MOMENTUM
Country and Global Leadership

IS YOUR HEALTH SYSTEM ADOLESCENT- AND GENDER-RESPONSIVE?

A Participatory Tool for Analysis and Action Planning

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MOMENTUM works alongside governments, local and international private and civil society organizations, and other stakeholders to accelerate improvements in maternal, newborn, and child health services. Building on existing evidence and experience implementing global health programs and interventions, we help foster new ideas, partnerships, and approaches and strengthen the resiliency of health systems.

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ABBREVIATIONS

AA-HA!	Global Accelerated Action for the Health of Adolescents
GAMA	Global Action for Measurement of Adolescent
GBV	gender-based violence
HMIS	health management information system
LGBTQI	lesbian, gay, bisexual, transgender, queer, and intersex
MOH	Ministry of Health
NGO	nongovernmental organization
QI	quality improvement
RMNCAH	reproductive, maternal, newborn, child, and adolescent health
SBC	social and behavior change
SDP	service delivery point
SRH	sexual and reproductive health
USAID	U.S. Agency for International Development
VYA	very young adolescent
WHO	World Health Organization

INTRODUCTION

Progress toward universal health coverage requires a transition from adolescent-friendly projects to adolescent-responsive health systems.

—World Health Organization

WHAT ARE ADOLESCENT- AND GENDER-RESPONSIVE HEALTH SYSTEMS?

In adolescent- and gender-responsive systems, all health system building blocks (see Box 1) address and respond to the health needs and rights of adolescents and proactively address gender determinants of adolescent health.[1–5]

Box 1: World Health Organization Health System Building Blocks

- Leadership and governance
- Service delivery
- Health workforce
- Health information
- Medical products
- Financing
- Community*

* We include the additional community building block as an essential component of a health system, particularly for adolescents.

As described in the Adolescent-Responsive Contraceptive Services Family Planning High Impact Practices Enhancement, this approach intentionally transitions the emphasis from creating separate adolescent-friendly spaces and corners to ensuring that all health services are responsive to the needs and rights of adolescents by incorporating adolescent-friendly elements that have demonstrated effectiveness.[1]

Adolescent- and gender-responsive health systems meet the comprehensive health needs of adolescents—not just sexual and reproductive health (SRH)—and contribute to improved adolescent well-being and equity as articulated in the logical framework in Global Accelerated Action for the Health of Adolescents (AA-HA!).

WHY SHOULD HEALTH SYSTEMS BE ADOLESCENT- AND GENDER-RESPONSIVE?

Despite reductions in adolescent mortality in the last 70 years, the pace of improvement has lagged behind that of younger children.[6] Adolescents continue to bear disproportionate burdens of poor health outcomes, including outcomes related to SRH, maternal health, nutrition, and mental health.[7–11]

To improve adolescent health and reduce inequities, health systems cannot treat adolescents like "small adults" or "big children."[2] Adolescents have unique biological and psychosocial needs.[12] They face unique barriers to accessing and using high-quality care, such as distance, cost, opening hours, fear of being seen and judged, disrespectful treatment by providers, provision of incomplete information and services, and restrictions on what services they can seek without parent and partner permission.[7,13–15] Furthermore, women and gender minorities face gender inequality and power disparities within the health system that inhibit their ability to access quality health services and practice positive health behaviors.[16] This is even more pronounced for adolescents due to the intersection of their gender identity and age, and can be further compounded by other intersectionalities such as socio-economic status, ethnicity, geographic location, disability, and more. [2,17]

To address the barriers adolescents face in seeking and using quality and comprehensive health services, country governments and partners have implemented adolescent-friendly health services.[18] Adolescent-friendly health services have demonstrated effectiveness, but the emphasis has often been on making individual health facilities adolescent-friendly.[1] To better align with the increased emphasis on universal health

coverage and to more sustainably meet the needs of adolescents—who make up a quarter of the population in many countries—we need to expand beyond individual facility-based approaches to meaningfully embed gender-equitable adolescent health considerations in all aspects of a health system.[2,19] In this responsive systems approach, adolescents can access high-quality, inclusive, and respectful health services anywhere they choose to go—at the community level, in the private sector, in facilities near to them or far, online through telehealth or digital apps, and through school- and workplace-based services. The approach is more scalable and may be more sustainable than a singular focus on adolescent-friendly spaces or corners because it uses the existing health system and builds in long-lasting features such as ensuring regular adolescent health data through age-disaggregation in the national health management information system (HMIS), rather than creating parallel processes and services.[1,2] Making a health system adolescent-responsive is not a light-touch or low-priority endeavor. On the contrary, it is a systematic undertaking to improve how the health system is organized, funded, and monitored to accelerate progress in adolescent health.

WHAT IS THIS ASSESSMENT TOOL? HOW CAN IT BE USED?

This assessment tool enables ministries of health (MOHs), civil society, nongovernmental organizations (NGOs), and adolescents to assess whether and how the health system currently responds to the needs and rights of adolescents, including how the system acknowledges and addresses gender barriers and opportunities that influence adolescents' receipt of quality care. For each health system building block, the tool lists key features of a health system that would make the system adolescent- and gender-responsive, including how well the health system works with other sectors, such as economic development and education, for a multisectoral positive youth development approach.[20]

This tool can be used to:

- Inform work plans and budget priorities for MOHs, the private sector, donors, civil society, and NGOs to improve the health system's responsiveness to adolescents at the subnational or national level.
- Inform national priority setting and the development of national adolescent health programs using the AA-HA! framework and guidance.
- Assess to what degree the Adolescent-Responsive Contraceptive Services High Impact Practices Enhancement is being implemented.
- Measure and monitor the system's progress in meeting the needs and rights of adolescents of all genders over time.

WHY IS THIS ASSESSMENT TOOL NEEDED? HOW IS THIS ASSESSMENT TOOL AND PROCESS DIFFERENT FROM OTHERS?

No existing tools enable practitioners to look across all elements of a health system at the subnational and/or national level (rather than at individual facilities) to identify areas of strength and areas for improvement in relation to adolescent health. While tools do exist to examine gender-sensitive or gender-responsive health services writ large, there are no tools that focus on the specific gender considerations needed to support adolescent health in particular. This tool aims to fill that gap, and make the rather nebulous concept of "adolescent-responsive systems" concrete, measurable, and actionable.

The tool complements several existing tools. It is designed to identify key priorities for action at national and subnational levels. Once those priorities have been identified, stakeholders can use the tools listed in Annex 1 to take action. For example, a district health management team that prioritizes embedding adolescent

quality standards in their quality improvement processes could use the World Health Organization's (WHO's) Global Standards for Quality Health-Care Services for Adolescents (link found in Annex 1) tool and resource. This applies to formative research tools, training tools, counseling job aids, supervision tools, accountability tools, and program/policy frameworks (e.g., AA-HA!), all of which can be found in Annex 1, mapped to the relevant building block, and ready for use based on the priorities determined through this assessment.

Importantly, **this is not a facility assessment tool and is not designed to determine the quality or adolescent-friendliness of a particular health facility or service delivery point.**

Although many health system assessment tools and guides are available (e.g., the U.S. Agency for International Development [USAID] Health Systems Assessment Approach), they either do not mention adolescents at all, or only mention adolescents in a list of health services. This adolescent- and gender- responsive assessment tool can complement a broader health system assessment. Or, an MOH or health management team conducting a broader health system assessment could incorporate key questions and features from this tool.

