

# 2017 TRANSFORMATIVE ACCOUNTABILITY FOR ADOLESCENTS

Accountability for the Health and  
Human Rights of Women, Children  
and Adolescents in the 2030 Agenda



INDEPENDENT  
**ACCOUNTABILITY**  
PANEL

EVERY WOMAN, EVERY CHILD, EVERY ADOLESCENT.

In September 2015, the United Nations Secretary-General launched the Global Strategy for Women's, Children's and Adolescents' Health to help further the Sustainable Development Goals (SDGs) and the 2030 Agenda for Sustainable Development. The Strategy builds on 15 years of progress under the Millennium Development Goals and the Every Woman Every Child (EWEC) movement. A key strategic priority for EWEC is to ensure strong implementation of the SDGs.

To this end, the United Nations Secretary-General appointed the Every Woman Every Child's Independent Accountability Panel (IAP). The Panel provides an independent assessment of progress and challenges to help strengthen the response from the international health community and countries.

The IAP is comprised of distinguished panellists from diverse regions and backgrounds that range from human rights experts to humanitarian leaders to statisticians. These panellists are empowered to command attention from the global community across the full range of the updated Global Strategy's accountability framework – to monitor, review, act and remedy – and across the spectrum of issues that comprise the Global Strategy's "Survive, Thrive, and Transform" themes.

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## Foreword

As members of the United Nations Secretary-General's Independent Accountability Panel, we have the great privilege, and important responsibility to help identify ways to accelerate progress towards our shared vision of a prosperous, sustainable and equitable world where the health and human rights of women, children and adolescents to survive, thrive and transform are honoured and given high priority.

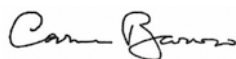
We take this responsibility very seriously, given the urgency and gravity of the situation facing the world's women, children and adolescents. We humbly submit this year's report with our recommendations to transform accountability for adolescents. In the world's efforts to promote the health and well-being of women and children, the adolescent age group has often been neglected. Our accountability for them has been fragile and needs special attention.

As a report on accountability, by its very nature, our emphasis is on gaps and shortcomings that we found are calling out to be addressed. But underlying our call is our excitement about the tremendous prospects for dramatic progress in the health and well-being of adolescents that beckons.

Today's adolescents – the first e-Generation in history – have the unprecedented opportunity to access health services, education and information to empower themselves and to help build a better world. We are entering an unprecedented era of demographic transition in the coming decades, principally in Africa and Asia but with potential impact in the whole world. Investing heavily and wisely in the health and education of women, children and especially adolescents at this time will have a profound positive impact for generations to come.

Independent accountability is a hallmark of democratic systems. It is needed to know what is working well, if we are making progress, and where we are falling short. It helps us to prevent mistakes, avoid overlooking marginalized sectors of our societies, and to enhance optimum use of scarce resources. It is essential to adjust our policies and investments to ensure world leaders' commitment to 'leave nobody behind', a core human rights tenet of the Sustainable Development Goals (SDGs).

We hope that our report and recommendations are helpful to embolden citizen-led voices and movements, from grassroots to global levels, and for leaders to redouble their efforts to achieve the ambitious goals set out by governments in their 2030 Agenda for Sustainable Development.



**Carmen Barroso**



**Kul Chandra Gautam**

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Co-Chairs of the IAP



**WHERE'S THE  
ACCOUNTABILITY TO  
ADOLESCENTS?**

# 1.

Charged by the United Nations Secretary-General with providing an independent snapshot of progress through the lens of accountability at regular intervals, this report explores the actions of all stakeholders as well as the opportunities for fast-tracking implementation of the Global Strategy for Women's, Children's and Adolescents' Health 2016–2030. The huge numbers, vast energy and creativity of adolescents are the focus of this year's report by the IAP, for this cohort of humankind represents the central promise for accelerated, lasting progress towards the SDGs.

With its emphasis on transformation, the report underscores the importance of tackling underlying drivers of ill health and marginalization that are rooted in inequality, poverty, discrimination and denial of human rights. This is especially relevant when it comes to adolescent health. It means moving beyond survival to foster their fuller enjoyment of physical, mental and social well-being. It also means civic engagement, independent review, meaningful oversight mechanisms and participatory accountability that place the voices of boys and girls at the centre of any formula for progress. The IAP calls for holistic, whole-of-government approaches that go well beyond the health sector.

Adolescents – 1 in 6 of the global population in the 10–19 age range – are the generation of the SDGs. By the 2030 deadline, they will be coming into their own and taking centre stage. They will set the stage for decades to come as our policy-makers, peace-builders, community leaders, parents and heads of families, innovators and engines of social, political, cultural, economic and environmental change. Strategic investments in every child, every day and everywhere, constitute the key to building new generations of resilient young people and adults in the future. But today, the health and rights of millions of adolescents are at risk of being eroded.

In the entire 2030 Agenda – the highest-level agreement adopted by 193 world leaders – adolescents are mentioned only once. Neither are they referenced as a distinct group in the New Urban Agenda 2030 adopted in 2016 – even though 60% of all urban dwellers are projected to be below 18 years old by 2030. Concerns with 'youth' are relatively prevalent in policy discourse,

and rightly so, as too many of them and their families face huge unemployment, instability and insecurity. But adolescents, who are the immediate precursors to the next generation of youth, tend to be invisible or overlooked by decision-makers. They remain in limbo between earlier childhood investments, on the one hand, and concerns with young adults, on the other – viewed, all too often, as workforces for economic growth or fuel for sustaining pension funds for ageing populations.

Adolescents face inequalities, and millions of them are constrained from opportunities and better life prospects. Due to their young age, they lack power, voice and vote. Their distinct stage of life, characterized by rapid emotional, physical and cognitive development, requires specific responses in policy and practice, yet this is silently downplayed or poorly understood. They also face the challenges of growing up in a fast-moving world that has given them a unique place in history. They are, after all, the e-generation, the first to have been born and raised in a digital environment, exposed to both the benefits and challenges of Internet and social media.

Adolescents face another disadvantage when it comes to protecting their health. Policies that are narrowly focused on mortality at the expense of other dimensions of health and well-being tend to exclude them. And while it is true that they die less often than younger children or adults, still every year 1.2 million perish at this early stage of life – more than 3,000 every day – often from preventable causes. They face a host of threats, some of which are more common in adolescence than in other stages of life, such as interpersonal violence and self-harm. Also alarming is that AIDS-related mortality is

## United Nations Secretary-General António Guterres said upon taking office:

*“A strong culture of accountability...requires effective and independent evaluation mechanisms”. We agree.*

rising among older adolescents, while dropping among all other age groups.

The potential impact of many policies is undercut when they are “adolescent-blind”, that is, when adolescents are rendered invisible. But it is in adolescence when many health and development issues that afflict adult populations begin or are ingrained, with life-long repercussions. Yet high impact, cost effective solutions to improve adolescent health can yield huge benefits and billions in savings, reaping demographic dividends. This calls for rapid paradigm shifts that can place them on better tracks for life.

In preparing this report,\* the IAP noted promising examples of political leadership and grassroots activism worthy of praise and emulation. We are especially grateful for all the responses and contributions received in response to our Call for Evidence, which have greatly enriched this report. Nonetheless, accountability gaps remain wide. The realities of adolescence stand in stark contrast to the fragility of political will and the absence of investments required to catapult progress forward.

With 1.2 billion adolescents in the world today and an estimated 1.3 billion by 2030, the time is NOW! Every day counts and the stakes are getting higher.

### **Background and context**

In 2015, 193 governments made promises to the world’s population by signing onto the 2030 Agenda as the blueprint for progress for the next 15 years, which was then distilled into the SDGs. These include reductions in poverty; gender equality; equity within and between countries; improving health and providing universal

health coverage; and access to justice. Many of these SDGs were embedded in the Global Strategy for Women’s, Children’s and Adolescent Health 2016–2030.

These promises come at a time when the world is seeing unprecedented suffering of populations affected by war and displacement, massive indifference to human misery on the part of many governments, and widespread loss of faith in representative democracy and liberal institutions. They come at a time of internal review of duplication and redundancy in the United Nations (UN) system. They come at a time of soul-searching about global governance and globalization itself. One thing is clear: without accountability for both processes and outcomes, the “renewed promises” enshrined in the SDGs risk becoming yet another instance of betrayal and fodder for disillusionment.

United Nations Secretary-General António Guterres said upon taking office: “A strong culture of accountability... requires effective and independent evaluation mechanisms”. We agree. The IAP, though small, is the only mechanism in the Every Woman Every Child ecosystem that provides an independent review of how efforts to achieve the Global Strategy are being conducted.

This report applies the accountability framework we set out in our first report, published in 2016: monitor, review, act and remedy, but with a focus on adolescents (Panel 1). Chapter 2 provides a snapshot of how far the international community has come on delivering commitments to women’s, children’s and adolescents’ health since last year’s IAP report, including a closer look at the monitoring of the Global Strategy. Chapter 3 presents recommendations for actors from national to international levels, based on the accountability framework which we have adopted in alignment with international law. The IAP’s recommendations are centred on transforming accountability in order to accelerate the pace of delivery on the promises of the Global Strategy and the SDGs for women, children and, in particular, for adolescents. As always, we welcome feedback and reactions to the report.

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\* In the interest of providing an environmentally-friendly shorter publication and for cost savings, readers will find the endnotes for this report on the web-posted version only, available at: <http://iapreport.org/>



## PANEL 1: UNDERSTANDING ACCOUNTABILITY, OUR FRAMEWORK

In line with the aims of the Global Strategy and international law, the IAP's accountability framework places particular emphasis on human rights and systemic action to enable people to live lives of dignity. Under a human rights-based approach, people are not passive beneficiaries of largesse or charity; they are active agents with entitlements who can make claims upon governments and other entities to fulfil their obligations.

In its 2016 report, the IAP presented an accountability framework – Monitor, Review, Act and Remedy – that built on the previous ones used by the Commission on Information and Accountability and the Independent Expert Review Group. “Monitor” refers to knowing what is happening and whether progress is actually being made based on adequate data, with a focus on revealing inequities through better metrics and disaggregation. The right indicators need to be monitored at the right levels, meaning that, for example, they have policy relevance at national levels while allowing for comparisons at global level.

“Review” refers to the function of independent oversight institutions, such as the courts, parliament and national human rights institutions, system and sector audits, national statistics authorities and information systems, as well as the investigative and watchdog role of the media. Without independent review, there is no way to hold to account executive branches of government or other duty-bearers, or to mobilize civil society in the process of securing action and remedies. Some of these independent oversight institutions, such as parliaments and judiciaries, can themselves provide action and remedy. This circle of accountability goes well beyond the health sector, and is necessary to transform the conditions that systematically deprive women, children and adolescents of their health and human rights.

Accountability requires more than monitoring. While independent review is essential, and sorely lacking at both national and international levels, real accountability also requires remedial action in order to be transformative. All too often, monitoring results receives the bulk of attention, at the expense of accountability to transform the conditions that lead to adolescents and others failing to thrive. Herein lies the greatest innovation of the Global Strategy, which is at the core of this report: to go beyond surviving, to thriving and transformation.

This requires: **(1)** addressing inequities in social determinants of adolescent health through multi-sectoral, national and sub-national action; **(2)** equitable and transparent financing at both national and global levels; **(3)** legitimate and transparent processes to determine priorities regarding health, including adolescent health, in efforts to achieve universal health coverage (UHC); and **(4)** transparent and effective oversight mechanisms that allow for independent review, as well as remedies that enable course corrections and public learning.

We emphasize throughout this report that a human rights-based approach to health requires that the people who are affected by laws, policies and programmes have an active voice in formulating, designing and evaluating them. With respect to adolescents, in particular, the application of a rights-based approach shifts away from stereotypes of youth as either engines of productivity or dangers to society. Rather, adolescents must be understood as rights holders, now and in the future, which in turn brings into focus intergenerational equity and the sustainability of development processes. They should not be burdened by the failings of current generations.



**MONITORING  
THE GLOBAL STRATEGY:  
HITS OR MISSES?**

# 2.

A key pillar of Global Strategy monitoring is the annual report prepared by the Partnership for Maternal, Newborn and Child Health (PMNCH) with Every Woman Every Child global partners. In July 2017, the first such progress report was issued, *Progress in Partnership*, which, among other sources, serves as the basis for the IAP's analysis and commentary on the state of monitoring efforts. It should be noted that our task was challenging since the monitoring report only became available a very short time before this IAP report went to press.

In spite of the many threats in today's fraught environment, the global movement for health, dignity and human rights for all saw various developments this past year that deserve recognition and concerted follow-through. One important example is the rapid rise of the She Decides initiative, a historic mobilization of solidarity with women, adolescents and their communities, fuelled by US\$358 million in donor pledges and crowdfunding. The IAP especially welcomes the recommendations of the High-Level Working Group on the Health and Human Rights of Women, Children and Adolescents, which embody a rights-based approach to public health and urge accountability for human rights, as well as the IAP's designated role in tracking them. Attention to adolescents has also intensified since they were added as a priority group under the new Global Strategy 2016–2030, with several reports taking stock of their health and well-being. Among the leading ones is the Global Accelerated Action for the Health of Adolescents (AA-HA!) report, aimed at country level implementation. Various initiatives are underway at regional levels, such as the campaigns in Africa to end child marriage and to decriminalize abortion, launched in 2016.

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## 2.1 The commitments

Despite threats of rollbacks and cuts to development aid, and beyond broader policy and budgetary supports to the Global Strategy under the SDGs, specific commitments to the Every Woman Every Child initiative have increased by 29% since September 2015, now totalling 215 commitments. They are primarily from low- and middle-

income country governments, the private sector and civil society. Most are focused on supporting the survive and thrive segments of the Global Strategy, with a focus on maternal mortality and under-five mortality. However, few address stillbirths and adolescent mortality. Overall, the attention to transformative interventions is limited.

About 30 new Every Woman Every Child commitments focused on adolescents were announced in 2015 and 2016. To assess how they are rolling out at country levels, the IAP requested a scan of their status. In the eighteen countries for which information was provided, we found their overall status to be encouraging, in contrast to the limited evidence of follow-through on policy pledges to young people in other reports. Findings reveal that in most of the countries surveyed, governments are putting in place large-scale national programmes on adolescent health, with monitoring and evaluation plans, and that young people, civil society and other stakeholders are being involved in the process. However, gaps in putting accountability at the forefront of policy planning and budgets are apparent: independent accountability mechanisms have not been institutionalized or strengthened, with some notable exceptions, and policy ambitions are not being matched with the requisite resources.

### Financial commitments

Resource flows for implementing the Global Strategy have also been rising, including overall spending in health by several developing country governments over the past decade, although they are still far from what is needed. By the end of 2016, specific commitments of financial support to the Every Woman Every Child

initiative amounted to US\$28.4 billion – which, it should be noted, does not reflect broader resource flows to women’s, children’s and adolescent health outside of this global initiative. Donors have sustained official development assistance (ODA), reaching US\$11.3 billion in 2015 – a 6.6% increase over 2014 levels. In contrast, funding for family planning remained flat in 2015, although on a positive note, some US\$2.5 billion was announced by 60 governments and partners during the Family Planning 2020 (FP2020) Summit in July 2017, pledged for hardest-to-reach women and girls, and over 40 commitments were made specifically to adolescents and young people. Another noteworthy initiative is the Pandemic Emergency Financing Facility (PEF), which also has the potential of saving many adolescents’ lives, and expects to provide over US\$500 million to developing countries over the next five years.

For adolescent health specifically, positive signs include the launch of the Joint Global Programme to End Child Marriage in 2016, with almost US\$100 million pledged for the United Nations Population Fund (UNFPA) and the United Nations Children’s Fund (UNICEF) in support of country efforts. Global funds are also investing in adolescents. More than US\$125 million in overall support to the Global Strategy has been disbursed in International Development Association (IDA)/Global Trust Fund financing, expected to rise to over US\$500 million by the end of 2018. Several of the new grants include components on adolescent health, some with a multi-sectoral approach. Within its broader resource envelope, the Global Fund to Fight AIDS, Tuberculosis and Malaria has a new US\$55 million catalytic matching fund, with 13 countries eligible to apply in order to decrease HIV incidence among adolescent girls and young women. As of mid-2017, more than US\$100 million of investments has been approved for programmes in these countries, some with multi-sectoral approaches. The IAP encourages the continuation and evaluation of this strategy, which other funders may look to emulate for scaling up responses, and we appreciate the Fund’s overall attention to human rights, gender equality and integrated service delivery, as well as its support to countries in disaggregating data by age and sex.

On other fronts, GAVI (the Global Alliance for Vaccines and Immunization) has committed US\$473 million

to immunize over 40 million girls with the human papillomavirus (HPV) vaccine by 2020, with over US\$38 million disbursed to date. The Bill & Melinda Gates Foundation estimates it has committed US\$79 million to its work for 10–24 year olds, primarily in the areas of family planning, HIV, nutrition and in cross-cutting components (e.g., gender equality; maternal, newborn and child health). The Children’s Investment Foundation Fund has various evaluations underway of the adolescent health programmes it has been supporting.

