonte (Senior Health Specialist, Results Monitoring), and Linda Schultz (Consultant, School Health Specialist).⁴⁹ The TAG members and the constituencies they represent are captured in the table below; they were self-selected by their IG constituencies.

Constituency	Member	Organization
Bilateral Financiers	Melodi Tamarzians	Government of the Kingdom of the Netherlands
	Alexanda Stefanopoulos	Government of Canada
Country Representative	Ng'ang'a Wangari	Government of Kenya
CSO Representatives	Suzanna Dennis	PAI
	Kosi Izundu	Youth Representative, GFF IG CSO Constituency
Multilateral Representative	Sameera Maziad Al Tuwajri	World Bank
Private Foundation	Gwyn Hainsworth	BMGF
UN Representative	Venkatraman Chandra-Mouli	WHO
	Cristina De Carvalho Eriksson	UNICEF
	Danielle Engel	UNFPA

⁴⁹ Additional contributions to this paper from Bahie Mary Rassekh (World Bank) and Cate Lane (FP2020).

ANNEX 2: Global/Multi-Country Initiatives and Guidance to Improve the Health and Wellbeing of Adolescents

Initiatives and Guidance	Partners Engaged	Activities	Geographies	Timeframe
Comprehensive Sexuality Education Campaign	UNESCO with support from Sweden	<ol style="list-style-type: none"> 1. Internet-based dialogue through focused stories on engaging families and adolescents on CSE 2. Regional workshops with policy makers and religious leaders to shape public opinion and influence behaviors 3. Technical guidance to inform the development of CSE curricula 	Global	2018 - present
AA-HA!	WHO together with UNAIDS, UNESCO, UNFPA, UNICEF, UN Women, and the World Bank	Comprehensive overview of adolescent health needs and compilation of corresponding evidence-based interventions for adolescent health.	Global	2017 - present
Global Programme to Accelerate Action to End Child Marriage	UNICEF and UNFPA with support from the Governments of Belgium, Canada, the Netherlands, Norway, the	<p>The Global Programme supports countries to diversify their efforts to leverage capacities and resources of other sectors, institutions, platforms and systems.</p> <p>The Global Programme aims to (i) empower adolescent girls; (ii) facilitate community dialogue and mobilization for social and behavior change; (iii) strengthen activities in health, education, and social protection sectors by linking to</p>	Countries with high-prevalence or high-burden of child marriage: Bangladesh, Burkina Faso, Ethiopia, Ghana, India, Mozambique, Nepal, Niger, Sierra Leone, Uganda, Yemen and Zambia	2016 - present

	United Kingdom and the European Union, as well as Zonta International	complementary funds; and (iv) build government ownership and commitment towards ending child marriage.		
The Spotlight Initiative: Ending Violence Against Women and Girls	EU-UN	<p>The Spotlight Initiative provides investments in prevention and essential services for survivors of violence and their families.</p> <p>The Spotlight Initiative is working closely with countries in Asia (the Safe and Fair programme for migrant women workers), Africa (with a focus on sexual and gender-based violence and harmful practices), and Latin America (focusing on femicide) with plans to extend activities to the Pacific and the Caribbean.</p> <p>A project to address gender-based violence in forgotten crises will be rolled out in 2019 and will include activities in Bangladesh, Cameroon, Chad, Ghana, Iraq, Liberia, Mali, Palestine, Sudan, and Yemen.</p>	Global	2018 - present
Sahel Women's Empowerment and Demographic Dividends Project	World Bank with coordination by UNFPA, BMGF, and ECOWAS	The Sahel Women's Empowerment and Demographic Dividend Project (SWEDD) will work across the sub-region to improve the availability and affordability of reproductive health services, strengthen specialized training centers for rural-based midwives, improve nursing services, and pilot and share knowledge on adolescent girls' initiatives	Benin, Cote d'Ivoire, Chad, Mali, Mauritania, Niger, and the Economic Community of Western African States (ECOWAS).	2014 - present