HOW TO USE THIS TOOL

The tool uses the WHO health systems building blocks as the primary organizing framework with the addition of the community building block.[3–5] There is one section for each building block. Each section lists features of the building block that would make the health system more adolescent- and gender-responsive and provides four benchmarks for each feature (a score of 0–3).[a] This tool is intended to be completed as a participatory assessment exercise by a team of stakeholders, under the leadership of the MOH, and in partnership with adolescents of different gender identities, health care practitioners, and civil society partners. The following steps describe how to use the tool.

STEP 1: DETERMINE THE PARAMETERS OF YOUR ASSESSMENT. This flexible tool should be used in a manner that will most effectively generate an understanding of how the health system currently responds to the needs of adolescents as well as areas for improvement. The tool can be used to assess a national health system, inclusive of public and private sectors. Or, it may be used to assess smaller health system units, such as a district- or provincial-level system or only the private or public sector. Determine (1) the unit of the health system you will assess, (2) whether you will assess the public or private health sectors, and (3) if you will assess all the building blocks (recommended) or selected building blocks.

STEP 2: ADAPT THE TOOL TO YOUR CONTEXT. Carefully revise the tool to align with your health system. Recommended adaptations include:

- Remove features that are not relevant to your assessment parameters and priorities. For example, if you are doing the assessment at the subnational level, remove national-level features. Or, if your health system does not have any demand-side financing initiatives, remove that feature.
- Revise the wording of features so they align with the local language and names of policies/priorities. For example, use the correct national term for community health workers and subnational units, for example, province, district, or county.
- Revise benchmarks to align with the existing health system structure and policies.

[a] The features were determined in two ways: 1) a review of the literature to identify which features have contributed to more accessible, acceptable, equitable, and effective services for adolescents; and 2) input from health system, gender, and adolescent health practitioners.

- While this assessment was developed considering the needs of adolescents ages 10–19, you could adapt it to include youth as defined by the country you are working in and expand the features and benchmarks accordingly.

STEP 3: GATHER KEY RESOURCE DOCUMENTS. Identify and gather key documents that will inform the process of assessing the system's adolescent- and gender-responsiveness. This includes copies of all national policies and procedures/standards of practice related to adolescent health, outlines of curricula used in pre-service education and in-service training, a list of HMIS indicators that are disaggregated by age and access to HMIS data to analyze recent service uptake as needed, quality improvement standards and processes, supervision forms, and data collection forms.

STEP 4: ENGAGE ADOLESCENTS TO UNDERSTAND THEIR PERSPECTIVES ON THE HEALTH SYSTEM'S RESPONSIVENESS. Adolescents must be engaged in the assessment process. For example, they could be involved in the following ways:

- Adolescents or adolescent- or youth-led organizations could facilitate the entire assessment process in partnership with the MOH.
- Adolescents could inform the assessment through workshops (as described below).
- Adolescents could participate in a workshop with the MOH and stakeholders to determine the final assessment scores.
- Adolescents could participate in the action-planning process.
- Adolescents could use the resulting action plan to hold the health system accountable.

How adolescents are engaged should be determined based on what will allow for the most meaningful contributions of adolescents considering existing partnerships and power dynamics in the particular setting (e.g., adolescents may feel more comfortable sharing their views in an adolescent-only workshop, rather than in the same workshop as the MOH). As with all adolescent engagement, steps should be taken to ensure diversity (i.e., adolescents of different ages, genders, life stages, marital status, urban/rural, in and out of school) and inclusion of adolescents most impacted by discrimination and inequality, who are not always represented in adolescent- and youth-led organizations (e.g., adolescents with disabilities; younger adolescent girls; lesbian, gay, bisexual, transgender, queer, and intersex [LGBTQI] adolescents; and adolescents living with HIV). In addition, adolescents should be prepared for engagement, oriented on the process and expected outcomes, and compensated for their time. For more guidance on meaningful adolescent and youth engagement and partnership, please see the High Impact Practice Strategic Planning Guide.

At a minimum, adolescents should be engaged as follows:

- Before conducting the assessment workshop with MOH decision-makers and stakeholders (Step 5, described below), hold assessment workshops with adolescents using the Supplemental Tool: Adolescent Workshop Guide for Assessing the Responsiveness of the Health System. Diverse adolescents should be engaged as described above. The group should also include both adolescents who are engaged with the health system (such as those in youth-led organizations working on health) and those not engaged with the health system. Workshops should be held in age, sex, and life-stage segmented groups, depending on power imbalances in the context, to ensure full participation. For example, in the pilot of this tool, adolescent workshops were conducted separately with girls and boys. The Supplemental Tool: Adolescent Workshop Guide for Assessing the Responsiveness of the Health System includes consent and assent forms that should be used to ensure adolescents and their parents/guardians (for adolescents under the age of majority) fully understand and consent to participate. In these assessment workshops, the facilitator

should guide adolescents to discuss and select the benchmark/score that they feel most closely represents their health system for each of the relevant features. Their score and the rationale for the score should be recorded in the Adolescent Workshop Guide. The facilitator will use this information in Step 5.

- Engage adolescents, including representatives of adolescent-led organizations and advisory groups, in the action-planning process (Step 6).
- Ensure adolescent-led organizations and other adolescent groups have a clearly defined role in the follow-up monitoring and accountability for the action plans (Step 7).

STEP 5: SELECT ONE OF THE FOLLOWING OPTIONS (5A OR 5B) DEPENDING ON YOUR NEEDS

Step 5A: Conduct participatory workshop(s) with the MOH and stakeholders to discuss and build consensus on a score for each feature.

- Hold a workshop with health system managers (i.e., from the MOH at either national or subnational level, such as district health management teams), representatives of public and private sector facilities, civil society organizations, and additional relevant stakeholders (e.g., adolescents, if power dynamics will allow for meaningful engagement).
- During the workshop, the facilitator should guide the group through a discussion of each feature within each building block. The facilitator should read a description of each feature to the group and facilitate discussion on which benchmark score (0–3) most closely resembles the current state of the health system. The facilitator should ensure that all voices in the room are heard and that power imbalance does not drive final scores. The facilitator (or adolescent representatives, if present) should share the adolescent scores (from Step 3). The facilitator should guide the group to select the benchmark (0–3) that most closely matches their reality, triangulating the views of the health system managers with the adolescent perspectives. It is okay if the health system reality does not match the benchmark exactly. Use the notes column to document the nuances of how the reality may differ from the benchmark as well as key points on the rationale for selection of that benchmark.

Box 2: Tip from implementation

In the pilot of this tool, the workshop to score each feature took two days. During this time, the facilitators used breakout groups so that health system actors with the most familiarity with the specific building block discussed each building block and reported their thinking back to the full group for final discussion and decision-making. The facilitator used an Excel sheet that automatically turned red, yellow, or green based on the score given to the feature, which allowed for easy visualization of areas of strength and key gaps. This Excel sheet is available for adaptation and use on the Adolescent- and Gender- Responsive Health Systems Assessment webpage.

OR

Step 5B: Rather than use the participatory self-assessment approach described above, the tool could be used to guide an external assessment of the system. For this alternative assessment method, an independent, external assessment team would use health system documents, key informant interviews, and site visits to determine the scores for each feature. This approach would be most useful if the users are looking for objective, comparable scores across districts or other parts of the health system.

STEP 6: DETERMINE PRIORITIES AND PLAN FOR ACTION: After conducting the assessment, the MOH, adolescents, and stakeholders should use the results to prioritize key features to strengthen and develop an action plan. Guidance on prioritization can be found at the end of this tool. The action plan should spell out the needed actions to move from one benchmark score to the next score, who will take that action, who will

fund the action, and the timeframe for the action. A list of tools and resources that can be used to take action on the priorities (e.g., tools to use for training, quality improvement [QI], supervision, counseling, and more) are available in Annex 1.