While prioritizing support for least developed and low-income countries is essential, the IAP reiterates the concern we voiced in 2016: With two-thirds of the world’s poor living in middle-income countries excluded from donor aid eligibility, there are serious risks of retrogression or stagnation in those countries without strategic support from donors.

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## 2.2 Broadening the scope

Accountability requires availability and disaggregation of data, and a focus on monitoring inequities. It also requires measuring what really matters to effectively monitor Global Strategy implementation and to know what needs to be improved, and for whom. The IAP believes that there are measures of success for monitoring the Global Strategy that could enable a more unified and comprehensive picture of women’s, children’s and adolescents’ health to guide decision-making and action.

The major gap in monitoring the Global Strategy is in the area of rights, as pointed out in the progress report. Human rights dimensions should be integrated throughout Global Strategy monitoring, in line with the recommendations of the High-Level Working Group on Health and Human Rights. This requires qualitative information on institutional reforms and practices, and legal and other protections of human rights, such as by integrating findings of national organizations, the international human rights system, the Office of the United Nations High Commissioner for Human Rights (OHCHR) and other specialized institutions, as well as citizen-generated data. External evaluations should also inform

future monitoring. Of particular relevance is assessing the effectiveness of the information index introduced by FP2020 to safeguard women’s and adolescents’ rights to informed choice and consent regarding various contraceptive methods. This has become all the more important as efforts to expand the availability of long-acting reversible contraceptives intensify.

The IAP welcomes the efforts in this year’s Global Strategy monitoring report to bring attention to the transform pillar, the dimension of the strategy receiving the least attention. The IAP appreciates the report’s call for countries to reassess their policy priorities on adolescents every five years. We underscore the importance of reassessing them now for alignment with strategic directions to accelerate progress, particularly on prevention.

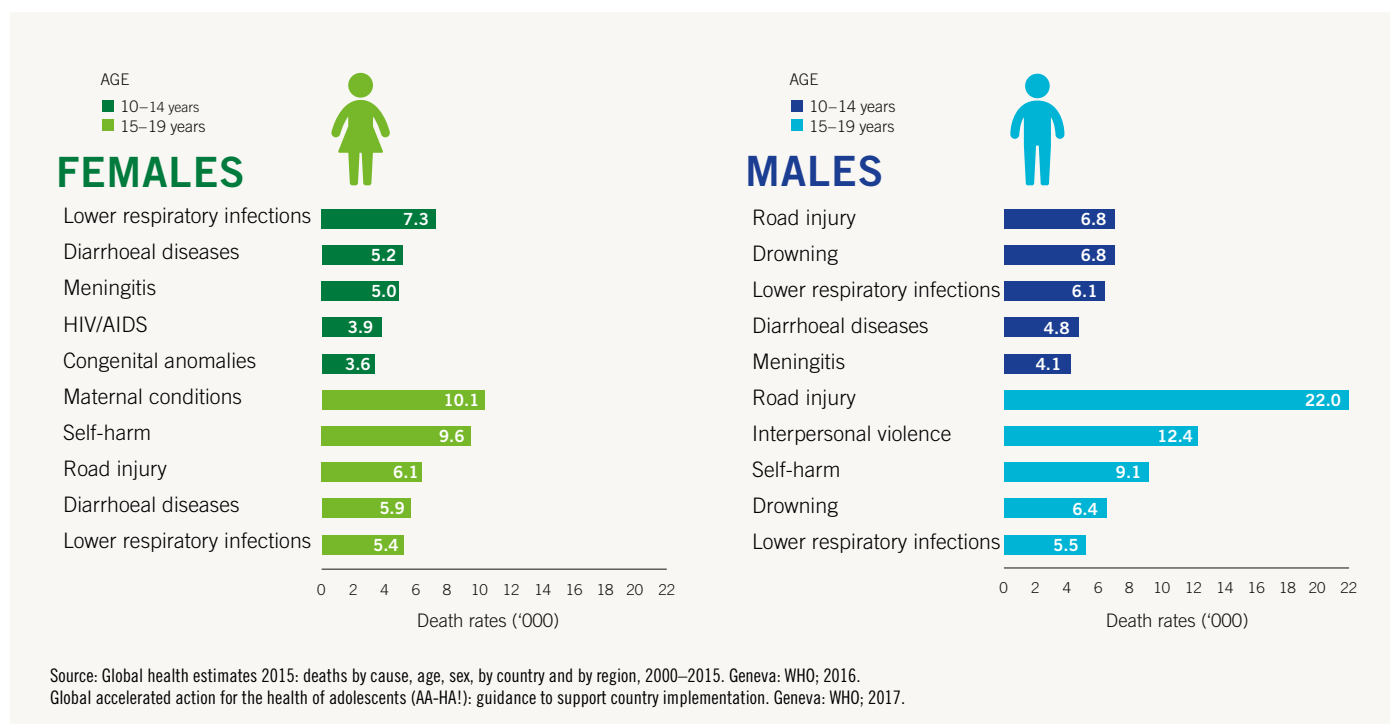
### Monitoring adolescent health

Monitoring adolescent health reveals starkly that health is not just a matter of biological processes, but also of stark differentials in power and agency. The health of adolescents is profoundly affected by the social, economic, cultural, political and legal context in which they live, and by the intersecting forms of discrimination faced by the

wide diversity of groups among them. This includes exclusion because they belong to poor, racial, ethnic, exploited or lesbian, gay, bisexual, transgender or intersex (LGBTI) communities, among other groups. But monitoring efforts tend to remain narrowly focused, rather than paying due attention to underlying social determinants of their health, unmasking inequities, forms of exclusion and gender norms that influence their well-being. Greater focus is also needed on using information about adolescents’ levels of knowledge, attitudes and skills for prevention of risks, such as gender-based violence, smoking, and unhealthy diets, which are among the key issues that are not going to be resolved by the health sector alone. While such data may not be available for all countries or always enable cross-country comparisons, it is invaluable for providing policy orientation and coherence, as well as accountability, at country level.

Monitoring must capture gender inequalities (acknowledged as essential in SDG 5), which begin early in life and become more pronounced as children enter adolescence. Every year, 1.2 million adolescents die from often preventable causes. Figure 1 shows the estimated top five causes of death by sex and age. In

**Figure 1: Top killers of today’s adolescents**  
Estimated top five causes of adolescent death by sex and age



general, adolescent boys have higher death rates than adolescent girls and the causes differ as well. For girls 15–19 years old, maternal conditions are estimated to be the leading cause of death. For boys 15–19 years old, road injuries and drowning pose higher risks, reflecting their fewer restrictions to mobility. Alarming, too, is the huge toll of violence and self-harm among both boys and girls and interpersonal violence among boys.

Beyond survival, gender and other intersecting forms of discrimination pose many other health risks for adolescent girls, especially if they live in poverty. While adolescent birth rates have declined since the turn of the millennium, they remain high in most of the developing world, especially among the poorest communities and countries. In developing regions, 60% of adolescent girls 15–19 years old, who are married or unmarried and sexually active but want to avoid having a child, have an unmet need for modern contraception. In some countries with restrictive legislation, unsafe abortion is a leading contributor to maternal mortality among girls with unwanted pregnancies. Intimate partner violence afflicts 30% of girls 15–19 years old. Child marriage is declining, but slowly, with 1 in 4 young women married by their 18th birthday. Female genital mutilation (FGM) prevalence remains high: in 30 countries, it is estimated that 1 in 3 girls (15–19) have undergone this harmful practice.

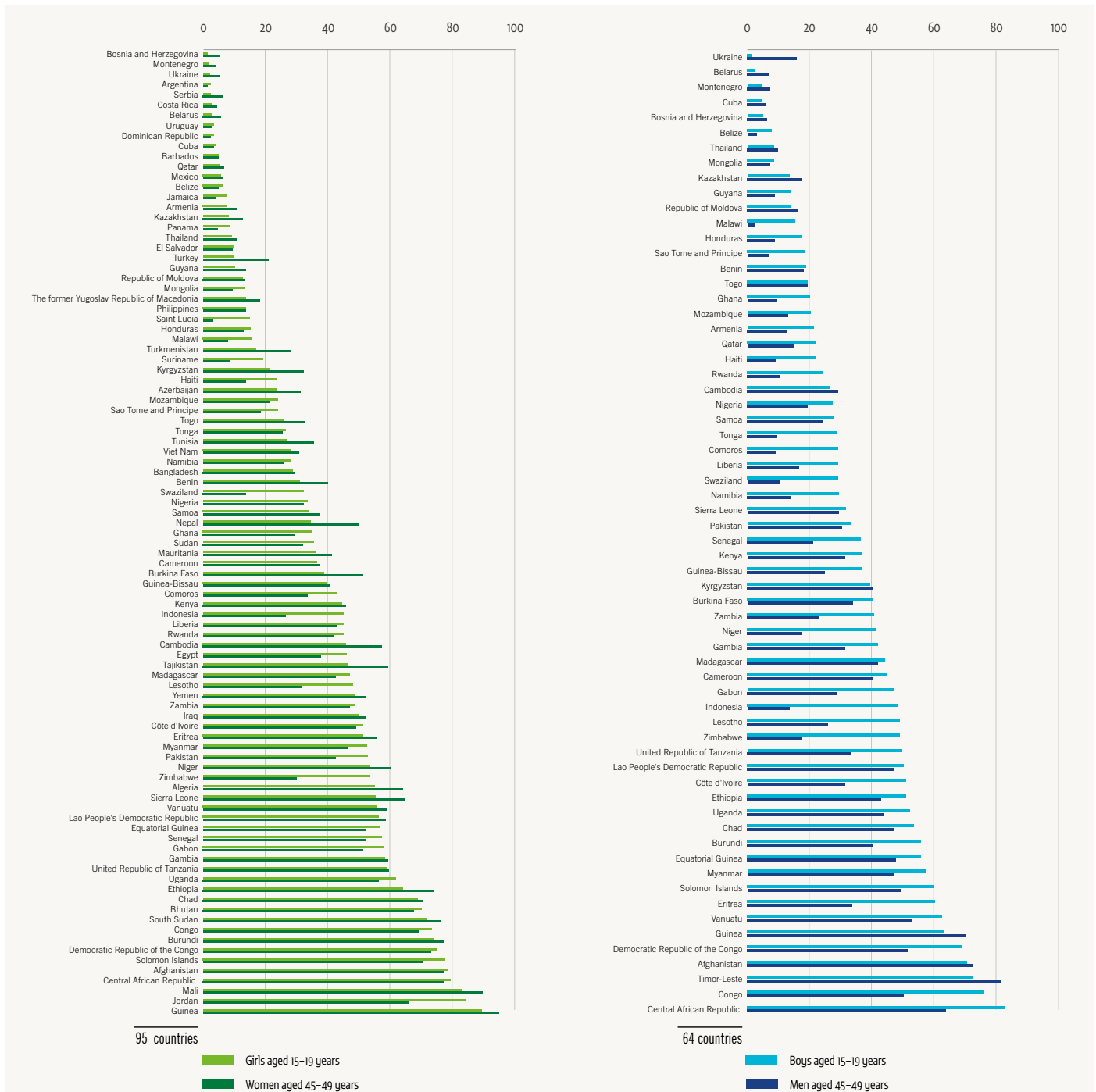
Despite gains, monitoring inequities in the area of education also shows especially worrying prospects for millions of adolescents. The poorest children are eight times more likely to be out of school than the richest in lower- and middle-income countries. In sub-Saharan Africa, more than half of all adolescents 15–17 years old and over one third of 12–14-year-olds are not in school. Only 1% of the poorest girls in low-income countries complete upper secondary school. It is estimated that global poverty could be cut by more than half if everyone completed secondary school, but 263 million children are out-of-school, a figure that has seen virtually no progress since 2012. Quality of education is also a major worldwide concern: even in high-income countries, 20% of 15-year-olds do not reach minimum proficiency levels in reading, mathematics and science. And globally, more than 1 in 10 adolescents and youth (aged 15–24) are

neither in the educational system nor employed in over three-quarters of countries with data, with young women disproportionately represented among the unemployed. This grim scenario points to the urgent need of investing early in quality education, relevant skills and school-to-work transitions for adolescents.

Violence afflicting girls and boys across stable and conflict-affected settings – a major underlying determinant of their health – provides another example of how Global Strategy progress can be more meaningfully monitored. One way is by tracking whether urgently needed multi-sectoral responses, budgets and evaluations are being effectively put in place. While more governments are adopting national plans and the international community is mobilizing to end violence, vast unmet needs and impunity prevail. Another under-utilized option is monitoring attitudes: While young people hold the greatest promise for rejecting harmful social norms, in an alarming number of countries, adolescent girls and boys justify violence against women more than their mothers and fathers. As Figure 2 reveals, in the majority of countries represented (50 out of 64), boys justify violence more than adult men – and in more than a fifth of the countries, over half of all boys do. Girls justify it more than older women in almost half the countries – and in a third of them, over half of girls do. By using these types of combined measurements, decision-makers could be better informed that current investments in prevention and transforming social norms are far from adequate.

Broadening the scope of the information used is also key to improving Global Strategy monitoring of other areas calling out for greater attention. These include: tracking improvements in data disaggregation across all 60 indicators; the number of countries with multi-sectoral strategies and joint monitoring processes for adolescent health; dedicated plans and budgets for adolescents' access to health care under universal health coverage schemes, including monitoring of out-of-pocket expenditures; lifting of specific legal barriers to health care, supplemented by qualitative information (e.g. on oversight and enforcement); and progress in the adoption of national strategies and budgets to tackle gender-based and sexual violence in adolescents' lives.

Figure 2: Adolescents' attitudes, justifying violence against women



Percentage of girls aged 15–19 years and women aged 45–49 years who think that a husband/partner is justified in hitting or beating his wife or partner for at least one of the following reasons: if she burns the food, if she argues with him, if she goes out without telling him, if she neglects the children or if she refuses sexual relations with him.

Percentage of boys aged 15–19 years and men aged 45–49 years who think that a husband/partner is justified in hitting or beating his wife or partner for at least one of the following reasons: if she burns the food, if she argues with him, if she goes out without telling him, if she neglects the children or if she refuses sexual relations with him.

Source: UNICEF global databases, 2017, based on DHS, MICS and other national surveys, 2010–2016. Prepared for the IAP by Nicole Petrowski and Claudia Cappa, Data Analytic Section, Division of Data, Research and Policy, UNICEF. See endnote for technical information on the country data.

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## 2.3 Slow progress on data gaps

Widening the array of measurements for Global Strategy monitoring is all the more necessary given major gaps in data availability across its 60 indicators and the absence of trends data year-to-year for more real-time tracking of progress. Relevant data for humanitarian settings is especially scarce and poor. The lack of disaggregated data by sex, age, disability, income and other variables keeps excluded groups and inequities hidden from policy radars. While efforts are underway to improve data disaggregation in line with SDG commitments, the process is slow, as shown by our analysis of the IAP's 16 core indicators of focus (Appendix). The availability of data for more than 75% of countries moved from 11 indicators to 15, still leaving a great deal to be accomplished. Disaggregation by age has now been included by the Institute for Health Metrics and Evaluation (IHME) on stunting among children under five and sexual violence, by UNFPA in data on adolescent birth rates, and by UNICEF, on sexual violence and birth registration. Also, Countdown now has disaggregation of under-five mortality by location.

Meaningful monitoring and genuine accountability suffer where such data limitations exist. They make informed policy and investment choices, as well as course correction to stay on track, all the more difficult. More investments are needed to harmonize and build up data and information systems. Initiatives that are worthy of note include the World Health Organization (WHO) Global Health Observatory, launched in 2017, which provides access to the latest available country data to monitor the Global Strategy, and the Health Data Collaborative and Global Financing Facility (GFF) investments in support of countries working to scale up civil registration and vital statistics.

The same is true for data on adolescents. There are many gaps and limited disaggregation by sex, age and disability overall, including on unmarried adolescents, as well as on 10–14-year-olds – in part because younger groups are excluded when indicators are defined. For monitoring the SDGs, which include several Global Strategy indicators, more than half the data related to children under 18 is unavailable, poor or limited. In this

year's SDGs monitoring report, due to data limitations, adolescent birth rates are not disaggregated for younger adolescents and the family planning target only measures women who are married or in union. Efforts are underway, such as to better disaggregate, by age and sex, adolescent and youth populations among refugee and asylum seekers registered with the United Nations High Commissioner for Refugees (UNHCR) globally. Significantly, at the FP2020 Summit of 2017, stakeholders and donors committed in the Global Adolescent Data Statement to improve collection and reporting of age and sex-disaggregated data.