Girls Not Brides: The Global Partnership to End Child Marriage	Global partnership of more than 1000 civil society organizations	Members bring child marriage to global attention, build an understanding of what it will take to end child marriage and call for the laws, policies and programmes that will make a difference in the lives of millions of girls.	Global	2011 - present
DREAMS Partnership	PEPFAR/US Government	DREAMS provides a comprehensive package of core interventions to address many of the factors that make girls and young women particularly vulnerable to HIV, including gender-based violence, exclusion from economic opportunities, and a lack of access to secondary school. DREAMS interventions also work with other interventions available through core PEPFAR activities (e.g., HIV testing and treatment; orphans and vulnerable children [OVC] programming; and voluntary medical male circumcision [VMMC]) to reduce risk in every sector.	Botswana, Cote d'Ivoire, Eswatini, Haiti, Kenya, Lesotho, Malawi, Mozambique, Namibia, Rwanda, South Africa, Tanzania, Uganda, Zambia, and Zimbabwe.	2014 - present
Gavi, The Vaccine Alliance	Public-private partnership supported by WHO, UNICEF, BMGF, the World Bank, Donor country governments, research agencies, private sector partners,	Aims to save children's lives by create equal access to new and underused vaccines and close the immunization gap for the full course of basic vaccines among children living in the world's poorest countries. Gavi supports countries by providing health system strengthening support, vaccine support, and tailored technical support.	HPV Vaccine Demo: Malawi, Tanzania, Kenya, Madagascar, Sierra Leone, Ghana, Niger, Lao PDR; Others scale-up eligible.	2000 - present

	vaccine manufacturers, CSOs, and implementing country governments			
Family Planning 2020	Secretariat at the UN Foundation. Core Conveners: UNFPA, BMGF, DFID, USAID	<p>The FP2020 governance structure complements and works closely with key partners and existing mechanisms and contributes to the UN Secretary General’s Strategy for Women’s and Children’s Health, <i>Every Woman, Every Child</i>. FP2020’s unique governance structure allows representatives from all sectors to coordinate activities, pool their talents, align agendas and collaborate together to address the policy, financing, supply, delivery and sociocultural barriers to women accessing contraceptives.</p> <p>The structure is comprised of four components to help achieve FP2020 goals, under guiding principles based on human rights, including choice, equity, and voluntarism. The components are: the Reference Group; the Performance Monitoring & Evidence Working Group; the Expert Advisory Community, and the Secretariat.</p>	Afghanistan, Bangladesh, Benin, Bhutan, Bolivia, Burkina Faso, Burundi, Cambodia, Cameroon, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, Democratic Republic of Congo, Djibouti, DPR Korea, Egypt, Eritrea, Ethiopia, Gambia, Ghana, Guinea, Guinea-Bissau, Haiti, Honduras, India, Indonesia, Iraq, Japan, Kenya, Kyrgyz Republic, Lao PDR, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mongolia, Mozambique, Myanmar, Nepal, Netherlands, Nicaragua, Niger, Nigeria, Norway, Pakistan, Papua New Guinea, Philippines, Rwanda, São Tomé and Príncipe, Senegal, Sierra Leone, Solomon Islands, Somalia, South Africa, South Korea, South Sudan,	2012-2020