STEP 7: DEFINE THE PLAN FOR MONITORING AND ACCOUNTABILITY. The team of the MOH, adolescents, and stakeholders who conducted the assessment and developed the action plans should determine who within the MOH is ultimately accountable for ensuring action plan implementation, and the process by which the relevant civil society stakeholders, including adolescents, will hold the MOH accountable. In addition, the team should determine the frequency of accountability check-ins on action plan implementation, how successes will be shared, and how frequently the adolescent- and gender-responsive health systems assessment should be done to track progress. In the pilot for this tool, subnational health system managers found that quarterly check-ins were useful for ensuring the progress of action plan implementation. In addition, the subnational health system managers felt the responsive systems assessment could be done annually to track progress and prioritize new areas for improvement.

ASSESSMENT TOOL

Parameters of the assessment:
Are you assessing the health system at the national or subnational level? What geography?

_____

_____

Are you assessing the public or private sectors or both?

_____

_____

PARTICIPANTS IN THE ASSESSMENT:

List all members of the participatory assessment workshop

Name	Affiliation and role	Contact information

BUILDING BLOCK 1: LEADERSHIP AND GOVERNANCE

Feature	Benchmarks				Score and notes
	0	1	2	3	
1.1 Adolescent engagement: Adolescents are engaged in national health policymaking, budget allocations, and accountability processes.	There are no mechanisms for adolescent engagement at the national level.	National health policymakers engage adolescents inconsistently in policymaking, budget decisions, and/or accountability processes.	National health policymakers engage adolescents consistently in policymaking, budget decisions, and/or accountability processes, but only some genders and subgroups of adolescents are represented.	Diverse adolescents are consistently engaged in national health policymaking, budget decisions, and accountability processes.	
1.2 Adolescent engagement: Adolescents are engaged in subnational health policymaking, budget allocations, and accountability processes.	There are no mechanisms for adolescent engagement at the subnational level.	Subnational health policy and budget decision-makers engage adolescents inconsistently in policymaking, budget decisions, and/or accountability processes.	Subnational policy and budget decision-makers consistently engage adolescent in policymaking, budget decisions, and/or accountability processes, but only some genders and subgroups are represented.	Diverse adolescents are consistently engaged in subnational policymaking, budget decisions, and accountability processes.	
1.3 Accountability: Adolescents lead accountability mechanisms to hold the health system accountable for quality services at the facility level (e.g., adolescents in health facility committees, community score cards, etc).	There are no adolescents engaged or leading accountability mechanisms at the facility level.	Adolescents are only occasionally engaged, and are not leading, accountability mechanisms at the facility level.	Adolescents are leading accountability mechanisms, but only some gender and subgroups are represented.	Diverse adolescents are consistently leading accountability mechanisms at the facility level.	

Feature	Benchmarks				Score and notes
	0	1	2	3	
1.4 Policy: **There is a national policy specifically addressing adolescent health.**	There is no national adolescent health policy.	There is a national policy, but it does not address all areas of adolescent health (e.g., it only addresses SRH or does not include nutrition).	There is a national policy and it addresses most areas of adolescent health.	There is a national policy that addresses most areas of adolescent health. Most providers are aware of the policy and it is usually implemented.	
1.5 Governance: **There is at least one designated full-time person for the national adolescent health program, and at least one focal point for adolescent health in each subnational unit (e.g., district or province).**	There are no full-time national or subnational focal points for adolescent health.	There is at least one national full-time person for adolescent health, but no subnational focal point.	There are both national and subnational focal points for adolescent health in some subnational units.	There is a full-time national person, and subnational focal points in nearly all subnational units.	
1.6 Policy: **Health policies do not include any parental/ guardian or spousal consent for counseling and advice services.**[b]	Health policies require parent/guardian or spousal consent for counseling and advice services.	Health policies are not clear on when parent/guardian or spousal consent is needed or not for adolescents to seek counseling and advice services.	Health policies guarantee the rights of adolescents to seek counseling and advice without parent/guardian or spousal consent. But, most adolescents and providers are not aware of and/or do not follow the policy.	Health policies guarantee the rights of adolescents of all ages to seek counseling and advice without parent/guardian or spousal consent, and most adolescents and providers are aware of and follow the policy.	

[b] This guidance is aligned with the AA-HA!. More details can be found on page 94 of the AA-HA! Guidance to Support Country Implementation Global Accelerated Action for the Health of Adolescents (AA-HA!) (who.int)

Feature	Benchmarks				Score and notes
	0	1	2	3	
1.7 Policy: **Health policies allow for adolescents to make informed decisions and consent for their own medical services or treatment based on careful understanding of their maturity and context.**[c]	Health policies require parent/guardian and/or spousal consent for all medical services or treatment for adolescents.	Health policies are not clear on when parent/guardian or spousal consent is needed or not for adolescents to seek medical services or treatment.	Health policies have an age above which adolescents may give consent for medical services that is lower than age 18, but do not include flexibility for health providers to determine if adolescents younger than this age have the maturity to consent to services or treatment in their context.	Health policies have an age above which adolescents may give consent for medical services that is lower than age 18, and the policy includes flexibility for health care workers to determine if adolescents younger than this age have the maturity to consent in their context.	
1.8 Policy: **Health policies do not restrict access to health services for adolescents based on marital status or parity.**	Law or policy restricts some services due to marital status and/or parity.	Law or policy does not mention (neither affirming nor denying) access to services based on marital status or parity.	Law or policy explicitly affirms adolescents' access to services regardless of marital status or parity, but most adolescents and providers are not aware of and/or do not follow the policy.	Law or policy explicitly affirms adolescents' access to services regardless of marital status or parity, and most adolescents and providers are aware of and follow the policy.	

[c] WHO has published guidance on assessing and supporting adolescents' capacity for autonomous decision-making in health care settings for health care providers, available at 9789240039568-eng.pdf (who.int). The document articulates the rationale for this as well as the steps that health care providers should use in making this determination.

Feature	Benchmarks				Score and notes
	0	1	2	3	
1.9 Service package: **The MOH has outlined a package of services for adolescents at each level of care, and this package aligns with global standards, inclusive of violence and injury prevention, nutrition, physical activity, SRH, maternal health, mental health, integrated management of common conditions, substance use, and immunization (see Annex 2).[d]**	No package of services for adolescents exists.	A national package of services exists but does not align with global standards and/or does not define services at each level of care.	The national package of services for adolescents aligns with global standards and defines services for each level of care, but is not usually implemented at each level of care.	A national package of services exists and is usually implemented and available at each level of care.	
1.10 Standards: **National standards for delivery of health services for adolescents exist—either as standalone standards or integrated into other health service delivery standards—and are in line with WHO guidance.[e]**	There are no national standards for health services for adolescents.	There are national standards, but they do not align with WHO guidance.	National standards exist and align with WHO guidance.	National standards align with WHO guidance, and systems to monitor implementation of standards are in place.	

[d] See Annex 2 for the list of services, which is from the WHO guidelines in Health for the World's Adolescents: A Second Chance in the Second Decade (WHO_FWC_MCA_14.05_eng.pdf;sequence=1).

[e] See WHO recommended quality standards at A guide to implement a standards-driven approach to improve the quality of health care services for adolescents (who.int).