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## 2.4 Revealing inequities

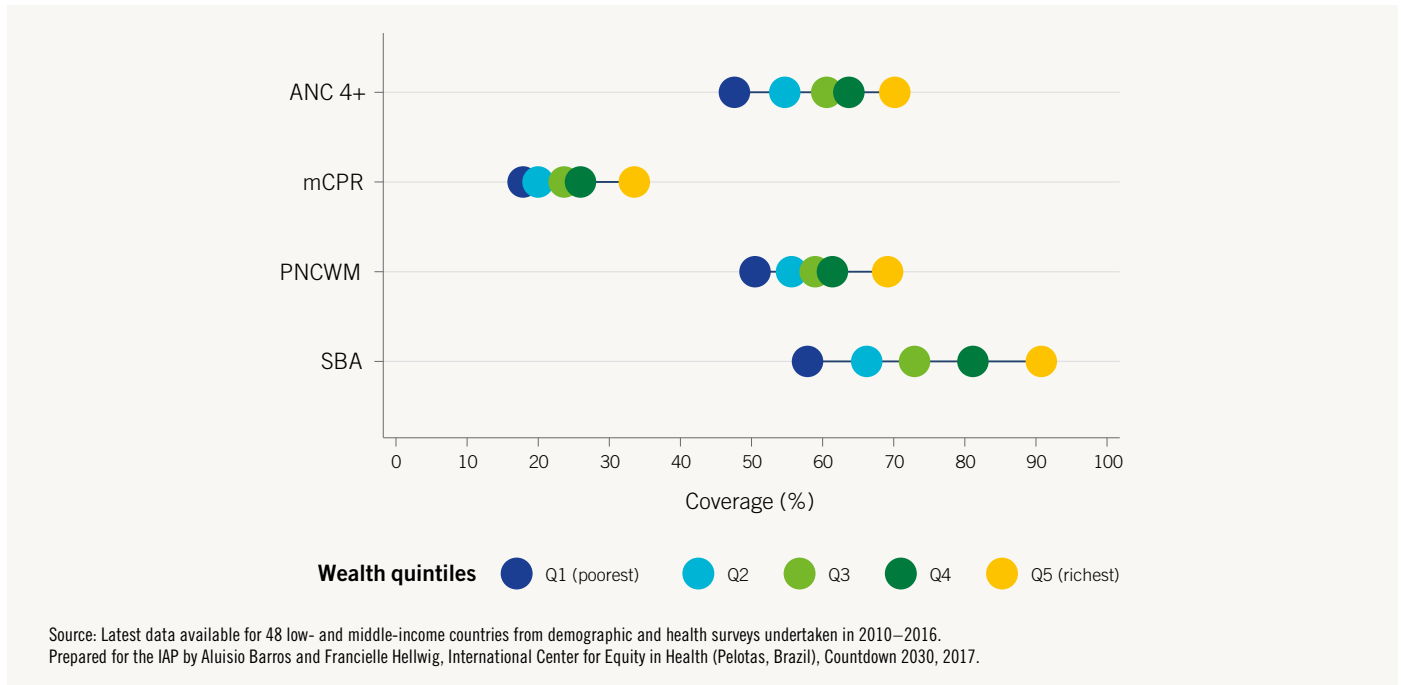
Despite the data gaps, opportunities exist to better leverage the data that is available for tracking what really matters under the Global Strategy. To zero in on the inequities that persist across women's, children's and adolescents' health, the IAP requested additional data analyses. For example, on maternal health in low and middle-income countries, we found that 80% of wealthier women have four prenatal visits compared to only 50% of the poorest. Similarly, while 90% of women in the wealthiest quintiles deliver their babies with skilled birth attendants, only half of those from the lowest income groups receive such support. We also used recent reports monitoring other health basics, such as immunization coverage and reduction of anaemia, and found that both have barely seen progress for several years, pointing to major equity gaps among and within countries.

Inequities in health care access among adolescents are also evident from analysis of disaggregated data. As Figure 3 shows, the poorest adolescent mothers consistently have less service coverage than the wealthiest adolescents – with gaps between the two groups of more than 20% for antenatal and postnatal care, more than 30% for skilled birth attendance during childbirth, and 17% for contraceptive access.



### Figure 3: Early pregnancy and the roulette of poverty

Adolescent girls (15–19), disaggregated by wealth quintiles, who access four health interventions: antenatal care (four or more visits), postnatal care for the mother, skilled birth attendance and contraceptive prevalence rate (modern methods)



### Capturing diversity and left behind adolescents

The lack of data availability and disaggregation is especially acute for marginalized groups of adolescents and neglected aspects of their health. They remain largely overlooked in current Global Strategy monitoring efforts. These data gaps represent a major challenge for improving accountability to close equity gaps. To further illustrate how using a wider scope of sources could help improve monitoring, the IAP takes a closer look below at select issues, drawing on a range of reports such as from special rapporteurs on human rights and treaty bodies.

For example, monitoring efforts need to address the discrimination and neglect faced by adolescents with disabilities across institutions and sectors, as they are prone to exclusion from education systems, subjected to violence and forced marriage, and denied access to justice. Since children with disabilities are less likely to be registered at birth, adolescents with disabilities face higher risks of exploitation. The situation of those with mental health conditions is especially disturbing,

including abuses and medical interventions without their consent, such as forced sterilization. The stigma that has historically fuelled disregard for these groups, as well as the chronic underfunding of programmes to support them, must be addressed and remedied.

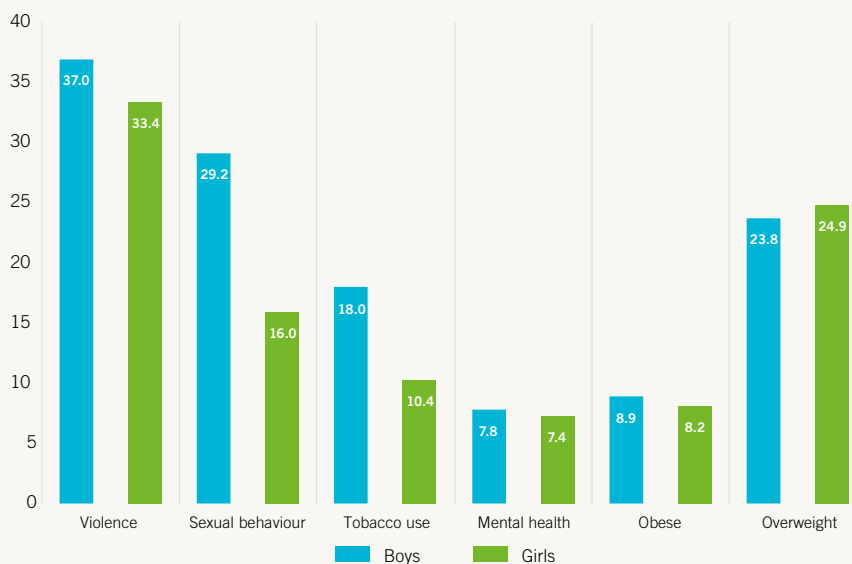
Monitoring efforts also frequently fail to adequately attend to the dire situation of adolescents in conflict-affected and other humanitarian settings. The Committee on the Rights of the Child has raised the alert on “the failure of humanitarian programmes to address the specific needs and rights of adolescents”. The specific requirements of children with disabilities in humanitarian situations are also not systematically addressed; and girls, in particular, are placed at increased risk of violence when safe sanitation facilities are not available. This bleak panorama may be changing, as evidenced, for example, by the launch of the Young People in Humanitarian Settings Compact, and the announcement of six new Every Woman Every Child commitments to end the deaths of women and adolescent girls in crisis settings in 2016.

The youngest adolescents aged 10–14 years, particularly girls, are another especially vulnerable group. Since data is limited for this cohort, the IAP sought out analysis to paint a better picture of their health and well-being – again, using available sources of information. We looked at what younger adolescents (aged 13–15) themselves say about their health status (Figure 4). More than 1 in 3 reported they had been affected by bullying; more than 1 in 5 had sexual intercourse (mostly boys); and more than 1 in 10 (13%) reported smoking cigarettes

(also predominantly boys). A high proportion are also overweight, mirroring the increasing global trend. Boys and girls also reported similar rates of mental health issues, measured as having no close friends (8%) – a serious signal of their sense of isolation. These findings reinforce the importance of multi-sectoral responses and using supplementary sources of information to improve Global Strategy monitoring of the health status and well-being of this younger age group.

**Figure 4: Thumbs up, or down? What adolescents say about their health, safety & well-being**

Self-reporting by students 13–15 years of age who experienced bullying one or more days in the past 30 days (violence), ever had sexual intercourse, smoked cigarettes in the past 30 days, have no close friends (mental health), and are overweight, by sex



Source: Global School Health Survey conducted among students aged 13–17 years compiled from 70 countries, based on surveys undertaken in 2010–2016. Prepared for the IAP by Edilberto Loaiza.



## RECOMMENDATIONS TO TRANSFORM ACCOUNTABILITY

## Recommendations to Transform Accountability

In our role as reviewer of how accountability is unfolding, the IAP presents six recommendations for consideration by stakeholders at all levels – governments, development co-operation partners, UN agencies (in particular the H6 Partnership), global funds, donors and civil society supporting the Global Strategy on Women's, Children's and Adolescents' Health 2016–2030. They are guided by human rights, equity and ethical principles to strengthen delivery and accountability of the promises made by the Every Woman Every Child community – with a focus on adolescents, as this year's report theme.

### **1: Leverage accountability to achieve the SDGs**

- 1.1 Lock in accountability for Every Woman Every Child commitments
- 1.2 Reduce overlaps and duplication among global partners

### **2: Make adolescents visible and measure what matters**

### **3: Foster whole-of-government accountability to adolescents**

- 3.1 Harness demographic dividends by focusing on adolescents and gender equality
- 3.2 Make schools work for adolescents' well-being
- 3.3 Ensure effective oversight institutions

### **4: Make universal health coverage work for adolescents**

- 4.1 Provide a package of essential goods and services for adolescents, including mental health and prevention of non-communicable diseases
- 4.2 Ensure that all adolescents have free access to essential goods and services

### **5: Boost accountability for investments, including for adolescents' health and well-being**

- 5.1 Increase resources and adopt adolescent-responsive budgeting
- 5.2 Strengthen accountability of development cooperation partners, including of members of the Organisation for Economic Co-operation and Development (OECD) Development Assistance Committee (DAC)

### **6: Unleash the power of young people**

- 6.1 Ensure young people's meaningful participation, move away from tokenism
- 6.2 Empower the e-Generation to seize the full potential of the digital age

# 3.

## Recommendation 1: Leverage accountability to achieve the SDGs

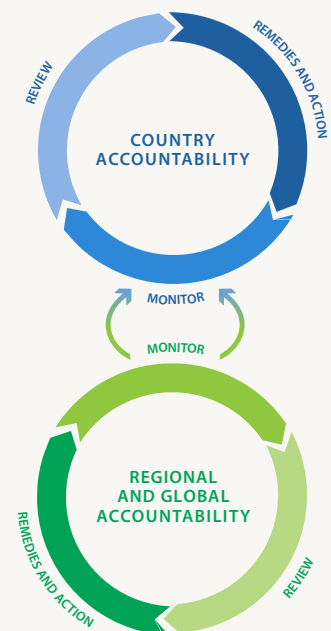
The Global Strategy’s Unified Accountability Framework – as adapted by the IAP in 2016 in line with international law – relies heavily on its review, remedy and act elements (Panel 2). Accountability cannot be achieved through one single “magic bullet”. It is complex, as multi-layered mechanisms for monitoring and accountability operate in parallel streams because different national and global actors have different obligations and they are evaluated according to different processes.

The Every Woman Every Child community must push forward swiftly on accountability, to better balance data collection and monitoring efforts with strengthening its review, remedy and act functions – especially at national and local levels, for the poorest and most marginalized members of society. The accountability of governments, donors and other partners, and remedies for timely re-direction of interventions and investments, require significant reinforcement to accelerate progress. Although in

### PANEL 2: UNDERSTANDING THE IAP’S UNIFIED ACCOUNTABILITY FRAMEWORK FOR THE GLOBAL STRATEGY

Ultimately, national governments are accountable for the Global Strategy and the SDGs, operating within a global legal and economic order. Global partners and donors are answerable to supporting national and sub-national implementation and alignment with this universal agenda.

At national level, the Global Strategy is often embedded in broader national health sector reviews, and also falls under multi-sectoral follow-up plans for achieving the SDGs. The IAP’s framework calls for oversight institutions at national level to evaluate and ensure progress, in keeping with human rights. At inter-governmental global and regional levels, review of countries’ progress primarily falls under the High-level Political Forum for Sustainable Development (HLPF) and regional sustainable development fora, the World Health Assembly (WHA), in government reporting to international human rights treaty bodies, and the Universal Periodic Review (UPR) of the UN Human Rights Council. An important layer for constructive accountability is provided through regional mechanisms, such as peer reviews among governments of the African Union and the Pacific Islands Forum, and reporting at the Inter-American System of Human Rights and the Organization of American States. UN General Assembly bodies dealing with social, economic, gender equality, health, population and development, and humanitarian affairs under the Economic and Social Council, as well as the Security Council, should also be understood to form part of this unified framework.



many cases parameters for efforts to achieve the Global Strategy are established at the global level, it is at country level where the focus on accountability can reap the greatest benefits for efforts to achieve the Global Strategy and the SDGs. This requires deliberate responsiveness not just to recommendations and agreements from global and regional processes, but first and foremost to a country's population, including the adolescents.

The political and institutional context in which accountability plays out is key. Accountability mechanisms often lack 'teeth', from national to global levels. While 115 countries enshrine the fundamental right to health in their constitutions, for example, many others do not and resistance remains to doing so. Recognizing the right to health in a constitution is not a prerequisite to protecting health-related rights (some countries do so through interpretations of the right to life, for example). However, it is critically important to establish and implement enabling legal frameworks in order to achieve the goals of the Global Strategy and transform the conditions that systematically disadvantage certain adolescents and other people. Having appropriate governance structures and functioning institutions is essential to deliver on both laws and the commitments made under the Global Strategy, as well as to effectively regulate actors and address inequities.

Because the Global Strategy relies on commitments from many stakeholders and a complex web of interactions among governments, funders, public-private sector partnerships, UN agencies, civil society, and various governance boards, accountability can be diffuse. Development cooperation for the Global Strategy and the SDGs is increasingly channelled through such multi-stakeholder partnerships. But specific roles and responsibilities by each of the partners around the table, and as a collective, can and must be better-defined in order to strengthen accountability.

At inter-governmental levels, global and regional mechanisms are not immune to deficits. Human rights can lose out to sovereignty, as the United Nations Secretary-General has pointed out. The functions of independent review are not systematically institutionalized in UN processes, nor necessarily welcome by Member States, as what should be the "new normal" of a UN culture of

accountability. Instead, from national to global levels, restrictions on rights to information and freedom of expression, and underfunding, are shrinking civil society space. In the first analysis of all UN Member States, civic space was found to be under serious threats in 106 countries, including from attacks on journalists, killings of peaceful protesters and LGBTI people, and legislation targeting civil society.

In line with the Global Strategy and given the accountability gaps and challenges discussed above, the IAP considers that Every Woman Every Child global partners and funders should move to a deliberate focus on supporting accountability for results, resources and rights at national levels, while continuing to strengthen global monitoring. The IAP presents its proposals for consideration by the Global Strategy's High-Level Steering Group and the Partnership for Maternal, Newborn and Child Health (PMNCH); and specifically expands on development cooperation partners and the global funds under Recommendation 5.

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## **1.1 Lock in accountability for Every Woman Every Child commitments**

The Every Woman Every Child movement has been a game-changer for women's, children's and adolescents' health in global health discussions. But there is broad recognition that a number of aspects are no longer "fit for purpose" and require updating, especially in the context of ongoing UN reform.

The IAP undertook inquiries with a number of the Every Woman Every Child global architects that were met with openness and responsiveness, a reflection of their keen interest and commitment to accountability, which bodes well for the way forward. Several of them reference accountability in their strategies and plans. Nonetheless, we found it difficult to pin down precisely how partners are translating into practice their stated commitments to accountability. Overall, we detected a limited vision of what accountability means, beyond data and monitoring. While these are clearly key to providing oversight as to how resources are being utilized and for whom, the review, remedy and act components of accountability are

of utmost importance but are not being systematically addressed. As such, the IAP provides proposals on areas for improvement below.

As an overarching proposal to encapsulate all our suggestions, the IAP encourages **the global architects to make sure that the new Every Woman Every Child 2018–2020 Partners Framework specifies explicit roles and plans for strengthening the review, remedy and act functions** within their purview. This Framework, endorsed by the High-Level Steering Group in 2017 with the aim of improving alignment and action among the partners, is an important step in this direction and offers a critical opportunity to enhance performance on accountability.