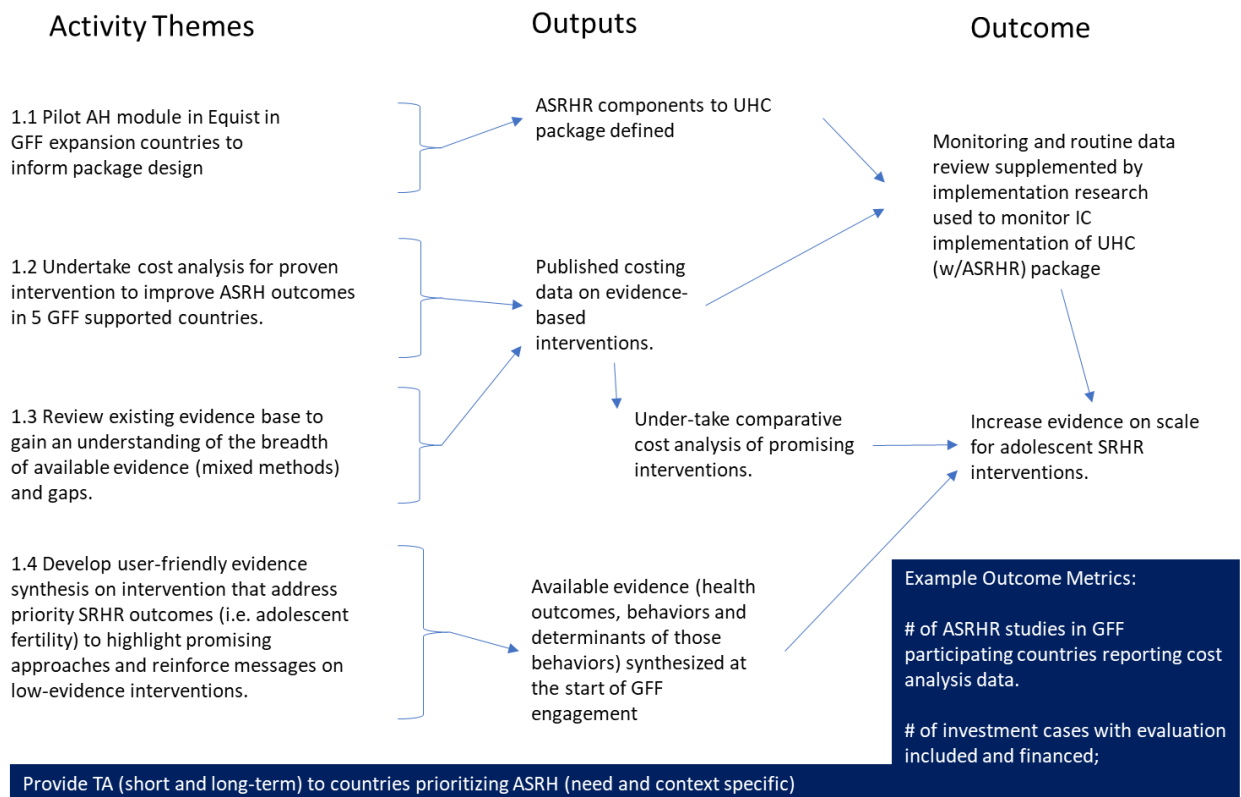
			Sri Lanka, State of Palestine, Sudan, Sweden, Tajikistan, Tanzania, Timor-Leste, Togo, Uganda, United Kingdom, Uzbekistan, Viet Nam, Western Sahara, Yemen, Zambia, and Zimbabwe	
HRP	UNDP, UNFPA, UNICEF, WHO and the World Bank, as well as the International Planned Parenthood Federation (IPPF) and UNAIDS	HRP is the main instrument within the United Nations system for research in human reproduction to identify and address priorities for research to improve sexual and reproductive health. It supports and coordinates research on a global scale, synthesizes research through systematic reviews of literature, builds research capacity in low-income countries and develops dissemination tools to make efficient use of ever-increasing research information.	Global	Ongoing

Note: This table is an illustrative overview of the current initiatives and guidance documents that exist to support countries in advancing adolescent health. This table was compiled by the authors of this report with input from the TAG.