Feature	Benchmarks				Score and notes
	0	1	2	3	
1.11 Coordination: **There are resourced cross-sectoral coordination mechanisms for ministries and partners working to advance adolescent well-being (e.g., with the ministry of education to promote health education and school health services, ministry of gender, or ministry of labor).**	There are no resourced coordination mechanisms among different cross-sectoral actors working with adolescents.	There are ad hoc collaborations between cross-sectoral actors, but no consistent mechanisms and no resources for coordination are available.	There are consistent, resourced mechanisms for cross-ministry collaboration to advance adolescent well-being, with only some ministries and partners collaborating.	There are consistent, resourced mechanisms for cross-ministry collaboration to advance adolescent well-being, with all relevant ministries and partners collaborating.	

BUILDING BLOCK 2: SERVICE DELIVERY [f]

Feature	Benchmarks				Score and notes
	0	1	2	3	
2.1 Service delivery points: Adolescent health services are offered through all service delivery points,[g] including at the community level, in the assessment area.	Adolescent health services are not offered at service delivery points.	Adolescent health services are offered at a few facilities through adolescent-friendly corners or spaces, but not through all service delivery points.[h]	Adolescent health services are offered through most facility-level service delivery points (either integrated or through corners/spaces), but not through community health services.	Adolescent health services are offered at most facility (either integrated or through corners/spaces) and community service delivery points.	
2.2 Adolescent engagement: Adolescents engage in the design and delivery of health services at community and facility levels.	There are no mechanisms for engagement of adolescents in design and delivery of health services.	Health system actors occasionally engage adolescents in the design and delivery of health services, but this is not consistent across facilities and over time.	Health system actors consistently engage adolescents in the design and delivery of services, but only some genders and subgroups are represented.	Health system actors consistently and systematically engage diverse adolescents in design and delivery of health services.	

[f] This assessment tool is not meant to assess whether an individual facility is offering quality services for adolescents. Several tools exist for that (see Appendix 1) and can be used as a complement to this broader system assessment tool.

[g] Service delivery points include public/private sector facilities, mobile/outreach services, community-based/community health worker services, drug shops/pharmacies, digital services, and school and workplace services.

[h] Note that adolescent-friendly services offered through corners or spaces in health facilities are distinct from youth centers, which are recreational centers for youth that may have some services provided. Youth centers are not effective for provision of health services for adolescents and are not a best practice.

Feature	Benchmarks				Score and notes
	0	1	2	3	
2.3 Service delivery points: Comprehensive school health services in line with WHO guidelines are available in the assessment area.[i]	School health services are not offered in the assessment area.	School health services are offered through a few schools in the assessment area, but they are not comprehensive in line with WHO guidelines.	School health services are offered through some schools in the assessment area, but they are not all comprehensive in line with WHO guidelines.	Comprehensive school health services in line with WHO guidelines are offered through most schools in the assessment area.	
2.4 Service delivery points: At least one service delivery point in each catchment area offers adolescent health services during nontraditional hours (after work and school hours and/or on weekends) to be convenient for adolescents.	No service delivery points are open during nontraditional hours.	At least one service delivery point is open per catchment area during nontraditional hours, but only occasionally.	At least one service delivery point per catchment area is open during nontraditional hours, but only on certain days.	At least one service delivery point per catchment area is open during nontraditional hours every day.	
2.5 Service delivery points: Service delivery points ensure visual and auditory privacy for adolescents.	Most facilities do not ensure visual and auditory privacy for adolescents.	Approximately 75% of facilities in the assessment area ensure a minimum of visual privacy (through use of curtains or private spaces).	Approximately 75% of facilities in the assessment area ensure audio and visual privacy.	Nearly all facilities in the assessment area ensure audio and visual privacy.	

[i] See WHO Guideline on School Health Services for more information. School health services are provided by a health worker to students enrolled in primary or secondary education, either within school premises or in a health facility situated outside the school premises that has an official agreement with the school to provide health services to the school's students. Comprehensive student health services should address at least four—but ideally all—health areas relevant to their student population, including: positive health and development; unintentional injury; violence; sexual and reproductive health, including HIV; communicable disease; noncommunicable disease, sensory functions, physical disability, oral health, nutrition and physical activity; and mental health, substance use and self-harm.

Feature	Benchmarks				Score and notes
	0	1	2	3	
2.6: Service delivery points: Service delivery points serving adolescents include case identification, firstline support, and case management (or referral for case management) for gender-based violence (GBV).[j]	No service delivery points offer any GBV services.	Some facilities in the assessment area offer case identification and firstline support for people experiencing GBV, but do not offer case management onsite or through referral.	Some facilities in the assessment area offer case identification and firstline support for people experiencing GBV, and offer case management onsite or through referral.	Nearly all facilities in the assessment area offer case identification and firstline support for people experiencing GBV, and offer case management onsite or through referral.	
2.7 Quality improvement: QI processes include measurable aims for improving quality of adolescent health services.	QI processes do not include anything related to adolescent health.	QI processes mention adolescents, but do not include measurable aims.	Measurable aims for quality adolescent health services are included in QI processes, but are used inconsistently across health facilities.	Measurable aims for quality adolescent health services are included in QI processes, and are routinely used across most health facilities.	
2.8 Quality improvement: QI processes include measurable aims for improving quality of gender-sensitive health services.	QI processes do not include anything related to gender.	QI processes include mention of gender in the standards, but not measurable aims.	Measurable aims for gender-sensitive health services are included in QI processes, but are used inconsistently across health facilities.	Measurable aims for gender-sensitive health services are included in QI processes, and are routinely used in QI strategies across most health facilities.	

j Caring for women subjected to violence: a WHO curriculum for training health-care providers, revised edition, 2021. https://www.who.int/publications/i/item/9789240039803

Feature	Benchmarks				Score and notes
	0	1	2	3	
2.9 Referrals: There is an appropriate[k] referral system in place to support movement of adolescents (and their information) to other health services within and between facilities as well as to non-health services, such as child protection services, legal, education, and economic services.	No functional referral system exists.	A referral system exists to move adolescents between different health facilities and services, but not to non-health services.	A referral system exists to move adolescents between different health and non-health facilities and services, but is not consistently used by health providers.	A referral system exists to both health and non-health services, and is consistently used.	
2.10 Diverse adolescents: Facility and community-based health services are designed to reach diverse and vulnerable adolescent with health services, including adolescents of different ages, genders, disability, and life stages.	Facility- and community-based health services are not designed to intentionally reach any adolescents.	Facility- and community-based health services are designed to reach adolescents, but lack specific strategies to reach diverse and vulnerable adolescents, including adolescents with disabilities.	Some facility - and community-based health services are designed to reach diverse adolescents, including adolescents with disabilities.	Facility- and community-based health services systematically reach adolescents and diverse and vulnerable adolescents, including adolescents with disabilities.	

[k] Referral systems for adolescent should ensure anonymity in any referral cards to avoid stigma or judgment if someone found the card. In addition, referral systems for adolescents should ensure that adolescent can access the services for which they are referred to (they aren't too far, too expensive, or restricted to adolescents) and track closed referrals.