The global partners should seize opportunities for leveraging their existing assets, capacities and commitments to this end, wherever possible. For example, PMNCH is developing a matrix to unpack its role in accountability across performance, financial, political and democratic dimensions. The partners should develop robust monitoring as part of the new Framework, with concrete responsibilities and plans for strengthening accountability functions, both for each partner and for joint progress review exercises, building on their work underway. PMNCH should facilitate the process for partners' mutual accountability, including through joint annual progress reviews (taking advantage of already planned meetings where global partners are present).

'Mutual accountability' should be understood as a process whereby each partner can appraise others' progress on their commitments; jointly identify good practices (including of accountability processes); share learnings and challenges transparently in order to find solutions together; constructively scrutinize key gaps in action; and, together, help identify remedies, redirect strategies and investments whenever needed. To the extent that partners are empowered to interact on an equal footing, this approach may be very well-suited for the new Partners' Framework, as it reflects and builds on their existing aspirations and plans.

**The Executive Office of the Secretary-General, in collaboration with the other partners, should revisit the procedures and current practices so that all**

**Every Woman Every Child commitment-makers undergo and satisfy the same screening, approval and reporting requirements.** New guidelines issued in 2016 introduced enhanced standards for the Every Woman Every Child application process. But these only apply to the non-government category, which includes civil society, the private sector, global partnerships and UN multi-lateral agencies, among others. There is no application requirement per se for Member States; they provide an official letter confirming their commitment to the Secretary-General. There is a widely perceived lack of clarity, rigour and consistency in applying standards, with submissions that may vary from the official announcements in the form of letters, to detailed plans. The IAP urges the adoption of a standardized and transparent system for the Every Woman Every Child initiative to measure and follow-up on government commitments as central to any meaningful accountability architecture for the Global Strategy.

**Reporting requirements should be complied with and apply to all stakeholder commitments, including those of governments with the support of United Nations H6 Partnership agencies.** Governments have been excluded from this reporting requirement to avoid additional reporting burdens, with the assumption that intergovernmental reporting, such as at the World Health Assembly (WHA) and the High-level Political Forum for Sustainable Development (HLPF), would serve this purpose. But as the first WHA session for reporting on the Global Strategy held in 2017 showed, the system currently in place is not necessarily conducive to meaningful reporting by governments. Nor does reporting under the SDGs and other agenda items fully satisfy unified, focused or comprehensive monitoring of women's, children's and adolescents' health – including on budgets and rights. Non-compliance with annual reporting by stakeholders was also found to be problematic in the past, as is the lack of mechanisms or capacities for validating self-reported information. Currently, 72% of non-government actors that made commitments are providing annual progress reports, which while a relatively positive response rate, is a figure that should be increased in future years.

**All Every Woman Every Child commitments, partnerships and programmes from global to**

**national levels should have explicit monitoring and accountability mechanisms built-in from start to finish.**

These frameworks should be finalized and made publicly accessible for transparency by 2019, when the HLPF will be held at heads of state and government level. While in formal terms lead responsibility lies with the Executive Office of the United Nations Secretary-General, which undertakes the screening of new commitments, other global partners with institutional capacity should be tasked with helping to carry out this recommendation, including retrofitting existing commitments with improved accountability frameworks, as needed. In particular, UN agencies in the H6 Partnership with health expertise and, which have country presence, should play the lead role in providing technical assistance to governments.

In the absence of a comprehensive external assessment across the over 200 commitments, it was not possible for the IAP to gauge to what degree monitoring or accountability plans are systematically built-in from the start. External assessments of results, rights and resources are not systematically undertaken, and if they are, governments are not included and their budgetary commitments are not tracked. Assessments should be undertaken periodically for strategically informing decision-making and action, with a clear focus on ensuring that investments pay off in value.

**All commitments and reports available should be posted in full on the public website of the Executive Office of the Secretary-General** for increased transparency. Currently, only brief highlights of these main accountability tools are accessible on the website where commitments to the Global Strategy are posted. The site was updated in 2017 as a platform for enhancing transparency, though its user-friendliness and contents could be improved. The reporting process and its timeline were found to be in need of improvement, better streamlining and greater clarity for stakeholders making commitments, as part of the effort to facilitate compliance.

**Countries should be supported to strengthen their government-led and social accountability processes with civil society and young people** through capacity development investments of the global partners, namely the UN agencies, the global funds, donors and PMNCH.

Various global partners have presence at country levels, capacity to broker and support government-civil society and multi-stakeholder processes. The H6 and other United Nations agencies have a key role in providing technical support to interested governments from central to local levels of administration; and along with civil society, facilitate citizens' hearings and integration of other social accountability processes. The Global Fund to Fight AIDS, Tuberculosis and Malaria will support investments for inter-ministerial processes to address the comprehensive needs of adolescent girls and young women, and joint platforms that help strengthen review and remedy functions. Based on its positive findings, the evaluation of the UN H6 Partnership also recommends dedicated support for participatory country planning and reviews. The global partners' plans under the new Framework to support work in a number of countries – including by the Global Financing Facility (GFF), FP2020, the UN H6 Partnership and PMNCH – offer ready opportunities to carry forward this recommendation.

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## 1.2 Reduce overlaps and duplication among global partners

The IAP proposes **resolving overlaps in mandates and functions among global partners by considering a merger across global partner secretariats.** Such a structural move – bringing together the Executive Office of the Secretary-General, PMNCH, the UN H6 Partnership (and possibly IAP) secretariats under one roof could significantly streamline and strengthen the current architecture for the Global Strategy. It could enhance efficiencies and coordination across operations, and improve delivery to country levels and strengthen accountability, as discussed above. The new "household" for helping to drive the Global Strategy at international level would need to operate in tandem with the GFF Secretariat based in the World Bank and maintain very close collaboration across the global funds. It should also consider incorporating the secretariats or focal points of the Every Newborn Action Plan, the Ending Preventable Maternal Mortality plan and FP2020, as well as any new such initiatives arising in the future, in order to promote integration as well as avoid fragmentation of the Global Strategy agenda.



*A merger across global partner secretariats... bringing together the Executive Office of the Secretary-General, PMNCH, the UN H6 Partnership (and possibly IAP) secretariats under one roof could significantly streamline and strengthen the current architecture for the Global Strategy.*

The PMNCH constituencies, including on adolescents and youth, would naturally be brought into this new fold, potentially bringing them in closer proximity to the day-to-day operations of all involved. This could enhance the strategic orientations and collaboration of Global Strategy constituencies with all global partners, especially at country levels, if attention is paid to how to galvanize and leverage them more fully.

Until such a merger is decided and implemented, the IAP urges sharpened clarity and communications with respect to the **division of labour among partners at global level, along the following lines:**

- The Executive Office of the Secretary-General and PMNCH should lead on strategic directions and advocacy, within their respective spaces of comparative advantage, to help drive policy priorities and resource mobilization; in publicizing critical findings and gaps from the Global Strategy monitoring and accountability reports to targeted constituencies that need to take action; and in intensifying their roles in proactively mapping and brokering partnerships and synergies across Every Woman Every Child commitments. In line with its accountability pillar of work, PMNCH should also lead on tracking and analysing commitments, and in coordinating the efforts to strengthen accountability.
- The UN H6 Partnership agencies and Countdown 2030, in collaboration with national statistics offices and other data hubs, should lead on data collection, disaggregation and analysis for monitoring.
- The IAP should continue in its accountability function, with its reports focused on review and remedy.

To address the perceived or actual duplication of **global progress reports**, the IAP proposes that **there should only be two central reports dedicated to the Global Strategy: One on monitoring data and the other on accountability**, with data hubs and research institutions contributing to both. This would not preclude the production of briefs and reports on data findings that fall outside the parameters of the two central reports, especially relating to information needed on country and regional levels, and across all equity, health and rights issues, such as by continuing Countdown2030's critical data analyses on coverage.

**Coordination across the global funds** – namely, the Global Financing Facility (GFF), the Global Fund to Fight AIDS, Tuberculosis and Malaria and GAVI – is reported to have been improving recently, and there are signs that the new PMNCH Global Financing Mechanisms constituency of which they are the members is off to a good start. However, there is room for improvement. The global funds should have in place a strengthened framework for coordination and collaboration from global to national levels, to systematically ensure synergies across investment portfolios, particularly relevant at national levels where more than one may operate. One opportunity, for example, is **joint funding by the Global Fund, the GFF and GAVI to secure integrated commodities packages for countries**. In particular, the global funds are encouraged to **harmonize their strategies for investment in adolescent health, development and rights**, which is an area of work for all of them, and clearly a priority for such collaboration. Consideration should also be given to involving the Bill & Melinda Gates Foundation and the Children's Investment Fund Foundation, as well as other major funders.

The IAP is confident that with institutional leadership at all levels, streamlining and accountability under the Every Woman Every Child global architecture can be sharpened to accelerate progress along the challenging, but achievable, roadmap to 2030.



## Recommendation 2: Make adolescents visible and measure what matters

While more governments and stakeholders are beginning to grasp the centrality of investing in adolescents, and investments for youth 15 and above are showing up in national policy documents, adolescents may lose out on the potential benefits in the absence of better targeted and tailored strategies. The same is often true at global level (Panel 3). While they have been receiving increased attention, adolescents are still not systematically featured in key inter-governmental mechanisms that form part of the Global Strategy’s Unified Accountability Framework.

One way the IAP proposes to improve policy attention to adolescents is for governments, national statistical offices, the UN system, donors, data hubs and civil society to exploit existing data more systematically for national planning and monitoring, and for reporting to inter-governmental review processes. While data on several indicators are collected for various age groups,

it is not fully exploited and disaggregated by sex and age to make adolescents visible in reporting, or for informing and monitoring policies for prevention and tailored interventions. For example, data on children up to 18 years of age should be further disaggregated by age sub-groups. New guidance available on decentralized data collection, such as on marginalized groups of adolescents, should also be leveraged. Data disaggregated for the 15–19 year old group to monitor the target on smoking prevention, for example, is absolutely essential since the vast majority of adults start smoking in their teens. Finer disaggregation of adolescent birth rates by age is also important: In several countries, new findings show that many girls give birth at the age of 15 and can face heightened risks of maternal mortality, but they are clustered in the 15–19 age group, thereby masking these potential threats to their health when decisions are made regarding the services they need.

### PANEL 3: HOW ARE ADOLESCENTS FARING? A GLANCE AT LEADING INTER-GOVERNMENTAL PROCESSES

To assess how visible adolescents are in the key mechanisms for monitoring and review of the Global Strategy and the SDGs, the IAP took a closer look. Naturally, given our mandate and global-level positioning, our emphasis in reviewing is on international forums, although we recognize that these are just the tip of the iceberg when it comes to review processes that are underway.

This year's World Health Assembly had a particular focus on the Global Strategy, as it was the first time a monitoring report was presented to Member States. With adolescents as the annual theme, it is not surprising they were highlighted in various Member State interventions – such as by referring to national strategies and plans on adolescent health, affirming the importance of sexual and reproductive health, legal reforms and protections of their rights to confidentiality, or expressing their concerns with girls in particular, or the need for HPV vaccination.

At the High-level Political Forum for Sustainable Development, among the areas of focus for this year's review were the SDGs on health and gender equality, both central to the Global Strategy. The global monitoring report on the SDGs only mentions adolescents twice – exclusively under the health goal, and only in relation to pregnancy and birth rates. They are also not explicitly referenced in reporting on family planning. Of the 43 reports presented by governments for their national voluntary reviews, just over half (26) mention adolescents, mostly concerned with adolescent pregnancy, and several referring to young people's participation. Few and rare references are made to early marriage, mental health, nutrition, anemia, HIV, smoking, road safety, social protection, universal health coverage or access to justice. Marginalized groups of young people are referenced, primarily in the context of poverty. Of note, only 31 address young people's health issues, 22 mention education, but only three refer to the right to quality education. Adolescent rights are mentioned explicitly in only six reports, alongside another 14 on the rights of youth. Of 25 countries that mentioned youth in relation to gender equality, few address gender inequalities in adolescents' education. Especially telling is that of the 15 countries which are among those with Every Woman Every Child commitments, just ten mention them as a distinct group. In four of the five that did not, adolescents may have been subsumed under references to youth.

To assess the Universal Periodic Review (UPR), an analysis was undertaken comparing recommendations made by Member States in the UPR cycle just completed (2012–2016) with the previous cycle (2007–2011). The findings reveal that, overall, adolescents are receiving greater attention in recent years, in particular in relation to sexual and reproductive health and rights – which increased by 52% in the second cycle. But of the close to 9,700 recommendations dealing with Global Strategy issues made to States in the most recent UPR cycle – such as those on the right to health, birth registration, maternal mortality, HIV, sexually transmitted infections, early marriage, sexual abuse, FGM, violence and sexuality education – only 52 recommendations referenced adolescents explicitly. On a more positive note, many more referred to girls (over 600), or to youth and young people, with adolescents implicit in the context of these discussions. Adolescent health issues most frequently raised were prevention of early marriage; FGM; sexuality education and early pregnancy – all which saw significantly increased attention in the second cycle. However, very disconcerting is the fact that no explicit recommendations were made specific to adolescents out of 138 relating to maternal mortality, morbidity and maternal health. And in terms of the quality of recommendations – meaning whether they specify actions meaningful for purposes of accountability – those pertaining to adolescents and young people rank low in comparison to other recommendations. As another analysis of eight countries found, adolescents are still disproportionately less visible by comparison to women and children, and when they are mentioned, it is often as part of the collective label “women, children and adolescents”.

To bring greater policy attention to women's, children's and adolescents' health, reporting should be informed by independent accountability at all levels. *At inter-governmental fora, for example, citizens' hearings and social accountability platforms should be convened during all HLPF, UPR and WHA sessions.*

**All Member States, United Nations system entities and other stakeholders should ensure reporting and the use of disaggregated data on adolescent health, development and rights across global, regional and national monitoring and accountability processes.** All UN reports, such as those produced by WHO and UNICEF and for monitoring the SDGs at the HLPF, should disaggregate data by age as well as sex. National statistics offices are encouraged to do the same, to both better inform national policy-making and improve their governments' reporting at regional and global levels. Disaggregation is critically important at sub-national and local levels of administration to help drive more equitable investments towards adolescents and marginalized groups. There are promising signs at regional levels, such as a recent report of the Economic Commission for Latin America and the Caribbean recommending that countries provide statistical visibility to inequalities for different age cohorts. African governments have committed to leading the continent's data revolution, and to provide timely and disaggregated data for decision-making, service delivery, citizen engagement and information. Implementation of these recommendations at national levels, with attention to ensuring disaggregated data on adolescents, should be followed through, and monitored.

**Another possibility for global partners, statistical bodies, specialized advocates and donors to consider is promoting the adoption of an adolescent health and well-being index.** Such an index would serve the purpose of strategically positioning adolescents for the remainder of the SDGs and beyond. Even if it does not officially form part of inter-governmental monitoring frameworks, it could be adopted by interested Member States for their own reporting, and serve as a powerful advocacy tool. The components of such an index should reflect the holistic, multi-sectoral approach needed in responding to adolescents' needs and rights. It could draw on existing data, including from the Global Strategy and SDG indicators, and build on lessons learned and related initiatives underway, such as the Commonwealth Youth Development Index and the UNICEF Adolescent Health Tracker.

**To bring greater policy attention to women's, children's and adolescents' health, reporting should be informed by independent accountability at all levels.** At inter-governmental fora, for example, citizens' hearings and social accountability platforms should be convened during all HLPF, UPR and WHA sessions, building on current practices, and addressing financial and visa barriers that continue to impede participation. They should also be considered by UN Secretariats and Member States as dedicated sessions in formal global and regional agendas for exchange among policy-makers, young people and other civil society constituencies, focused on identifying accountability gaps and priority remedial actions for follow-up, such as linked to HLPF annual review themes. And of course, community members and civil society representatives should be empowered at national and sub-national levels, which are closest to home, to participate in policy and budgetary formulation and programme review.



### Recommendation 3: Foster whole-of-government accountability to adolescents

Following on the IAP's 2016 call for new mechanisms of cross-sectoral accountability, this recommendation implies bold, prompt action and a major paradigm shift that will require determined leadership from decision-makers. Indeed, under the Convention on the Rights of the Child it is a State obligation to implement multi-sectoral national strategies to address root causes of rights violations faced by adolescents, and to monitor legislation, policies, services and budgets to this end. But public health approaches still tend to focus narrowly on mortality and clinic-based approaches, without paying adequate attention to prevention or to underlying risks to adolescents' health and well-being that require collaboration by a range of sectors.

All **ministries that affect adolescent health and well-being**, particularly those relevant for prevention, **should ensure that multi-sectoral plans and monitoring, review and remedy systems are effectively in place**. All key stakeholders should align their approaches and contributions with human rights legal obligations and

standards – including UN agencies, donors and the global funds. Parliaments, courts, auditors' offices and human rights institutions should provide oversight and enforcement.