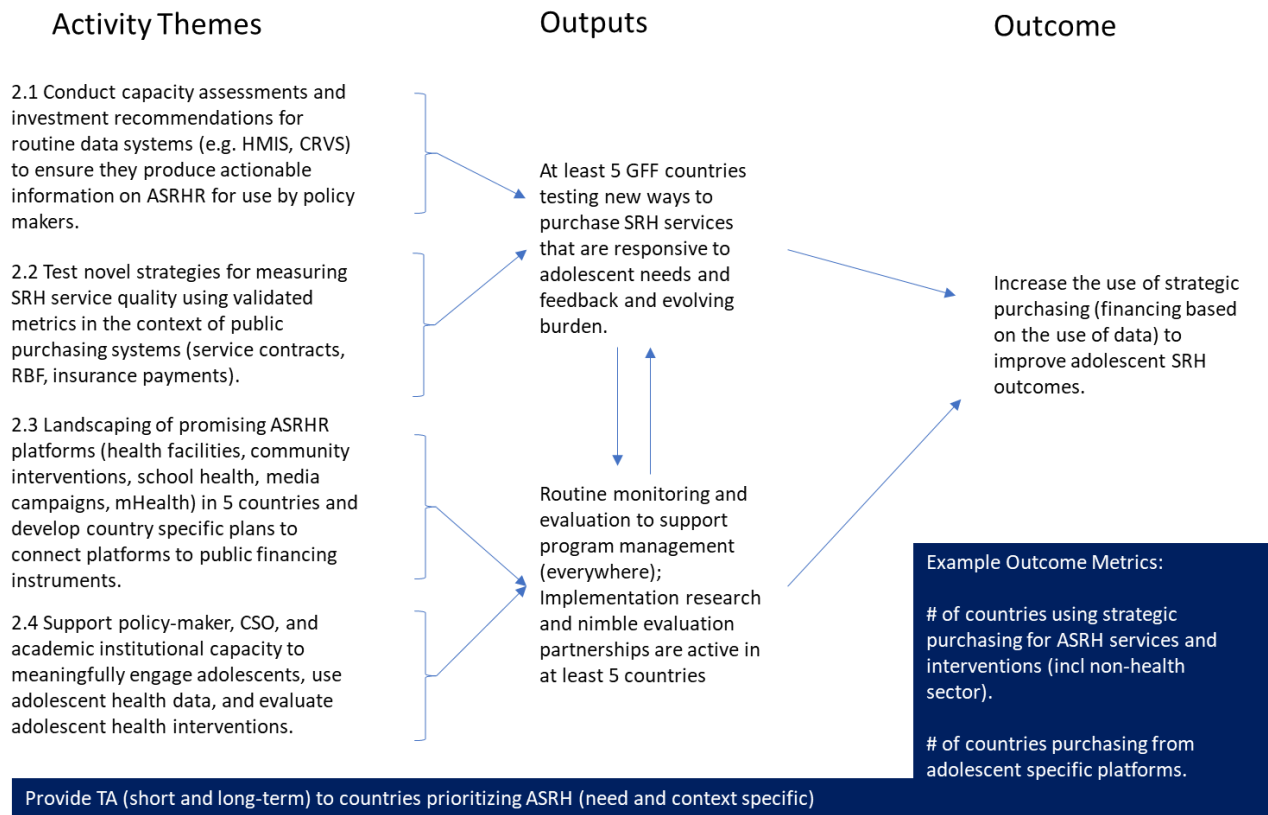
ANNEX 3: Theories of Change That Underpin GFF Support to Countries for Adolescent Sexual and Reproductive Health and Related Health Services