BUILDING BLOCK 3: HEALTH WORKFORCE

Feature	Benchmarks				Score and notes
	0	1	2	3	
3.1 Competencies: **There are national competencies for health workers in adolescent health, and they are included in the national pre-service education curriculum for all cadres.**[l]	There are no national adolescent health competencies for health workers.	There are national adolescent health competencies, but they are not addressed in the national pre-service education curriculum.	There are national adolescent health competencies and they are included in the national pre-service education curriculum for some (but not all) cadres.	There are national adolescent health competencies for health workers, and they are included in the national pre-service education curriculum for all cadres.	
3.2 Competencies: **There are national competencies for health workers in gender-sensitive service delivery, and they are included in the national pre-service education curriculum for all cadres.**[m]	There are no gender-sensitive service delivery competencies for health workers.	There are gender-sensitive competencies, but they are not addressed in the national pre-service education curriculum.	There are gender-sensitive competencies and they are included in the national pre-service education curriculum for some (but not all) cadres.	There are gender-sensitive service delivery competencies for health workers, and they are included in the national pre-service education curriculum for all cadres.	
3.3 Provider values: **Routine trainings, mentorship, or supervision provide systematic opportunities for facility, community, and school-based providers to reflect on their values and change attitudes and behaviors toward adolescents.**	No opportunity for reflection and attitude change.	Ad hoc opportunities for reflection and change in one-off trainings or meetings only.	Systematic opportunities for reflection (as part of supervision, mentorship, routine trainings or meetings) and dialogue for some cadres only.	Routine supervision, mentorship, pre-service, and in-service training all have opportunities for reflection and dialogue for all cadres.	

[l] See WHO's Core competencies in adolescent health and development for primary care providers.

[m] See Jhpiego Gender Service Delivery Standards Tools and Facilitation Guide: https://www.jhpiego.org/wp-content/uploads/2022/01/Gender-Service-Delivery-Standards-web-final.pdf

Feature	Benchmarks				Score and notes
	0	1	2	3	
3.4 Continuous professional education: **There is a continuous professional education system (including in-service training) for providers on adolescent health, including for facility, community, and school health professionals (including nonclinical).**	There is no continuous professional education system for providers on adolescent health.	Continuous education is available, but very few providers have received it.	Only clinical staff receive adolescent health continuous professional education.	All clinical and nonclinical staff and community-based cadres receive adolescent health continuous professional education.	
3.5 Continuous professional education: **There is a continuous professional education system (including in-service training) for providers on gender-sensitive service delivery, including for facility, community, and school health professionals (including nonclinical).**	There is no continuous professional education system for providers on gender-sensitive service delivery.	Continuous education is available, but very few providers have received it.	Only clinical staff receive continuous professional education on gender-sensitive service delivery.	All clinical and nonclinical staff and community-based cadres receive continuous professional education on gender-sensitive service delivery.	
3.6 Supervision: **The competency of health care workers to provide care to adolescents is strengthened during routine supervision for all cadres, including community health workers.[n]**	Adolescent competencies are not included in routine supervision tools.	Adolescent competencies are included in routine supervision tools for some cadres.	Adolescent competencies are included in routine supervision tools as relevant to each cadre.	Adolescent competencies are included in routine supervision tools as relevant to each cadre, and are regularly examined during supervision.	

[n] See WHO's Core competencies in adolescent health and development for primary care providers.

Feature	Benchmarks				Score and notes
	0	1	2	3	
3.7 Supervision: **The competency of health care workers to provide gender-sensitive service delivery is strengthened during routine supervision for all cadres, including community health workers.[o]**	Gender-sensitive service delivery competencies are not included in routine supervision tools.	Gender-sensitive service delivery competencies are included in routine supervision for some cadres.	Gender-sensitive service delivery competencies are included in routine supervision tools as relevant to each cadre.	Gender-sensitive service delivery competencies are included in routine supervision as relevant to each cadre, and are regularly examined during supervision.	
3.8 Health workforce: **Systems and structures are in place to support and encourage adolescents, particularly young women, to enter into the health workforce, including in nontraditional roles.[p]**	No systems or structures are in place.	Ad hoc steps are taken to encourage adolescents, particularly young women, to enter the health workforce.	Systems are in place to support adolescents, particularly young women, to enter the health work force, including in nontraditional roles, but have not yet demonstrated success.	Systems are in place to support adolescents, particularly young women, to enter the health work force, including in nontraditional roles, and are demonstrating success.	

[o] See Jhpiego's Gender Service Delivery Standards Tools and Facilitation Guide at https://www.jhpiego.org/wp-content/uploads/2022/01/Gender-Service-Delivery-Standards-web-final.pdf

[p] Examples of strategies include: intentional mentorship, flexible hours, family-friendly policies, reporting mechanisms for discrimination. Please see the evidence synthesis in Youth and Decent Work in the Health and Social Care Sector by the Youth Hub of the Global Health Workforce Network.

BUILDING BLOCK 4: HEALTH INFORMATION

Feature	Benchmarks				Score and notes
	0	1	2	3	
4.1 Data collection: **The health system collects and reports age-disaggregated data for key health service use indicators[q] at community, facility, subnational, and national levels in five-year age groups (i.e., 10–14, 15–19, and 20–24).**	No key indicators are age-disaggregated at subnational and national levels.	Some key indicators are age-disaggregated at subnational and national levels, but not in the recommended five-year age groups.	Most key indicators are age-disaggregated at subnational and national levels in five-year age groups.	All of the key indicators are age-disaggregated at subnational and national levels in five-year age groups.	
4.2 Data collection: **The health system collects and reports sex-disaggregated data at facility, subnational, and national levels.**	No indicators are sex-disaggregated at subnational and national levels.	Some indicators are sex-disaggregated at subnational and national levels.	Most indicators are sex-disaggregated at subnational and national levels.	Most indicators are sex-disaggregated at subnational and national level and include an option for "other."	
4.3 Data use: **Health system managers at facility, subnational, national levels systematically analyze and use sex- and age-disaggregated health service data to adapt service delivery strategies and improve quality and equity.**	There are no systematic processes by which the health system uses data to improve quality and equity.	Most facilities systematically use sex- and age-disaggregated data to improve quality and equity, but data is not analyzed by sex and age at subnational and national levels.	Most facilities and subnational units systematically use sex- and age-disaggregated data to improve quality and equity, but the national-level units do not.	Facility, subnational, and national levels systematically use sex- and age-disaggregated data to improve quality and equity.	

[q] Examples of key indicators include (1) Contraception first time user, (2) Percentage of postpartum women delivering in a facility initiating a contraceptive method before discharge, (3) Percentage of antenatal clients with first visit before 12 weeks, (4) Percentage of deliveries in health facilities by caesarean section, (5) Number of women who die in the health facility either while pregnant or within the first 42 days of the end of pregnancy, (6) Percentage of pregnant women who receive iron and folic acid supplementation during an antenatal care (ANC) visit, (7) Proportion of women who are counseled on nutrition during ANC visits or family planning counseling. Drawn from World Health Organization's Analysis and Use of Health Facility Data: Guidance for RMNCAH Programme Managers.

Feature	Benchmarks				Score and notes
	0	1	2	3	
4.4 Data use: **Health system managers use other data about adolescents (e.g., from population-based surveys or health facility assessments) to inform decision-making, resource allocation, and priority setting within the health system.**	Decision-makers at the facility, district, regional, or national levels do not use adolescent data from other sources.	Health system managers at all levels rarely use adolescent data from other sources for decision-making.	health system managers at some levels sometimes use adolescent data from other sources.	Managers at all levels of the health system regularly use adolescent data from others sources to inform decision-making.	
4.5 Data use: **Health system managers use other data about gender (e.g., from population-based surveys or health facility assessments) to inform decision-making, resource allocation, and priority setting within the health system.**	Decision-makers at the facility, district, regional, and national levels do not use gender data from other sources.	Health system managers at all levels rarely use gender data from other sources for decision-making.	Health system managers at some levels sometimes use gender data from other sources to inform decision-making.	Managers at all levels of the health system regularly use gender data from others sources to inform decision-making.	
4.6 Data confidentiality: **All adolescent data and information disclosed during counseling or service provision, including digital services, are maintained in a way that ensures confidentiality, including from parents/guardians. The conditions under which data must be disclosed are clear.**	Adolescent data are not maintained with any confidentiality.	Adolescent data are sometimes maintained with confidentiality, but it is not clear to adolescents or providers when data and information must be disclosed.	There are clear standard operating procedures for situations when adolescent data may be shared with other providers or other people due to legal requirements, and providers are aware of these.	There are clear standard operating procedures for situations when adolescent data may be shared with other providers or other people due to legal requirements, and both providers and adolescents are aware of these.	