All sectors that influence social determinants of adolescent health should be involved, addressing issues such as poverty, discrimination, gender inequality, malnutrition, harmful practices, violence, traffic accidents, use of tobacco, commercialization of unhealthy foods, self-harm and unsafe sex. Virtually all government ministries – first and foremost health and education but also including ministries of justice, gender equality, water and sanitation, food security, social protection, housing, transportation, urban planning, youth and sports, labour, immigration, agriculture, environmental protection, telecommunications and foreign affairs – are relevant and may play a range of roles across different national contexts. The education sector, in particular, is a powerful ally in advancing adolescent health and development.



#### PANEL 4: SMART POLICIES, SMART INVESTMENTS

Economists have increasingly come around to the view that countries that do not invest in adolescents will not be competitive in the global economy. Data available for low- and middle-income countries support the compelling case for investing in adolescent health, showing a ten-fold cost-benefit ratio in social, economic and health returns.

Education: Expanding the coverage and quality of secondary education for all boys and girls at a cost of only US\$22.6 per capita per year would yield 12 times as much in economic benefits and an additional 12 million formal jobs for people aged 20–24 years.

Adolescents' physical, mental and sexual health and reducing child marriage: Investments in least-developed countries between the years 2015–2030 of a modest US\$4.6 per capita per year would yield returns 10 times higher – averting 12 million adolescent deaths and preventing more than 30 million unintended teenage pregnancies. This represents billions in savings to national budgets from delayed pregnancy, prevention of cervical cancer through HPV vaccine programmes, and preventing road traffic injuries. Reducing child marriage, at a cost of US\$3.8 per capita per year, would have a 5.7-fold return on investment that could cut child marriage by one third, especially in low-income countries. Trillions in savings could be generated by ending child marriage, with multiple benefits for girls' education and their children's health.

Road safety: Improvements would yield about US\$6 in savings for every 60 cents spent per person per year, and prevent nearly 500,000 adolescent deaths by 2030.

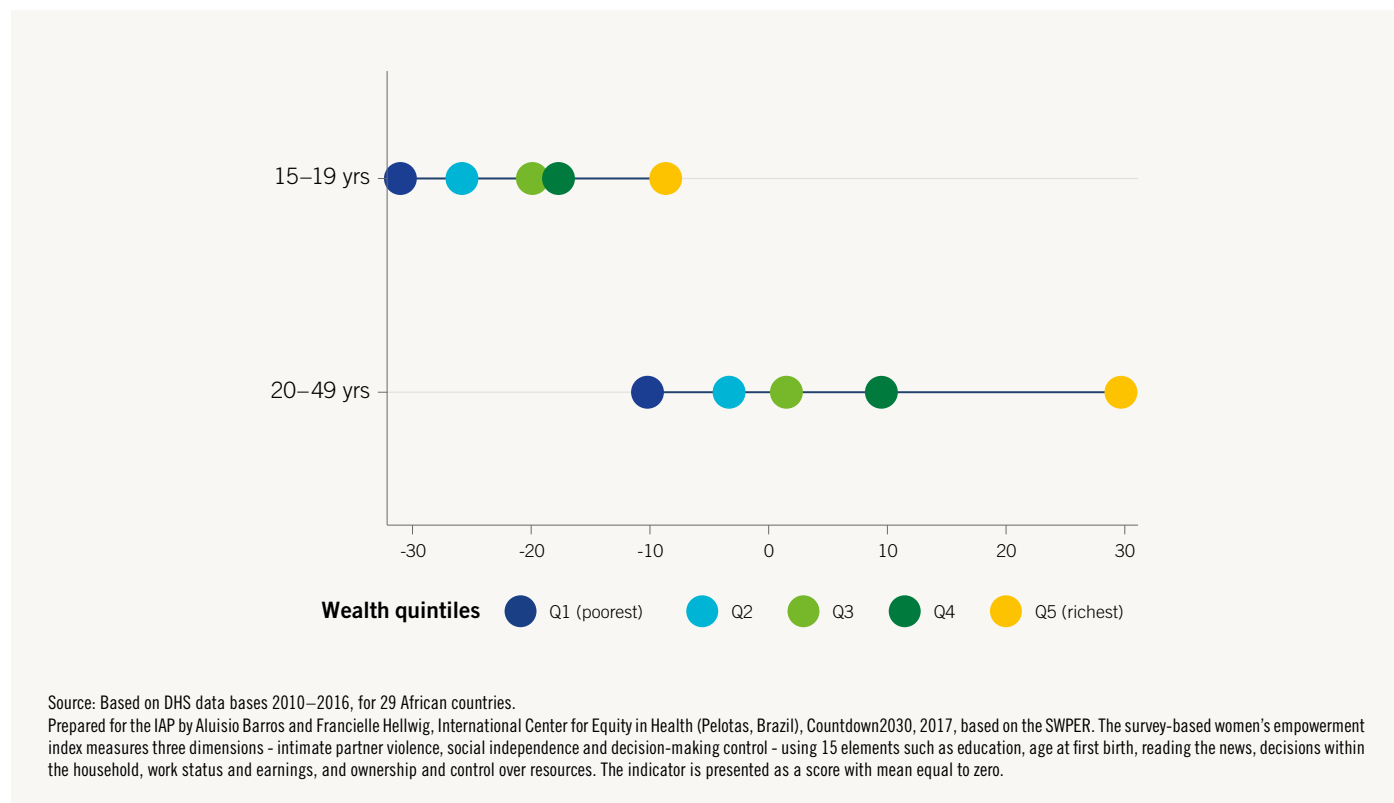
**Clear monitoring and accountability processes should be established within and across all sectors, under a common framework.** Particular attention will need to be paid to addressing inequities among groups of adolescents and neglected health issues; to supporting and linking up decentralized and local levels of cross-sectoral planning, review and remedy; and to transparent tracking of sectoral budgets at all levels. This recommendation also applies to humanitarian settings, to the extent possible, where much more holistic responses are needed for adolescents.

The most impressive results for adolescent health and well-being are those achieved through multi-sectoral, multi-level, scaled-up approaches involving local levels of implementation. For example, a recent evaluation of the UN H6 Partnership found that participatory joint mechanisms that extended to district and facility levels were the most important factor influencing effective programme coordination and responsiveness – an element appreciated by all government counterparts from the African countries that took part in the assessment.

In addition, new data reveal the benefits to be gained from such approaches in economic and financial terms (*Panel 4*). Adopting integrated approaches at scale will also be needed for countries to be able to capitalize on their demographic dividends, a crucial make-or-break issue of our time. The IAP acknowledges the foresight and political leadership demonstrated by countries that have implemented robust national, multi-sectoral policies and plans for adolescents. This includes pioneering efforts in the United Kingdom over a period of many years, with built-in accountability that led to success in reducing teenage pregnancy, an approach Thailand is also planning to pursue. Mexico, the United Republic of Tanzania and Uruguay, among others, have also launched multi-sectoral policies and plans across a range of adolescent health issues. The IAP encourages all countries with such plans to fully develop or fine-tune participatory monitoring and accountability frameworks, as necessary, with the involvement of civil society and young people.

**Figure 5: Adolescent girls' empowerment and decision-making in sub-Saharan Africa**

Women's empowerment index according to age and wealth quintiles



### 3.1 Harness demographic dividends by focusing on adolescents and gender equality

Investments made today in adolescents are the key to successfully managing demographic transitions in many developing countries. The question at hand is whether the world will mobilize the political will and resources to avert a demographic catastrophe of massive numbers of under-educated, jobless and restive youth, by harnessing demographic dividends for social and economic stability and growth. The implications extend to industrialized countries as well, given the inter-relationships of national demographic trends with global migration, the viability of social security and pension schemes, and the radicalization of youth.

Countries that see windows of opportunity for reaping the potential boost of demographic dividends to their economies tend to focus on youth at prime working age. Policies may not make the crucial connections between access to jobs for youth, on the one hand, and

health and gender dynamics in adolescence, on the other. And while they do often focus on education for work preparedness, they may ignore the fact that the roots of female unemployment, high fertility and inter-generational transmission of poverty can be traced to gender discrimination and young women's teenage years. Early marriage, school abandonment, violence and early motherhood are among the underlying drivers that deprive them of both education and access to decent work. As Figure 5 shows, in sub-Saharan Africa, poorer women are overall less empowered to make decisions than those from wealthier quintiles, but adolescents girls, regardless of their income level, have the most limited decision-making control over their health and lives.

To effectively harness demographic dividends, the IAP encourages **governments to develop and track multi-sectoral plans and investments on adolescents' health, gender equality and rights**, with the support of development cooperation partners.

Africa, for instance, could gain US\$500 billion per year from capitalizing on the potential of demographic dividends. The African Union Roadmap on Harnessing De-

demographic Dividends Through Investments in Youth, launched in January 2017, provides renewed opportunities for doing so. The continent is home to 196 million adolescents, who are expected to rise to 28% of the world's adolescent population by 2040. The Roadmap, developed with the participation of youth, serves as an accountability framework committing countries to report on progress. It calls for multi-sectorality to improve reproductive, maternal, newborn, child and adolescent health, in tandem with reforms of laws, policies and customs "that have a discriminatory impact on youth, especially girls and young women." It also calls for "Accountability in the delivery of services and the effective performance of accountability institutions, particularly parliaments, the judiciary and civil society organizations," with decision-making participation of women and youth, and independent youth commissions at national and sub-regional levels.

Encouragingly, in the first six months following the adoption of the African Union agreement, no fewer than 13 countries had already launched the initiative and 40 others had completed national studies to feed into the development of national roadmaps. Parliamentary networks are also preparing plans with a strong focus on gender equality, rights and sexual and reproductive health. Early developments signal that adolescents may be taking centre stage of demographic dividend approaches in some countries. In addition, a gender scorecard on the demographic dividend was launched in June 2017.

As more countries launch their initiatives, an essential piece will be the development of a "robust performance monitoring and accountability mechanism... at national, regional and continental levels, including for youth-focused investments policies and programmes," as articulated in the Roadmap. National information systems will need support in order to adequately capture the reality of adolescents in their diversity and ensure inclusive policies and tracking of implementation. If the Road-map is followed – with particular attention to adolescents – the region stands to benefit from the emergence of multi-sectoral, participatory planning, monitoring and accountability systems covering girls' education, delayed pregnancy and child marriage, sexual and reproductive health, prevention of gender-based and sexual violence, and youth employment.

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### 3.2 Make schools work for adolescents' well-being

As more children are enrolled in education, schools are set to become an essential hub for promoting adolescent health and development. Many health issues are best addressed outside the health sector, and schools are especially strategic for reaching adolescents early with prevention education that can empower them with knowledge and critical thinking skills for self-care and informed decision-making. School-based programmes, including through guidance counsellors, teachers, nurses, clinics, community social workers and referrals, can help adolescents address many of their health issues, while pooling other sectors' resources in the process.

Education systems can contribute to addressing an array of health issues, both in and out-of-school, including smoking, poor diet, lack of physical exercise, ensuring vaccinations (including for HPV), prevention and early detection of mental health conditions and violence, sexual and reproductive health, and inadequate hand washing (the lead risk factor for 10-14-year-olds). Special attention to issues that pose barriers for girls to attend school will be required, such as protection from sexual violence in and on the way to school, access to adequate menstrual hygiene facilities and commodities, and addressing cultural norms and practices, including early marriage and motherhood. At the same time, schools can become centres for educating communities and parents about adolescent health, and in turn involve them alongside adolescents in monitoring school performance.

The IAP recommends that **ministries of health and ministries of education, in collaboration with ministries of finance, establish joint planning, monitoring and accountability mechanisms to ensure that schools are of quality, and that they are accessible, equitable, affordable, safe and provide appropriate sanitation facilities for all girls and boys.**

It is no secret, however, that schools often fall short. For example, bullying is so widespread a problem that the United Nations Secretary-General's first report on the topic called for whole-school, whole-community programmes and monitoring for prevention and



prompt action. In one UNICEF survey, 9 in 10 children acknowledged bullying to be a problem, and in OECD countries, close to 1 in 5 reported experiencing it. Moreover, LGBTI adolescents are more likely to experience bullying in schools than in their homes or communities, correlating with higher rates of depression, suicide and homelessness. The 2016 Call for Action on education sector responses to violence based on sexual orientation and gender identity and expression is a ground-breaking inter-ministerial agreement that can serve as an accountability guidepost for tracking implementation within and outside of schools.

Legislative and policy reforms, and monitoring and oversight of the education sector, are therefore particularly important to address all forms of discrimination and violence in educational institutions, such as those based on disability, HIV or LGBTI status, among other factors. A range of measures are needed to address such problems, including removing prohibitions for pregnant girls to stay in school, and not allowing schools to skirt their obligations by educating them separately, alleging they are a bad influence, as well as affirmative action, flexible class schedules or day care centres for young mothers and fathers, or for those who have to work, so they are able to complete their education. The private sector also requires oversight in order to avoid situations like the court-ordered closure of Bridge Academy schools in Kenya and Uganda that failed to uphold basic quality standards, including unsanitary conditions, unqualified teachers and improper certification.

For meaningful monitoring of adolescent health and well-being, metrics should go beyond standard measurements of achievement in reading, writing and mathematics. The OECD's Programme for International Student Assessment (PISA) adopts the broader view, offering novel ways to understand students' happiness, relationships and their out-of-school activities, linked to evidence of their social and cognitive development. PISA surveys of 15-year-olds from around the world find that, while most teenagers are happy, anxiety over schoolwork and bullying are major issues, and girls are less happy than boys.

### 3.3 Ensure effective oversight institutions

Lip service to accountability is prevalent throughout global institutions as well as at national level. Robust, independent oversight is what can make all the difference for ensuring genuine accountability. To this end, the **autonomy, authority, capacities and awareness of national human rights institutions, independent auditing agencies, courts and parliaments to protect human rights and health, including of adolescents, must be strengthened.**

Adolescents are not merely patients who require services, or targets of family planning programmes – they are also rights holders. Health systems alone cannot ensure that adolescents, or others, can enjoy or claim their rights. All countries that have ratified the Convention on the Rights of the Child assumed obligations to embed the principles and provisions of the Convention in their national legislation. Many countries already recognize special protections for children, including their health (up to 18 years of age) in their own constitutions.

Meaningful oversight means putting curbs on the discretionary power of political branches of government, which means ceding power, and is often unpopular. Therefore, accountability requires strong and stable institutions capable of standing up to political influences. This in turn requires:

1. Adequate **ex ante and ex post autonomy**. That is, oversight institutions must have independence from the political organs of government in both the selection of personnel and in the actions undertaken thereafter as part of their mandates. They cannot be fired or demoted for political retaliation, nor can their budgets be cut as a result of decisions affecting vested interests.
2. Adequate **authority** to investigate and review, and order remedies of gaps and flaws that are uncovered. This requires legal mandates that are sufficiently broad to allow independent oversight mechanisms to address issues encompassed under the Global Strategy, as well as the power to ensure compliance with court judgements.

### PANEL 5: OVERSIGHT IN ACTION

In a landmark case in Colombia in 2008, the Colombian Constitutional Court ordered an overhaul of the government's health system, calling, among other things, for unification of the contributory and subsidized regimes, as the legislation had initially set out, but which had not been achieved. The authorities and health regulatory agencies were ordered to unify adult plans progressively in accordance with available resources, but found that differentiating among children based upon their parents' employment status was discriminatory. Therefore, the court called for immediate unification of child health plans. The government initially claimed that this requirement concerned children 0–12 years old, in accordance with the Child Code. The Constitutional Court clarified importantly, however, that the ruling applied to children 0–18 years of age as defined in the Convention on the Rights of the Child. The government complied and together with a series of other interventions, including a new Framework Law on Health, there is improved equity of access and oversight as a result of this ruling.

To improve oversight, the roles and capacities of national human rights institutions to proactively conduct assessments and public inquiries on adolescents' health and rights should be strengthened. In Malawi, for example, a public inquiry was launched to investigate human rights concerns of violence against women and sexual and reproductive health rights, particularly for vulnerable groups, including adolescent girls. District-level public hearings on people's experiences with using health services were presided over by a judge of the High Court alongside the Malawi Human Rights Commission and non-governmental organizations. A national task force was created to monitor implementation of the recommendations that emerged from the inquiry. Training has been undertaken for service providers and civil society organizations at district levels to strengthen officials' human rights capacities, establish real time reporting and early warning signs of human rights violations, and improve service delivery. Also under consideration is follow-up on placing "quality officers" at public health facilities responsible for handling users' complaints or referring them to relevant authorities.

### The critical role of parliaments in oversight and accountability

Enabling legal frameworks, including budgetary appropriations, are necessary but not sufficient for adolescents (and all people) to enjoy their rights. As the law-making branch of government, parliaments have special responsibilities to ensure adolescents' health and rights. Adolescents, especially girls, are afflicted by a range of human rights issues and violations that require legal protection, enforcement and remedies. Chief among them are gender-based violence and sexual and reproductive rights violations, including in humanitarian and armed conflict situations.