Hypothesis 1

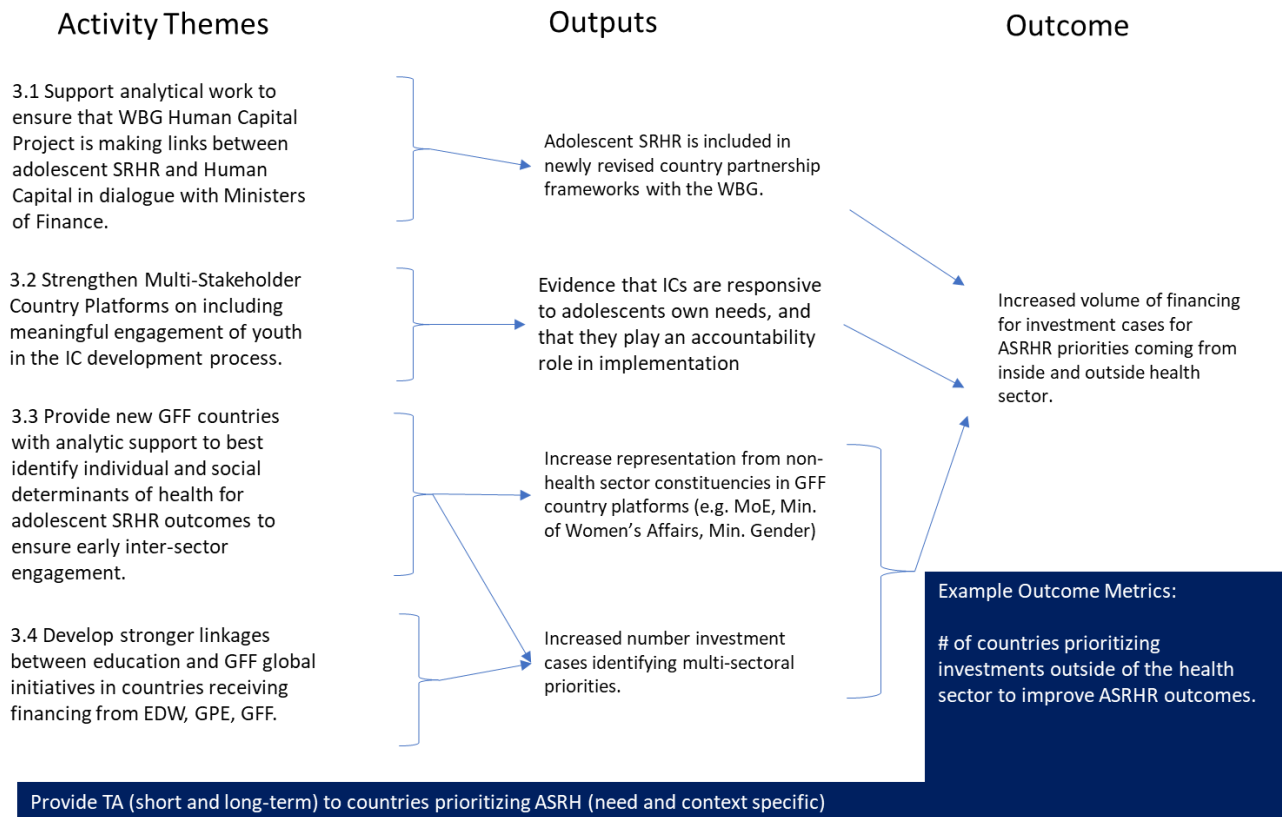
Hypothesis 1: Evidence for ASRHR interventions has improved dramatically in recent years, but key gaps limit choice of intervention, implementations in new contexts, and scale.



Hypothesis 2. Many health and social service systems lack the financing instruments to use resources in ways that respond to adolescent SRHR needs.



Hypothesis 3: There is a need for multi-sectoral responses and accountability to maximize potential financing and impact for ASRHR outcomes.



Overall ToC: Increasing financing for adolescent sexual and reproductive health and rights

1. Increase evidence on scale for adolescent SRHR interventions.

2. Increase the use of strategic purchasing (financing based on the use of data) to improve adolescent SRH outcomes.

3. Increased volume of financing for investment cases for ASRHR priorities coming from inside and outside health sector.

Increasing financing for adolescent SRHR

Example Outcome Metrics:

% increase in on-budget expenditure for adolescent SRH services and/or adolescent SRHR delivery platforms.

Provide TA (short and long-term) to countries prioritizing ASRH (need and context specific)