BUILDING BLOCK 5: ESSENTIAL COMMODITIES AND TECHNOLOGY

Feature	Benchmarks				Score and notes
	0	1	2	3	
5.1 Commodity restrictions: **There are no policy restrictions on adolescent access to all commodities including through self-care, regardless of marital status, parity, gender, or age.**	Policies restrict adolescent access to key commodities (for example, long-acting reversible contraception or self-injection of DMPA) on the basis of age, marital status, gender, or parity.	Policies do not mention (neither confirming nor denying) access to commodities based on age, marital status, gender, or parity.	Policies affirm that adolescents may access and use all commodities (in accordance with medical eligibility) without restriction, but some providers or facilities are not aware of this policy and impose restrictions.	Policies affirm that adolescents may access and use all commodities (in accordance with medical eligibility) without restriction and providers are aware of and adhere to policy.	
5.2 Commodity forecasting: **The commodity forecasting system uses age-disaggregated data to ensure sufficient products are available to meet adolescent needs and preferences.**	Commodity forecasting does not use age-disaggregated data, and adolescents often encounter stock-outs.	Commodity forecasting does not use age-disaggregated data, but adolescents rarely encounter stock-outs.	Commodity forecasting does use age-disaggregated data, but adolescents often encounter stock-outs.	Commodity forecasting does use age-disaggregated data and adolescents rarely encounter stock-outs.	

BUILDING BLOCK 6: FINANCING

Feature	Benchmarks				Score and notes
	0	1	2	3	
6.1 Cost of services: **Services for adolescents do not require any formal or informal out-of-pocket payment.**	Adolescents have to make informal and/or formal out-of-pocket payments for all health services at public and private facilities.	Adolescents do not have to make formal or informal out-of-pocket payments for some key services in the public and private sector, but other services require informal or formal out-of-pocket payments (e.g., purchasing medical supplies before receiving care, bribes).	Adolescents do not have to make formal or informal out-of-pocket payments for any services in the public sector, and services are offered on a sliding scale in the private sector.	Adolescents do not have to make any formal or informal out-of-pocket payments for any services in both the public and private sector (all services for adolescents are free).	
6.2 Insurance: **Adolescents are eligible for financial pooling arrangements, for example, an explicit public insurance program or access to facilities that are financed by prepaid pooled funds.**	There are no insurance or other financial pool arrangements available to adolescents.	Few adolescents are eligible for a financial pooling arrangement.	Adolescents who live with their parents are eligible for a financial pooling arrangement.	All adolescents are eligible for a financial pooling arrangement.	
6.3 Demand-side financing: **Demand-side financing mechanisms, such as vouchers, explicitly include adolescent health services and are available to adolescents.**	Demand-side financing mechanisms are not available to adolescents and do not include adolescent health services.	Demand-side financing mechanisms are not explicitly reaching adolescents and do not explicitly include adolescent health services, but adolescents could use them.	Demand-side financing mechanisms do include adolescent health services, but are not explicitly reaching adolescents.	Demand-side financing mechanisms are explicitly reaching adolescents and include adolescent health services.	

Feature	Benchmarks				Score and notes
	0	1	2	3	
6.4 Supply-side financing: **Supply-side financing mechanisms, such as performance-based financing, explicitly include adolescent health metrics as part of the performance measures.**	Performance-based financing approaches do not include any metrics relevant to adolescents.	Performance-based financing approaches include indicators that are relevant to adolescent, but no explicit adolescent health metrics.	n/a	Performance-based financing approaches explicitly include adolescent health metrics.	
6.5 Adolescent health resource allocation: **There are national and subnational budget allocations to adolescent health.**	There are no budget allocations to adolescent health.	There is national or subnational budget allocation to adolescent health, but not both.	There are national and subnational budget allocations to adolescent health, but it is not funded at a level that is proportionate to the size of the adolescent population.	There are national and subnational budget allocations to adolescent health, and it is funded at a level that is proportionate to the size of the adolescent population.	

BUILDING BLOCK 7: COMMUNITY

Feature	Benchmarks				Score and notes
	0	1	2	3	
7.1 Adolescent knowledge and assets, family, and community support: **There are partnerships between the health system and community and youth-led interventions to improve adolescent health knowledge, gender-equitable attitudes and norms, and behaviors, as well as parent and community support for adolescent health.**	There are no partnerships.	There are ad hoc partnerships that are not consistent.	There are systematic partnerships, but health system actors are not engaged in the programming.	There are systematic partnerships. Health system actors engage in the programs, and referral mechanisms between the program and health facility are clear.	Please note the type of activities being implemented through the partnership.
7.2 School partnerships: **The health system has partnerships with primary and secondary schools for referral, onsite services, nutrition, collaboration on comprehensive sexuality education, and/or as part of health-promoting schools.**[r]	There are no partnerships between the health system and primary and secondary schools.	The health system has occasional, but not systematic, partnerships with primary and secondary schools.	The health system has systematic partnerships with primary and secondary schools for one purpose (e.g., only referrals), but not other purposes.	The health system and primary and secondary schools have systematic partnerships for referrals and at least one other activity, which may include health-promoting schools, on-campus provision of health and nutrition services, and comprehensive sexuality education.	Please note the type of activities being implemented through the partnership.

[r] See WHO Making Every School a Health-Promoting School for more information, and Annex 3 for definitions.

Feature	Benchmarks				Score and notes
	0	1	2	3	
7.3 School partnerships: **The health system has partnerships with tertiary and/or other educational institutions (e.g., technical or vocational training institutes) for referral, onsite services, nutrition, collaboration on comprehensive sexuality education, and/or as part of health-promoting schools.[s]**	There are no partnerships between the health system and tertiary and other educational institutions.	The health system has occasional, but not systematic, partnerships with tertiary and other educational institutions.	The health system has systematic partnerships with tertiary and other educational institutions for one purpose (e.g., only referrals), but not other purposes.	The health system and tertiary and other educational institutions have systematic partnerships for referrals and at least one other activity, which may include health-promoting schools, on-campus provision of health and nutrition services, and comprehensive sexuality education.	Please note the type of activities being implemented through the partnership.
7.4 Multisectoral partnerships: **The health system has coordination mechanisms with non-health programs that benefit adolescents, such as economic development and civic engagement and leadership programs.[t]**	There is no explicit coordination mechanism between the health system and other sector programs that benefit adolescents.	There is ad hoc coordination between the health system and other sector programs that benefit adolescents.	There is systematic coordination between the health system and only one other sector program that benefits adolescents.	There is systematic coordination between the health system and more than one other sector program that benefits adolescents.	

[s] See WHO Making Every School a Health-Promoting School for more information, and Annex 3 for definitions.

[t] Coordination mechanisms could include joint programming, referrals between health and non-health services for adolescents, and multi-ministry/multisectoral coordination committees for adolescent development.

PRIORITIZATION AND ACTION PLANNING

After completing the responsive system assessment, the MOH, adolescents, and other stakeholders who conducted the assessment will need to prioritize which actions to take to improve the responsiveness of the health system to the needs and rights of adolescents.