Law reform is not sufficient, but is critical to accountability. Adolescents' needs and rights are often trampled by ideological, socio-cultural and gender-based biases, which in many cases influence the content of policies, laws and institutional practices governing their lives. Adolescents are also disproportionately affected when governments fail to effectively regulate tobacco and sugary drink manufacturers. Recent legal reforms in various countries are encouraging – such as new legislation to raise the legal age of marriage, to make

3. Adequate **capacity**, both **human and financial**, which requires sustained and adequate budgeting, as well as improved training for some officials.
4. Adequate **public awareness** of how to obtain or provide information to such oversight mechanisms, as well as of the standards and laws that guide their reviews. This requires easily accessible communication channels and formats as well as ample opportunities for public participation, with particular attention to gender- and youth-responsiveness, and facilitation of young people who seek redress.

comprehensive sexuality education mandatory in secondary schools, as well as to curb advertising of tobacco products. But all **laws and policies that pose barriers to their health and violate their rights must be lifted, including third-party authorization requirements to access services, criminalization of services that are solely for women, or of consensual sexual relations among adolescents, or discriminatory laws against people with HIV.** Sometimes violations are perpetrated within health care institutions themselves: key examples are forced sterilization and forced abortion, including of girls with mental or physical disabilities, or who are living with HIV, or humiliating and abusive treatment of pregnant girls (especially if they are unmarried).

**Parliaments also must pass the legal reforms that establish institutional oversight in the areas of adolescent health** discussed above. Legislatures in democratic systems are central to accountability, because they have the autonomy to scrutinize the performance of executive branches of government with

respect to outcomes as well as budgets. In a welcome development, the Inter-Parliamentary Union (IPU), a formal network of parliaments from around the world, is intensifying plans to strengthen parliamentary oversight capacities for multi-sectoral adolescent health policies and programmes – working across congressional committees on health, education and gender equality.

Legal restrictions on adolescents' access to health care pose serious challenges, but so does the absence of clear legal guidance for health providers, and institutions that affect adolescent health directly or indirectly. The United Nations Committee on the Rights of the Child has issued guidelines that provide clarity for reforming relevant laws affecting adolescents' health, which ministries of health, parliamentarians and national human rights institutions should pursue to guarantee adolescents' rights to health (Panel 6). The Committee also adopted a set of recommendations regarding the obligations of States to regulate private business activities affecting children's development and well-being.

## PANEL 6: ADOLESCENTS' RIGHTS TO DECISION-MAKING: CAPACITY FRAMEWORK FOR HEALTH PROVIDERS

In December 2016, the Committee on the Rights of the Child called on States to consider introducing a “legal presumption that adolescents are competent to seek and have access to preventive or time-sensitive sexual and reproductive health commodities and services.” The fact that an adolescent recognizes the need for and seeks out services should serve as evidence that he or she has the capacity to make decisions and use services appropriately. Moreover, the Committee affirmed the right of adolescents to independently seek confidential medical counselling and information, regardless of age. It also urged States to revise legislation in order to guarantee the best interests of pregnant adolescents and ensure their views are always heard and respected in abortion-related decisions, affirming girls' rights to make reproductive health decisions. The Special Rapporteur on the right to health also calls for governments to adopt legislation that recognizes a legal presumption of capacity for adolescents who seek counselling and services.

When a service provider has concerns about the capacity of an adolescent to make decisions, the provider should follow the course of action that is in line with the adolescent's best interests, with this assessment weighted towards the adolescent's preferred choice. This approach takes into account:

- Why the adolescent is seeking a particular health service;
- If the services are most appropriate for the adolescent's needs;
- Whether the adolescent is capable of following the treatment regimen;
- What the consequences are for the adolescent if the provider denies the services.



## Recommendation 4. Make universal health coverage work for adolescents

Despite all the intensive discussions on UHC to position it as an SDG target, adolescents for the most part have received only limited attention in these dialogues. As the roll out of UHC intensifies, it will be critical to ensure that adolescents' health, and the particular barriers they face, are addressed. As such, **ministries of health and ministries of finance** should **ensure adequate and equitable financing** so that all **adolescents have free access at the point-of-service delivery to essential goods and services – with specified monitoring, accountability and oversight mechanisms for protection of their right to health.** WHO in collaboration with the UN H6 Partnership agencies should develop guidance to support countries to this end.

UHC packages of commodities and services should be the result of evidence-informed deliberative processes, which include inputs from affected populations. Because almost all adolescents are minors, with few influential

actors negotiating on their behalf, concerted efforts will be required for their engagement. Once the plans are adopted, they need to be transparently publicized in language that is accessible to adolescents, with targeted outreach so they know what medicines and services they are entitled to, and know how to protect their rights when they access them. The institutions with responsibility for oversight and protection of adolescents' right to health under these schemes should be clearly spelled out. Complaint mechanisms should be put in place, and adolescents should be made aware of how to use them to seek redress. And redress must be real, not a complaint box that goes to nowhere.

Monitoring should track what proportion of adolescents (and groups of adolescents) are being covered, by what range of goods and services, how costs are covered and where costs are not covered. It will also require assessments, with adolescents' inputs, on the quality

Globally, an estimated 10–20% of all adolescents are afflicted with mental health conditions, with depression an important cause of illness and disability among them. Up to half of all mental health issues start before 14 years of age. But as noted elsewhere: *“Suicide has become one of the main killers of adolescents but its roots in gender or other social systems of power are rarely viewed as concerns for UHC.”*

and dignity of the care they are receiving, identifying where discriminatory, abusive or inappropriate treatment constitutes a barrier to access. Special attention may be required to remove barriers faced by adolescents with disabilities, members of sexual minorities, those who face added burdens of stigma and disadvantage, those who are involved in child labour, or are married, among others.

From the planning phase onward, special care is needed to identify and address obstacles adolescents may face in accessing services, medicines and other commodities under standard UHC schemes, and policy and legislative reforms should be instituted to remove them. For example, in some countries the legal age for accessing contraception is higher than the legal age for marriage. If adolescents must depend on their parents’ insurance or consent, they will not have their right to privacy protected. Panel 7 shows the legal and regulatory status in 42 countries for adolescents to be able to access key services without parental or spousal approval. Of those represented with data reported, an alarming 78% of countries impose partial or complete restrictions on adolescents’ access, nine countries fully deny access and only nine countries allow full access. These are among the essential services for adolescents spelled out in the Global Strategy.

Prompted by the IAP’s request for evidence, a recent survey on barriers to adolescent girls’ access to emergency contraception covered 36 countries from across several regions. Thirty per cent of them were found to have restrictive policies such as age limits.

Leading barriers to access to emergency contraception were identified as low awareness of the method (a factor in virtually every country), negative attitudes on the part of health providers and high cost.

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#### 4.1 Provide a package of essential goods and services for adolescents, including mental health and prevention of non-communicable diseases

Ministries of health should lead in defining and monitoring universal access by adolescents to a package of essential health interventions in line with those identified in the Global Strategy, devised in accordance with the best available scientific evidence, free of gender-based, cultural or religious biases. A range of health services should be considered, including for mental health, anaemia prophylaxis, HPV vaccination, comprehensive sexuality education, and counseling and services for sexual and reproductive health and for survivors of gender-based and sexual violence.

**Adolescents living with disabilities, HIV and mental health conditions will require special attention in all countries.** Globally, an estimated 10–20% of all adolescents are afflicted with mental health conditions, with depression an important cause of illness and disability among them. Up to half of all mental health issues start before 14 years of age. But as noted elsewhere: *“Suicide has become one of the main killers of adolescents but its roots in gender or other social systems of power are rarely viewed as concerns for UHC.”*

An especially intransigent and still neglected issue is iron-deficiency anaemia, the top-ranked cause of disability-adjusted life years lost among adolescent girls and boys under 15 years of age and for girls and young women 15–19 years old. The condition can be reversed at low-cost, as illustrated by the experience of Gujarat, India, where anaemia among adolescent girls was reduced by 24% within a single year – at a cost of only \$0.58 cents per adolescent, per year.

Among vaccines, the HPV vaccine should also be considered for inclusion in national immunization plans.

## PANEL 7: RESTRICTIONS TO ADOLESCENT HEALTH AND RIGHTS IN NATIONAL LAWS AND REGULATIONS

Laws and regulations that allow adolescents (15–19 years of age) to seek the following services without parental or spousal consent

Country	Contraceptive services except sterilization	Emergency contraception	HIV testing and counselling services	Harm reduction intervention for injectable drug users
Afghanistan	No	No	Yes	Yes
Argentina	Yes	Yes	Yes	Yes
Bhutan	Yes	Yes	Yes	No
Bolivia (Plurinational State of)	No	No	No	No
Brazil	Yes	Yes	Yes	Yes
Cambodia	Yes	Yes	Yes	Yes
Colombia	Yes	Yes	Yes	Yes
Costa Rica	Yes	No	Yes	No
Cuba	Yes	Yes	Yes	No Data
Dominican Republic	Yes	Yes	Yes	Yes
Egypt	No	No	No	No
El Salvador	Yes	Yes	Yes	Yes
Guatemala	Yes	Yes	Yes	No
Guyana	No	No Data	Yes	No Data
Haiti	Yes	No	No	No
Indonesia	No	Yes	Yes	Yes
Iran (Islamic Republic of)	No Data	No Data	No Data	Yes
Iraq	No	No	Yes	No
Lao People's Democratic Republic	No	No	No	No
Lebanon	No	No Data	Yes	No Data
Libya	No	No	No	No
Malaysia	No	No	No	No
Marshall Islands	Yes	No	Yes	No
Micronesia (Federated States of)	No	Yes	Yes	Yes
Mongolia	Yes	Yes	Yes	Yes
Morocco	No	No	No	Yes
Myanmar	Yes	Yes	Yes	No Data
Oman	No	No	Yes	No Data
Pakistan	No	No	No	No Data
Palau	Yes	Yes	Yes	No Data
Paraguay	Yes	No	No	No Data
Peru	No	No	No	No
Rwanda	No	No	No	No
Saint Vincent and the Grenadines	No	No	No	No
Solomon Islands	No Data	No Data	No	No
Sri Lanka	Yes	Yes	Yes	No
Spain	Yes	Yes	Yes	Yes
Suriname	Yes	Yes	Yes	No Data
Timor Leste	No	No	Yes	No
Trinidad and Tobago	No	No	No	No
Uruguay	Yes	Yes	Yes	No Data
UK	Yes	Yes	Yes	Yes

**Yes:** Interventions **allowed** to adolescents without parental or spousal consent  
**No:** Interventions **restricted** to adolescents without parental or spousal consent

Source: Information from countries that responded to the Global Maternal, Newborn, Child and Adolescent Health Policy Indicator Survey 2016 undertaken by the Department of Maternal, Newborn, Child and Adolescent Health: WHO.  
Prepared for the IAP by Dr. Laura Laski.



The vaccine is the first to prevent cancer in history and it is included on WHO's list of essential medicines. It is often neglected, however, including due to ideological reasons. Given to adolescents, it can protect them from cervical cancer later in life, currently a leading cancer killer of women. To date, 74 countries (38%) have rolled it out for adolescent girls – whereas the global target is for 70% of countries to deliver the vaccine through their national immunization programmes by 2020.

The huge benefits for the health and well-being of large numbers of women, children and adolescents that could be attained at relatively low cost and cost-effectively indicates that all governments, with support from the UN H6 Partnership agencies, GAVI and other development partners, should consider **ensuring early universal coverage of anaemia prophylaxis, care for mental health conditions, and HPV vaccination** – especially now that the price for the latter is lower under GAVI-supported efforts for eligible countries.

Of course, how UHC will deliver for adolescents also depends on overall health system strengthening. Crucial will be an adolescent-friendly health workforce, trained in human rights and gender equality dimensions, including midwives. To cite one example of how this could be addressed, in Northern Nigeria, adolescents and young women are part of the solution: thousands are being trained as health workers for deployment to rural areas, and adolescent support groups have already reached thousands of young women with improvements in child-birth in health facilities and immunization for their babies.

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## 4.2 Ensure that all adolescents have free access to essential goods and services

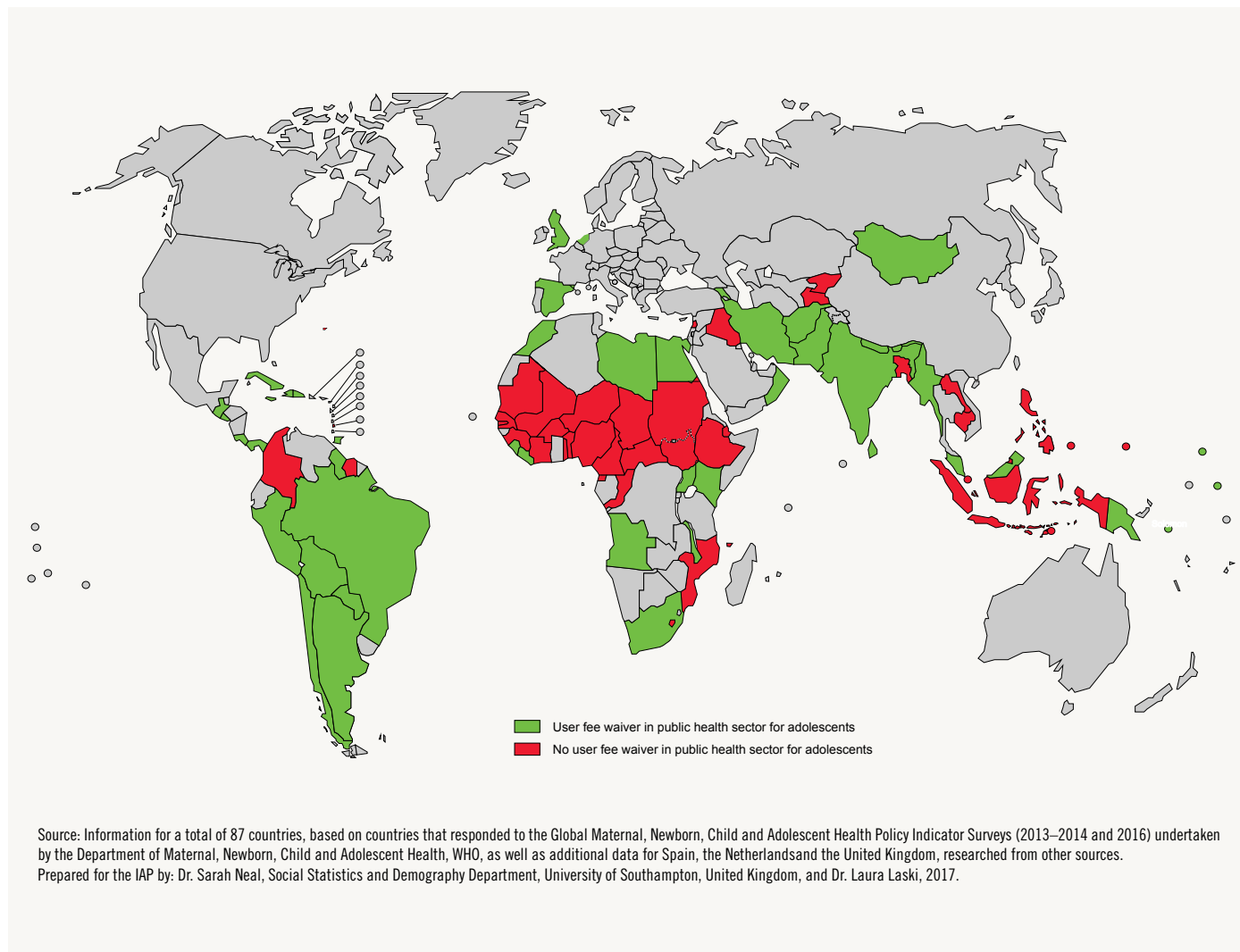
From an equity perspective, adolescents should have access to a package of essential health goods and services with no out-of-pocket expenditures at the point of service delivery, paying particular attention to disadvantaged groups, such as those living in poverty, with HIV, disabilities or mental health conditions. This suggests extending a basic treatment package to all adolescent populations before adding additional treatments for adults. The benefits of no-cost care to

adolescents are also economically clear because they have their productive and reproductive years ahead of them. In Europe, for instance, providing free or subsidized contraceptives is associated with contributing to relatively low unintended pregnancy and birth rates.

Out-of-pocket expenses are a key issue to consider in UHC plans, as costs represent a barrier for adolescents and many others. As illustrated by the map, while nearly 53% of countries represented do have user fee waivers for adolescents in public health facilities, almost 47% of countries – 22 of them in Africa – require adolescents to pay for services. In setting priorities in the context of budgetary constraints, governments should be guided by the principle of progressive realization and their obligations to take measures to the maximum of their available resources in fulfilling adolescents' rights to health. It means setting priorities based on the best available evidence of the most pressing health needs of adolescents and on what adolescents themselves define as their needs. On this basis, informed decisions can be made as to which services may need to come first as part of the package, and which to incorporate over time.