Each assessment team will prioritize differently based on the unique country context. For the action plan to be feasible, we recommend only selecting one to four priority actions as a result of the assessment. This section includes guiding questions to support prioritization as well as two templates for action planning. Annex 1 includes a matrix of resources for strengthening the key aspects of the system that can be used to support the prioritized actions. For example, if the assessment team prioritizes strengthening an adolescent-competent workforce, they can find WHO's resources on core competencies in adolescent health and provider pre-service education materials in Annex 1. As described in the instructions for using this tool, the team should determine the frequency with which they will follow up on the action plans to ensure completion and the frequency with which they will repeat the responsive systems assessment to track progress and identify new priority areas. In the pilot for this tool, the subnational health system planned quarterly monitoring meetings and aims to repeat the system assessment annually.

GUIDING QUESTIONS FOR PRIORITIZATION:

- Given the final assessment scores, would the team like to prioritize the features scoring the lowest or those scoring 1 or 2 and needing improvement to 3?
- Which features, if improved, would have meaningful impact on the key barriers to services for adolescents in your context?
- What do adolescents suggest would be most urgent and important to prioritize to immediately meet their health needs?
  - Are there different priorities for different subpopulations of adolescents—for example, very young adolescents, older adolescents, married adolescents, first-time adolescent parents—and for adolescents of different genders?
  - Which subpopulation is a top priority given current health needs and context?
- Who will be the primary actors working to strengthen the system as a result of this assessment? At what level do they work—national, subnational, or facility? What are their strengths and expertise? Are there building blocks where they have more influence and more chances to improve?
- What financial and human resources are available to strengthen the responsiveness of the system? Which building blocks/features does the team have the ability to change and impact with limited additional resources?
- What timeframe is available for the primary actors to make these system improvements?
- Are there "quick wins," that is, any areas that can easily be addressed with limited resources that can have a positive impact or build momentum for further change?

ACTION PLANNING

We recommend a two-step prioritization and action-planning process. First, the MOH and relevant stakeholders should determine the priority features to improve using the prioritization considerations above. Teams may choose one or more priorities, but should limit priorities to what is feasible (roughly one to four action items).

FILL IN THE PRIORITIES MATRIX (TABLE 1) WITH THE FOLLOWING:

- The building block that you will strengthen.
- The feature of the building block that you will strengthen.
- The current score (0–3) that the assessment team gave to that feature.
- A short narrative description of the current status of that feature.
- A short description of the improvements you want to achieve. We recommend selecting the next benchmark for the particular feature. For example, if the feature selected is currently scoring zero, you could select the benchmark for score 1 or 2 as a realistic future state.
- Determine where change is needed. Is it at the national, subnational, health facility, or community level?
- What group or individual is responsible for driving the improvements forward? This might be a unit or focal point in the MOH, an international NGO or local NGO partner, a team within a partner organization, or another health system actor.
- Timeline available to make the desired improvement in the prioritized feature.
- A description of the budget implications of this work, for example, is sufficient budget available, will additional funding be needed, and are there major costs to the system?
- The key next steps. For nearly all priorities, the next step will be for the responsible party to work with key stakeholders to develop a detailed implementation plan using Table 2.

Then, the team responsible for each priority in Table 1 should develop a detailed implementation plan using Table 2. Each priority should have its own detailed implementation plan.

TABLE 1: PRIORITY MATRIX

Building block	Feature to improve	Current score (0–3)	Description of current status of the feature	What is the end state (goal) that you hope for with this feature over the long term? (Use Table 2 to fill in short-term steps)	Responsible group or individual	Timeline	Budget implications	Next step
1.								
2.								
3.								
4.								

TABLE 2: DETAILED IMPLEMENTATION PLAN FOR EACH PRIORITY

Building block: _____

Feature to improve: _____

What end state/goal do you want to see in this feature (i.e., the measure of success)?_____

Responsible group or individual:_____

PLEASE FILL IN THE DETAILED ACTION STEPS TO TAKE TO MAKE PROGRESS ON THIS FEATURE:

Action step	Timeline (start to finish)	Individual responsible	Who will help the individual responsible?	What key actors need to be engaged to implement the action step?	Who is the final decision-maker for this action step?	Budget

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ANNEX 1: RELEVANT RESOURCES FOR STRENGTHENING RESPONSIVENESS OF THE HEALTH SYSTEM

Resource	Organization	Link
Overarching tools and resource banks		
Adolescent Health Resource Bank	World Health Organization	https://www.who.int/teams/maternal-newborn-child-adolescent-health-and-ageing/adolescent-and-young-adult-health/resource-bank-for-adolescent-health
Adolescent and Youth Sexual and Reproductive Health Toolkit	The Challenge Initiative	https://tciurbanhealth.org/adolescent-youth-sexual-reproductive-health-toolkit/
Positive Youth Development Framework	USAID	https://www.youthpower.org/positive-youth-development
Health facility assessment tools		
Adolescent-Friendly Services Quality Assessment Guidebook	World Health Organization	https://www.who.int/publications/i/item/9789241598859
Health Policy Project Tools for Assessing Gender in Health Policies and Programs	Health Policy Project	https://www.healthpolicyproject.com/pubs/121_ToolsforAssessingGenderinHealthPolicFINAL.pdf
Youth-friendly Services Assessment Tool	Pathfinder International	https://www.pathfinder.org/publications/clinic-assessment-youth-friendly-services-tool/
Youth-friendly Services Certification Tool	Pathfinder International	https://www.pathfinder.org/publications/certification-tool-youth-friendly-services/

Resource	Organization	Link
Building block: Leadership and governance		
Global Accelerated Action for the Health of Adolescents (AA-HA!)	World Health Organization	https://www.who.int/publications/i/item/global-accelerated-action-for-the-health-of-adolescents-(-aa-ha!)-guidance-to-support-country-implementation
Adolescent Health: The Missing Population in Universal Health Coverage	WHO, UNICEF, PLAN, International Association of Adolescent Health, Child Health Initiative, PMNCH	https://www.childhealthinitiative.org/media/708305/adolescent_health_missing_population_in_uhc_final_may_2019.pdf
Youth Family Planning Policy Scorecard	Population Reference Bureau	https://scorecard.prb.org/youthfpscorecard/en/
The Power of Youth Voices: How Youth Are Holding Their Health Systems Accountable for Family Planning and Reproductive Health	MOMENTUM Country and Global Leadership	https://usaidmomentum.org/wp-content/uploads/2021/01/MCGL-Youth-Social-Accountability-Landscape_Final.pdf
A Guide to Using Community Score Cards for Youth-Led Social Accountability	Get Up, Speak Out for Youth Rights! Project	https://www.ippf.org/sites/default/files/2021-03/Youth%20Led%20Social%20Accountability%20Manual%20-%20IPPF%20-%20v2_0.pdf
Partnership Defined Quality for Youth	Save the Children	https://www.savethechildren.org/content/dam/global/reports/health-and-nutrition/pdq-y-manual.pdf
NOT WITHOUT US! **A Tool for AYRH-Responsive Planning**	Evidence to Action Project	https://tarp.e2aproject.org/
Quality and Standards Framework for Human-Centered Design	HCD Exchange and YLabs	https://static1.squarespace.com/static/5ea7b2cd859d291f18d9dfb9/t/61f03012ba2f52580654366a/1643130917634/HCD+Exchange+QSWG_Framework_JAN2022.pdf