Some countries have been paving the way on adolescents and UHC. For example, in Senegal, health coverage has been expanded for all primary and secondary school students – something Egypt had introduced years ago. In Mexico, HPV vaccines have been incorporated into the *Seguro Popular*, the country's UHC insurance; this is also the case of Rwanda, where 90% of girls are now immunized. In Moldova, adolescents participated in shaping the National Health Insurance Fund, and the scheme includes youth-friendly services. The Netherlands exempts adolescents from insurance premiums and guarantees contraceptive access without third-party authorization.

## Map of user fee waivers for adolescents



Source: Information for a total of 87 countries, based on countries that responded to the Global Maternal, Newborn, Child and Adolescent Health Policy Indicator Surveys (2013–2014 and 2016) undertaken by the Department of Maternal, Newborn, Child and Adolescent Health, WHO, as well as additional data for Spain, the Netherlands and the United Kingdom, researched from other sources. Prepared for the IAP by: Dr. Sarah Neal, Social Statistics and Demography Department, University of Southampton, United Kingdom, and Dr. Laura Laski, 2017.





## Recommendation 5. Boost accountability for investments, including for adolescents' health and well-being

Through various consultations, the IAP inquired about investment flows for adolescents. We found an overall dearth of evidence of governments, donors and global funds transparently allocating or tracking resource flows for adolescent health and well-being, outside of dedicated programmes, with only a few exceptions. This poses a major challenge for assessing the state of accountability to this age group. In Central America, for example, an analysis of national budget expenditures from 2007–2013 revealed that governments in this sub-region invested on average less than one dollar per day on children and adolescents, with the exception of Costa Rica and Panama. This reflects the historical trend of severe underfunding and small projects in support of the health and well-being of adolescents, although several significant large-scale initiatives and investments have emerged in recent years.

Government **ministries, development cooperation partners** and the **global funds** supporting the Global Strategy **should adopt and strengthen strategic investment and accountability frameworks on adolescent health and well-being**. This includes improving adolescent-responsive tracking and reporting, aligning strategies on adolescents' health with the best available evidence, and addressing social determinants of their health. Leading examples include the United Kingdom and the United States, which have launched large-scale strategies for adolescents with significant budgets based on rigorous research and analysis. Another is the Global Fund to Fight AIDS, Tuberculosis and Malaria, with its holistic, evidence-based strategy and increasing investments in adolescents. The Bill & Melinda Gates Foundation is acknowledged for its recent decisions to strengthen its strategies on adolescents, and is encouraged to bring its parallel streams of work on this age group under one overarching strategic framework.

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## 5.1 Increase resources and adopt adolescent-responsive budgeting

**Ministries of health and education, and other key sectors** responsible for **implementation of policies and programmes for adolescents**, should **pay explicit attention to this age group in preparing budgets**, tracking **resource flows** and presenting **expenditure reports to ministries of finance and parliaments**. In answering for their budgets, sectoral ministries should justify investments in line with adolescents' health and development priorities, evidence on how they are being addressed, and how they are securing results for poor and especially excluded groups. Decentralized and local levels of administration should also adopt this approach, involving local constituencies, including adolescents and youth, in the process of defining budget priorities, where they can also undertake social accountability to track and provide feedback on how those resources are being spent in their communities.

Part of the challenge with improving tracking of resource flows for adolescents, as with gender equality issues, is that budgets are spread across different sectors, and resources subsumed in generic budget lines. But experience shows that it is not an insurmountable challenge. For many years, gender-responsive budgeting was resisted, considered unfeasible, but under the pioneering efforts of UNIFEM (a precursor to UN Women), it has been taken up over the past several years by 80 governments, as well as a number of UN agencies and other institutions. The concept of adolescent-responsive budgeting may be new, and its methodologies incipient, but the IAP believes it is adolescents' turn for better tracking and reporting on resources. This becomes all the more important as investments in this age group increase. Experts in these fields should provide enabling support, and WHO should contribute by including adolescents in its guidance for national health accounts.

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## 5.2 Strengthen accountability of development cooperation partners, including of members of the Organisation for Economic Co-operation and Development (OECD) Development Assistance Committee (DAC)

The IAP reiterates its call, made in our 2016 report, for all bilateral donors, including members of the OECD/DAC, to be held accountable for fulfilling their commitments to finance the 2030 Agenda and for meeting the targets of committing 0.7% of their gross national income to ODA, including 0.15–0.20% for the least developed countries. This is not just about the volume of resources provided, but also about its effectiveness, which is critical both to maximize impact and to achieve long-term, sustainable development.

Given the growing number and diversity of donors, development cooperation support to the Global Strategy faces complex challenges of governance and management, which can also lead to investments in duplicate and fragmented efforts. Fortunately, we know what to do to make development cooperation more effective: Donors should renew their commitment to the Busan principles on development effectiveness, agreed in 2011, to support inclusive development partnerships that build country ownership, focus on results, promote transparency and shared responsibility, and reduce transaction costs.

### **Organisation for Economic Co-operation and Development/Development Assistance Committee**

As the leading forum of major donor countries and standard-setter for donor behaviour, the OECD/DAC has a key role to play in strengthening accountability for development cooperation. OECD members provide 83% of global development assistance, including significant financial support for the Global Strategy. Presently, as discussed earlier, there are many challenges to improving accountability due to the lack of transparency and multiple organizations operating across a variety of partnerships.

The OECD/DAC should re-invigorate its work on development effectiveness, in collaboration with the Global Partnership for Effective Development Cooperation. Now is the time to update DAC norms and standards for the SDGs, including strengthening mutual accountability in the context of the Global Strategy. The IAP encourages the OECD/DAC to use the opportunity provided by the current DAC reform process to strengthen its accountability functions both in relation to its members' bilateral programmes as well as to the multi-stakeholder partnerships they support.

**The IAP encourages OECD/DAC and its members to consider specific options such as:**

- **adopting an adolescent policy marker to track ODA** resource flows, building on the experience with the gender equality and the reproductive, maternal, newborn and child health policy markers;
- **supporting peer learning on adolescent health and well-being**, informed by thematic reviews of donor investments in this area, in order to develop best practice guidelines and processes for monitoring and accountability;
- **supporting countries' own accountability mechanisms and processes** with the participation of youth groups and other civil society organizations, as well as directly resourcing social accountability, which could in turn incentivize multi-sectoral mechanisms.

**Parliaments**

The role of parliaments in ensuring oversight of national development cooperation is another key entry point to sharpen the focus on accountability for women's, children's and adolescents' health. The IPU is a signatory to the Busan Partnership Agreement and as such, the Global Partnership for Effective Development Cooperation, of which it is also a constituent, should consider how parliamentarians can strengthen their role in this area. Parliamentarians may also wish to introduce a thematic focus, including on adolescents, in reviews of their national development cooperation portfolios.

**UN system entities**

In line with the principles of development effectiveness, ongoing improvements and oversight are needed on institutional effectiveness from the highest levels of UN agencies' leadership to the country programmes they support. This is especially important as regards the UN H6 Partnership. In addition, United Nations entities – and their governance boards and donors – may wish to consider assessing cost-effective measures to ensure compliance with human rights and ethical standards in the country programmes they support, where it is especially relevant in the case of women's, children's and adolescents' health, groups that are particularly vulnerable to abuses. By way of example, the World Bank Inspection Panel has an independent complaints channel to report and investigate harmful impacts of its programmes.



## Recommendation 6. Unleash the power of young people

Accountability is ultimately about achieving better outcomes, equity and results and holding governments to those promises. But key to accountability is the process of ‘how’. In this, participation as a right is essential, through inclusive and transparent engagement of the people they are intended to serve in all processes relating to public policy and budgeting. Since adolescents in most countries do not have the power of the vote, their ability to influence decision-making is quite restricted. Young people in positions of power is also limited: of the 45,000 parliamentarians in the world, only 1.9% are under 30 years of age.

The IAP calls for transforming accountability processes by meaningfully engaging civil society, adolescents and youth organizations at all levels of decision-making. We present two sub-recommendations below, one for all implementers of the Global Strategy, and the other, to empower young people to master this digital age of

technology for their health, well-being, civic activism – and for demanding accountability to their needs and rights.

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### 6.1. Ensure young people’s meaningful participation, move away from tokenism

The notion of adolescent and youth participation, and more specifically, its value added for development, may be poorly understood or relatively novel for many policy-makers. However, under the Convention on the Rights of the Child and international human rights standards, involving children and adolescents in decision-making is an obligation of States. Governments have also committed to youth involvement in General Assembly resolutions and various inter-governmental agreements. Yet adolescent and youth movements in many corners of

## PANEL 8: YOUNG PEOPLE'S CIVIC ENGAGEMENT: ACCOUNTABILITY AT WORK

In **Peru**, a landmark case was won where more than ten thousand youth successfully challenged the constitutionality of the criminalization of consensual sex among teens, which was blocking their access to health services. In 2013, the courts ruled in their favour, declaring that young people aged 14–18 years had a right to personal autonomy and self-determination with regard to their sexuality. In 2016, building on this landmark case, new Ministry of Health family planning guidelines removed a major barrier to adolescents' access, enabling 15-18-year-olds to seek contraceptive services without their parents' accompaniment.

In districts of the **State of Gujarat, India**, adolescent girls and boys (aged 11–18 years), from diverse villages with tribal populations, urban slums and migrants, were supported to claim their rights under government programmes. Girls trained in filing official forms on the right to information were able to take action on issues of sanitation, water and transportation under a government programme for out-of-school children. Adolescents were also instrumental in ensuring that the local health worker reported for duty and complied with basics such as weighing girls or administering their iron tablets. Most girls and boys retained new knowledge about gender-based discrimination, sexual harassment, hygiene and menstruation as well as rights to education. All the adolescent girls and boys who took part said they would continue civic activism, having gained confidence in initiating dialogue with officials managing the programmes.

In **South Kivu Province, Democratic Republic of the Congo**, 12–17 year old boys and girls have joined grassroots youth clubs to address sexual and gender-based violence and other issues of concern. They have set up committees to monitor violence in educational settings and follow up with schools' responses. New and younger adolescents who join the clubs are mentored by adult facilitators. The project, which began in 2011, also allows for advocates from legal clinics to work with the adolescents on reporting violations, thereby enabling them to better understand their rights and the law, and to encourage and refer their peers to various services. As they phase out from the youth clubs at 17 years of age, they have grown up with knowledge of multi-sectoral responses to violence, and have the skills and confidence to continue civic engagement and monitoring in their communities, for longer-term change.

the world are facing the same crackdowns, censorship, harassment, and funding restrictions as other civil society actors are experiencing. States must be held to account for enacting appropriate legislation and protecting the rights of adolescents to freedom of expression, information, movement and association. This includes ensuring that young human rights defenders, especially adolescent girls and young women, are protected from threats and violence.

**Governments, donors, the UN System, the global funds and civil society should establish and strengthen**

**mechanisms for young people's effective participation in holding Global Strategy stakeholders to account** at global, regional and national levels.

Efforts to increasingly and more meaningfully engage young people – beyond the tokenism of one-off invitations to meetings and consultations – signal the potential of an emerging 'new normal'. A case in point is a unique initiative at the highest levels of government that recently emerged in Canada, where a Youth Council was established in 2017 to advise the Prime Minister's office and cabinet.

## Transformation is needed in how programmes are developed with and for adolescents and how we practice accountability, recognizing their rights, their roles as change agents and as experts for informed, effective policy development.

In the area of social accountability, assessments show that governments stand to benefit from the participation of young people. Local accountability mechanisms involving community-based organizations and municipal authorities can help improve efficiencies of resource use, quality of services, equitable access, tamp corruption and enhance real-time remedial action.

Across the world, young people's activism in overseeing programmes is at work to improve services and strengthen responsiveness to their needs, as shown by the case studies received by the IAP for this report (some of which feature in Panel 8). More investments and research are needed on young people's participation in improving service delivery and accountability to bolster the evidence base. Particular attention is also needed on involving younger adolescents in decision-making and monitoring at national and local policy levels, building on the cumulative experience on children's rights and participation.

Various new initiatives and tools are becoming available to build young people's capacities to advocate for their rights and engage in national and inter-governmental processes in the framework of the Global Strategy, including their inclusion in citizens' hearings and use of community scorecards. These are very relevant initiatives worthy of investment and further research to build up the evidence base on good practices and their integration into broader accountability processes. Such efforts, especially at national, district and local levels, are bringing greater official attention to health service delivery gaps and bottlenecks. This is particularly the case where government-civil society trust is being strengthened and where initiatives are followed up and supported appropriately. However, where such support is absent or initiatives are 'one-offs' or face entrenched resistance from authorities, these efforts can lead to disillusionment and participation fatigue.

Transformation is needed in how programmes are developed with and for adolescents and how we practice accountability, recognizing their rights, their roles as change agents and as experts for informed, effective policy development. More investments are needed in building up young people's capacities and engagement in national and local planning, monitoring and accountability, as well as in decision-makers' own learning and capacities to do so meaningfully, to adopt and institutionalize their involvement in systematic, continuous ways. All governments, funders and partners committed to the Global Strategy are encouraged to adopt modalities and standards for engaging young people in decision-making and reviews of policies and programmes to reap the benefits of participation.

At global level, there are a considerable number of mechanisms and modalities for young people's participation across various UN agencies and inter-governmental fora. However, to what extent these mechanisms are moving from tokenism to meaningful involvement is difficult to gauge. The global funds and major initiatives are also encouraged to continue or strengthen meaningful participation of young people in decision-making and programme reviews, at both global and country levels. We found varying degrees of young people's engagement, sometimes very positive, in others more limited.

The Global Fund to Fight AIDS, Tuberculosis and Malaria's multi-stakeholder country coordination mechanisms are one venue through which young people's voices can be pooled to inform decision-making. At global level, while there is no designated seat for young people on its Board, some delegations include them as members. The GFF Investors Group's adoption of a Civil Society Engagement Strategy is a very welcome step to support civil society's role in accountability and independent monitoring. It outlines responsibilities for governments, the GFF, global partners and civil society, as part of strengthening overall GFF accountability. Its roll-out and tracking will be of special interest to the IAP in the coming years. The Investors Group also decided to include a youth representative as an alternate to the civil society seats. For its part, FP2020 already involves youth networks. Plans are being developed to engage civil society and youth organizations in its country focal



points system, as well as have a youth representative in their governance mechanism. And a youth accountability strategy is under development to advocate at country levels for governmental fulfilment of commitments, including to adolescents.

These are all moves in the right direction, especially if modalities and plans for young people's engagement translate into transforming how decision-making responds to their contributions and recommendations for change.

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## 6.2 Empower the e-Generation to seize the full potential of the digital age

No discussion of adolescents in today's highly-connected world would be complete without addressing the e-Generation. This generation of young people is the first in history who have been raised with modern technologies and the Internet since infancy. Adolescents' access to the Internet opens a world of opportunities for them, but there are also serious risks, and efforts to protect them must safeguard their rights to privacy, information and freedom of expression. Oversight mechanisms to prevent potential harms are incipient and patchy, reflective of the overall limited regulation of the private sector and the vast speed at which the technology itself is evolving.

The future of today's adolescents will depend heavily on their ability to harness the power of modern information and communication technologies as civic agents for change, for skills-building as they transition to the world of work, for learning about the world around them, and for exercising their rights to participation in decisions affecting their lives.

The IAP calls for **empowering the e-Generation to leverage the full potential of the digital age for civic participation and accountability for their health and rights.**

One in three Internet users in the world are children, numbering over two billion. However, digital equity gaps exist: not all adolescents have access to the Internet, with age, geography and gender as the key

dimensions of exclusion from this access. Numerous efforts are working to bridge these divides, such as the launch of the #eSkills4Girls initiative and the recent G20 commitments, among others.

Technology today allows for real-time feedback for adolescents to actively engage in monitoring and holding governments to account, such as on the quality of public services in their communities, schools, health facilities and cities. Successful initiatives point to the opportunities at hand. For example, UNICEF's U-Report engages them through text messaging and the data compiled are used to map local areas where children and adolescents are reporting problems, then shared with national partners to promote solutions. Impressive results are reported for children's health, HIV, protection, livelihoods and in humanitarian situations. Governments overall seem receptive. In Uganda, all parliamentarians signed up for the U-Report to know what is happening in their districts, and in Liberia, youth were mobilized during the Ebola crisis for preventing its spread through self-care tips.

Other initiatives include *Da Subject Matter* in Nigeria, which has used Facebook to promote adolescent's access to health services for the first time. ATHENA's #WhatWomenWant initiative engaged adolescent girls and young women from across Eastern and Southern Africa through WhatsApp and Twitter to dialogue with policy-makers on what they want on HIV prevention. Under the Virtual Internship Programme of the West African Academy of Public Health, professors and subject experts mentor students to launch social media campaigns for youth on adolescent health issues, with the aim of improving public health literacy and youth civic engagement in health accountability.

There are many obvious benefits and opportunities for young people, but cyberspace also poses grave new risks and children themselves report the downsides of this exposure – Internet scams, scary images or news, harassment, hate speech, gender-based violence and sexism, cyberbullying, sexual grooming and exploitation, trafficking, child pornography, recruitment by armed groups, extremism and radicalization – and changes to social interactions and community cohesion that are poorly understood. Content remains virtually



unregulated, and both economic and sexual predators lurk. Parents are largely unaware of what is taking place. Various efforts to counteract these threats are underway, such as the We PROTECT Global Alliance to End Child Sexual Exploitation Online, which has secured commitments from governments and the technology industry, and the Global Kids Online research initiative to protect their rights more broadly.

Governments, the education system, technology companies, parliaments and other oversight mechanisms need to take concerted measures to stop online abuses, including through legislation and by establishing and requiring standards and their compliance by information and communications businesses, to hold the private sector to account. Governments also need to protect children's rights to privacy and prevent the use of data about them for commercial and marketing purposes. A leading example of regulation and enforcement of

telecommunications giants is under the United States' 1998 Children's Online Privacy Protection Act (COPPA).

Most critical for protecting adolescents is empowering them with the knowledge and skills to avoid negative consequences and learn critical thinking and decision-making skills to filter in the good, and filter out the bad. Furthermore, digital access must be directed to empowering them with knowledge about their rights, a major gap to date in the content they view. Governments, the education system and technology companies should promote training on digital literacy and online safety as part of the educational curriculum, and also train parents, teachers and other professionals who work with adolescents – all with their direct engagement – to embrace the e-world we live in.



**LOOKING  
AHEAD**

# 4.

To deliver on adolescent health, development and human rights and the Global Strategy more broadly, transformative leadership will be required, especially from governments and the partners and institutions supporting national implementation, and from local authorities and health facilities.

The United Nations must set the example. We are confident that the new UN leadership will take accountability forward and raise the bar. We applaud the United Nations Secretary-General for placing accountability and transparency among his top priorities for the UN Development System. He has also responded to the abysmal record of sexual violence and exploitation by UN peacekeepers, calling for accountability and remedies for victims, among other measures to end impunity.

For his part, the new WHO Director-General, in line with his campaign pledge and commitment to gender equality and accountability, is now in a position to make those pledges meaningful by championing human rights across the organization's work and the UN system, including the recommendations of the High-Level Working Group on the Health and Human Rights of Women, Children and Adolescents. Importantly, he is mandated by Member States to push forward on the Global Strategy, since WHO is the only entity with an explicit mandate from its governing board, the World Health Assembly, to have specifically endorsed it at inter-governmental level.

However, these positive UN developments must be seen in the context of a growing lack of confidence in leadership and democratic institutions. Although some governments have demonstrated exceptional commitment to women's, children's and adolescents' health and well-being, as mentioned in examples throughout this report, others appear to be backtracking on issues relating to gender equality, reproductive health and rights, and basic freedoms, such as access to information and expression. All of this poses a threat to meaningful accountability and the goals of the Global Strategy.

Despite the examples of progress cited in the first section of this report, our collective and individual efforts for the health, rights and well-being of women, children and adolescents are falling far short of what needs to be done. Generally speaking, we are not seeing commitments, strategies and plans being sufficiently translated

into the effective, large-scale and sustainable actions demanded by our troubled times, when the very fate of the planet hangs in the balance.

The urgency and gravity of the situation facing the world's women, children and adolescents is what inspires partners in the Every Woman Every Child movement to continue their dedication to keep the promises that brought this dynamic global initiative together. Accountability must be at the heart of our efforts on the road to achievement of the SDGs in 2030. No matter what place we occupy in the web of institutions, mandates, plans, campaigns and strategies, we all must answer, ultimately, to the largest constituency of all – humankind.

The recommendations in this report are submitted not as judgements from on high. We make them with candour and humility, recognizing each and every institution and individual working every day with great passion and dedication. But by its very nature as an accountability report, the emphasis is on gaps and shortcomings calling out to be addressed. Our critique, our concerns, should be addressed on the merits, but should not be taken as negativity or gloom and doom.

Several of our recommendations will require soul-searching and hard decisions. Can we reduce duplication and overlap across the UN system and beyond to overcome any institutional vested interest while pursuing the broader global mandate and strategy? Can we overcome the lack of transparency that characterizes many initiatives? Can we applaud all the monitoring and reviewing that is being done while demanding of ourselves that remedy and action become the 'new normal' and inescapable measures of success?

We trust that our recommendations will lead to a constructive dialogue that will result in greater accountability, transparency and, above all, more effective, measurable actions that make a real difference for – and with – the world's most disadvantaged and excluded people.

## Appendix: Summary Availability of Indicators

**Table 1: Scoring key, based on table 6 of the World Health Statistics (WHS) report, of the availability and disaggregation of IAP indicators**

This scoring only deals with presence or absence of data at country level, rather than the quality of that data.		
Scoring	WHS methodology	Adaptation for IAP indicators
Good in IAP 2016	Data was already reported available in the 2016 IAP Report	
Good	Data is available for more than 75% of countries where the indicator is relevant (2010 or after) <sup>1</sup>	World Health Surveys assessed based on the availability of data in WHO countries only, so IAP has only assessed against WHO countries, rather than all the UN countries.
Fair	Data is available for 40–74% of countries where the indicator is relevant (2010 or after)	
Poor	Data is available for less than 40% of countries where the indicator is relevant (2010 or after)	

<sup>1</sup> Based on WHO list of 194 countries. 75% =145, 40% =77.

**Table 2: Progress on data availability and disaggregation since 2016**

(\*) No change observed

(\*\*) Changed from fair to good

(\*\*\*) Changed from “in preparation” to poor

(\*\*\*\*) Changed from “in preparation” to good

(\*\*\*\*\*) Increase in the number of countries that have disaggregation

Grey indicates non-applicable disaggregation. Note that the shading of the boxes is aspirational and not necessarily reflecting what these data collection sources currently capture or intend to in the future.

Indicator	Data source	Country data availability	Availability of disaggregated data				
			Age	Cause of death	Location	Sex	Wealth
1. Maternal mortality (3.1.1)	UN MMEIG <sup>1</sup>	Good *					
	IHME GBD <sup>2</sup>	Good *	X	X			
2. Under-5 mortality (3.2.1.)	UN IGME <sup>3</sup>	Good *		X		X	
	UNICEF <sup>4</sup>	Fair *					X
	GHO HEM <sup>5</sup>	Poor *			X	X	X
	Countdown 2030	Good**			X*****		X
	GHO	Good*			X		
	IHME <sup>6</sup>	Good *	X	X		X	

Indicator	Data source	Country data availability	Availability of disaggregated data				
			Age	Cause of death	Location	Sex	Wealth
2b. Neonatal mortality (3.2.2)	UN IGME <sup>7</sup>	Good *					
	UNICEF <sup>8</sup>	Fair *					X
	GHO HEM <sup>9</sup>	Poor *			X	X	X
	IHME <sup>10</sup>	Good *					
2c. Stillbirth	Lancet article (2016) <sup>11</sup>	Good *		X			
3. Adolescent mortality	WHO GHO <sup>12</sup>	Good *	X	X		X	
	IHME GBD <sup>13</sup>	Good *	X	X		X	
4. Demand for family planning satisfied with modern methods (3.7.1)	UN Population Division/DESA <sup>14</sup>	Fair *					
	UNFPA <sup>15</sup>	Fair *	X				
	GHO HEM <sup>16</sup>	Poor *					X
5a. Stunting among children under 5 (2.2.1)	Countdown <sup>17</sup>	Fair *	X				
	JME UNICEF WHO WB <sup>18</sup>	Good *					
	UNICEF <sup>19</sup>	Fair *			X	X	
	WHO HEM <sup>20</sup>	Poor *				X	
	IHME <sup>21</sup>	Good****			X	X	
5b. Overweight among children under 5 (included in 2.2.2)	JME UNICEF WHO WB <sup>22</sup>	Fair*					
	UNICEF <sup>23</sup>	Fair*					X
	GHO HEM	Poor *				X	
	IHME	In preparation			X	X	
6. Adolescent birth rate (3.7.2)	UN Population Division <sup>24</sup>	Good *	X				
	UNFPA <sup>25</sup>	Good **	X*****		X		X
	GHO HEM <sup>26</sup>	Poor *	X				X
7. Poverty (1.1.1)	World Bank <sup>27</sup>	Good *					
8. Education attainment of proficiency level (41.1)	UNESCO IUS <sup>28</sup>	Poor*				X	
9. NEET (8.6.1)	World Bank/ILO <sup>29</sup>	Fair*					
10a. SRH legal rights (5.6.2)	UNFPA <sup>30</sup>	In preparation					

Indicator	Data source	Country data availability	Availability of disaggregated data				
			Age	Cause of death	Location	Sex	Wealth
10b. Legal protection from domestic violence (proxy for 5.1.1)	UN Women (for 5.1.1) <sup>31</sup>	Not available				X	
	OECD Gender Index <sup>32</sup>	Good*					
10c. Public opinion on domestic violence (incl. 5.1.1)	UN Women (for 5.1.1) <sup>33</sup>	Not Available					
	OECD Gender Index <sup>34</sup>	Fair*					
11. Birth registration (16.9.1)	UNICEF <sup>35</sup>	Good*	X*****		X	X	X
12a. Child Marriage (5.3.1)	UNICEF <sup>36</sup>	Fair*	X				
12b. Sexual violence (16.2.3)	UNICEF <sup>37</sup>	Poor*	X*****			X	
	IHME <sup>38</sup>	Good****				X*****	

This Appendix was prepared for the IAP by Dr. Laura Laski.

- 1 Trends in maternal mortality: 1990 to 2015. Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division (<http://www.who.int/reproductivehealth/publications/monitoring/maternal-mortality-2015/en/>).
- 2 Levels and trends in child mortality. Report 2015. Estimates developed by the UN Inter-agency Group for Child Mortality Estimation. New York: UNICEF; 2015 ([http://www.childmortality.org/files\\_v20/download/figme%20report%202015%20child%20mortality%20final.pdf](http://www.childmortality.org/files_v20/download/figme%20report%202015%20child%20mortality%20final.pdf)).
- 3 Ibid.
- 4 Under-five mortality. UNICEF data: monitoring the situation of women and children. UNICEF [website]; updated October 2016 (<https://data.unicef.org/topic/child-survival/under-five-mortality/>).
- 5 Hosseinpoor AR, Bergen N, Schlottheuber A, Victora C, Boerma T, Barros AJ. Data resource profile: WHO Health Equity Monitor (HEM). *Int. J. Epidemiol.* 2016;45(5):1404–1405e (<https://academic.oup.com/ije/article/45/5/1404/2450924/Data-Resource-Profile-WHO-Health-Equity-Monitor>).
- 6 GBD 2015 Child Mortality Collaborators. Global, regional, national, and selected subnational levels of stillbirths, neonatal, infant, and under-5 mortality, 1980–2015: a systematic analysis for the Global Burden of Disease Study 2015. *Lancet.* 2016 Oct 7; 388:1725–1774 (<http://www.healthdata.org/research-article/gbd-2015-under-5-mortality>).
- 7 Levels and trends in child mortality. Report 2015.
- 8 Neonatal mortality. UNICEF data: monitoring the situation of women and children. UNICEF [website]; updated January 2016 (<https://data.unicef.org/topic/child-survival/neonatal-mortality/>).
- 9 Hosseinpoor, et al. Data resource profile: WHO Health Equity Monitor.
- 10 GBD 2015 Child Mortality Collaborators. Global, regional, national, and selected subnational levels of stillbirths, neonatal, infant, and under-5 mortality, 1980–2015.
- 11 Lawn JE, Blencowe H, Waiswa P, Amouzou A, Mathers C, Hogan D, et al. Stillbirths: rates, risk factors, and acceleration towards 2030. *Lancet.* 2016; 387(10018):587–603 ([http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(15\)00837-5/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(15)00837-5/fulltext)).
- 12 Global Health Observatory data. WHO [website] ([http://www.who.int/gho/mortality\\_burden\\_disease/en/](http://www.who.int/gho/mortality_burden_disease/en/)).
- 13 Institute for Health Metrics and Evaluation [website] ([http://www.healthdata.org/search?search\\_terms=adolescent+mortality](http://www.healthdata.org/search?search_terms=adolescent+mortality)).
- 14 World contraceptive use 2017. United Nations Department of Economic and Social Affairs, Population Division [website] (<http://www.un.org/en/development/desa/population/publications/dataset/contraception/wcu2017.shtml>).
- 15 Family planning dashboard. UNFPA [website] ([http://dashboard.unfpaopendata.org/family\\_planning/](http://dashboard.unfpaopendata.org/family_planning/)).
- 16 Hosseinpoor, et al. Data resource profile: WHO Health Equity Monitor.
- 17 Personal communication to the IAP Secretariat by International Center for Equity in Health, Pelotas, Brazil.
- 18 Joint child malnutrition estimates – levels and trends (2017 edition). Global database on child growth and malnutrition. WHO [website] (<http://www.who.int/nutgrowthdb/estimates2016/en>).
- 19 The state of the world's children report 2016. A fair chance for every child. New York: UNICEF; 2016 ([https://www.unicef.org/publications/files/UNICEF\\_SOWC\\_2016.pdf](https://www.unicef.org/publications/files/UNICEF_SOWC_2016.pdf)).
- 20 Hosseinpoor, et al. Data resource profile: WHO Health Equity Monitor.
- 21 GBD results tool results. Global Health Data Exchange. Institute for Health Metrics and Evaluation [website] (<http://ghdx.healthdata.org/gbd-results-tool/result/fcb25c2e8552302eb56983b901dae94e>).
- 22 Levels and trends in child malnutrition. UNICEF/WHO/World Bank Group joint child malnutrition estimates: key findings of the 2017 edition ([http://www.who.int/nutgrowthdb/jme\\_brochure2017.pdf?ua=1](http://www.who.int/nutgrowthdb/jme_brochure2017.pdf?ua=1)).
- 23 Undernutrition contributes to nearly half of all deaths in children under 5 and is widespread in Asia and Africa. UNICEF data: monitoring the situation of children and women. UNICEF [website]; updated June 2017 (<https://data.unicef.org/topic/nutrition/malnutrition/>).
- 24 Fertility. United Nations Department of Economic and Social Affairs, Population Division [website] (<http://www.un.org/en/development/desa/population/theme/fertility/index.shtml>).
- 25 The state of world population 2016. 10: how our future depends on a girl at this decisive age. New York: UNFPA; 2016 ([http://www.unfpa.org/sites/default/files/sowp/downloads/The\\_State\\_of\\_World\\_Population\\_2016\\_-\\_English.pdf](http://www.unfpa.org/sites/default/files/sowp/downloads/The_State_of_World_Population_2016_-_English.pdf)).
- 26 Hosseinpoor, et al. Data resource profile: WHO Health Equity Monitor.
- 27 Poverty. The World Bank data [website] (<http://data.worldbank.org/topic/poverty>).
- 28 UNESCO Institute for Statistics [website] (<http://data.uis.unesco.org>).
- 29 Share of youth not in education, employment or training, total (% of youth population). International Labour Organization, key indicators of the labour market database. The World Bank data [website] (<http://data.worldbank.org/indicator/SL.UEM.NEET.ZS>).
- 30 Indicator 5.6.2. is Tier III of the SDGs indicators.
- 31 SDG indicators global database. United Nations Department of Economic and Social Affairs, Statistics Division [website]; updated 28 July 2017 (<https://unstats.un.org/sdgs/indicators/database/>).
- 32 Information about discriminatory social institutions for 160 countries and economies. Social Institutions and Gender Index. OECD Development Centre [website] (<http://www.genderindex.org/countries>).
- 33 SDG indicators global database.
- 34 Social Institutions and Gender Index. OECD Development Centre (<http://www.genderindex.org/data/>).
- 35 Indicator: 16.9.1 – Proportion of children under 5 years of age whose births have been registered with a civil authority, by age. SDG indicators global database (<https://unstats.un.org/sdgs/indicators/database/?indicator=16.9.1>).
- 36 Is every child counted? Status of data for children in the SDGs. New York: UNICEF; March 2017 (<https://data.unicef.org/wp-content/uploads/2016/09/SDGs-and-Data-publication.pdf>).
- 37 Ibid.
- 38 GBD results tool results. Global Health Data Exchange. Institute for Health Metrics and Evaluation [website] (<http://ghdx.healthdata.org/gbd-results-tool/result/fcb25c2e8552302eb56983b901dae94e>).





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