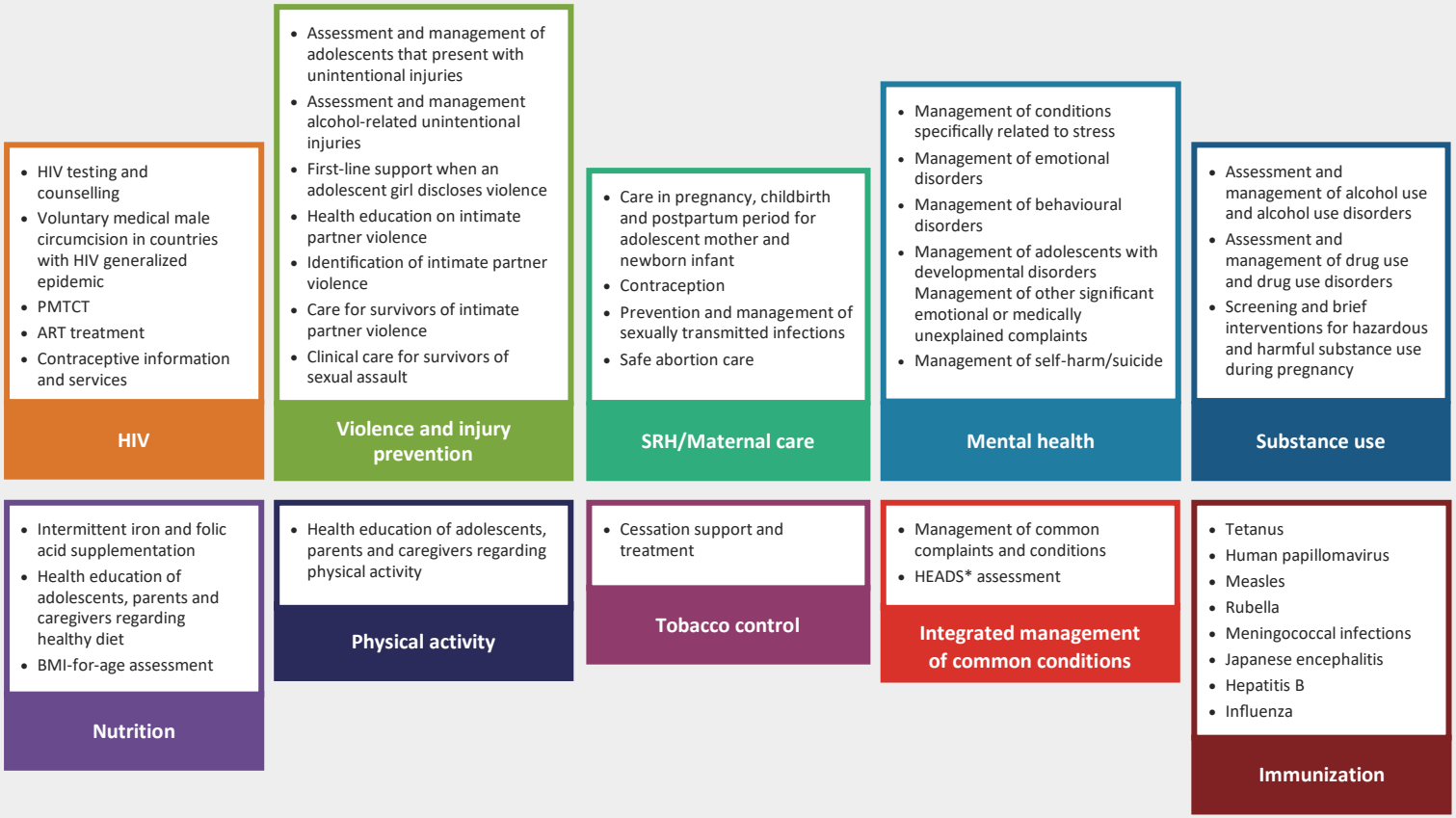
Resource	Organization	Link
Building block: Service delivery		
Global Standards for Quality Health-Care Services for Adolescents	World Health Organization and UNAIDS	Volume 1: https://www.who.int/publications/i/item/9789241549332 Volume 2 Implementation guide: http://apps.who.int/iris/bitstream/handle/10665/183935/9789241549332_vol2_eng.pdf;jsessionid=4E0103B6DE00F68C7AA1C45A307C74B7?sequence=4 Volume 3 Tools to conduct quality and coverage measurement surveys to collect data about compliance with the global standards: http://apps.who.int/iris/bitstream/handle/10665/183935/9789241549332_vol3_eng.pdf?sequence=5 Volume 4 Scoring sheets for data analysis: http://apps.who.int/iris/bitstream/handle/10665/183935/9789241549332_vol4_eng.pdf?sequence=6
Gender-Sensitive Service Delivery Standards	Jhpiego	https://www.jhpiego.org/wp-content/uploads/2022/01/Gender-Service-Delivery-Standards-web-final.pdf
Digital Quality Improvement System for Adolescent Health	World Health Organization	https://www.who.int/news/item/04-01-2015-a-web-platform-to-monitor-global-standards-for-quality-of-health-care-services-for-adolescents
Adolescent Health Job Aid	World Health Organization	https://apps.who.int/iris/handle/10665/44387
Assessing and Supporting Adolescents' Capacity for Autonomous Decision-Making in Health-care Settings: A Tool for Health-care Providers	World Health Organization	https://apps.who.int/iris/bitstream/handle/10665/350208/9789240039568-eng.pdf?sequence=1&isAllowed=y
How to plan and conduct telehealth consultations with children and adolescents and their families	World Health Organization	https://www.who.int/publications/i/item/9789240038073
Guideline on School Health Services	World Health Organization	https://www.who.int/publications/i/item/9789240029392

Resource	Organization	Link
Adolescent Age & Life-Stage Assessment Tools and Counseling Cards	Maternal and Child Survival Program	https://www.mcsprogram.org/resource/adolescent-age-life-stage-assessment-tools-counseling-cards-2/
Guideline: Implementing effective actions for improving adolescent nutrition	World Health Organization	https://apps.who.int/iris/handle/10665/260297
Building block: Health workforce		
Adolescent competencies for providers	World Health Organization	https://apps.who.int/iris/bitstream/handle/10665/148354/9789241508315_eng.pdf?sequence=1
Orientation programme on adolescent health for health-care providers	World Health Organization	https://www.who.int/publications/i/item/9241591269
Adolescent Competencies for Family Planning Service Providers	HRH2030	https://hrh2030program.org/adolescent-competencies-brief/
Gender Competencies for Family Planning Service Providers	HRH2030	https://hrh2030program.org/gender-competency-tech-brief/
Gender transformative supportive supervision framework	USAID	https://msh.org/resources/gender-transformative-supportive-supervision-framework-and-technical-brief/
The Training Resource Package for Pre-Service Education in Family Planning and Adolescent and Youth Sexual and Reproductive Health	Evidence to Action Project	https://www.pathfinder.org/the-trp-in-fp-and-aysrh/
Gender Transformation for Health: A Participatory Toolkit	Jhpiego	https://www.jhpiego.org/wp-content/uploads/2022/03/Gender-Transformation-for-Health-Full-Manual.pdf

Resource	Organization	Link
Building block: Health information		
Proposed indicators for global adolescent health measurement by the Global Action for Measurement of Adolescent Health (GAMA) advisory Group	World Health Organization	https://www.who.int/docs/default-source/mca-documents/advisory-groups/gama/gama-list-of-indicators-draft-2-v20201020.pdf?sfvrsn=f6d00176_6
Analysis and use of health facility data: guidance for RMNCAH [reproductive maternal, newborn, child, and adolescent health] programme managers	World Health Organization	https://www.who.int/publications/m/item/analysis-and-use-of-health-facility-data-guidance-for-rmncah-programme-managers
Guidance for community health worker strategic information and service monitoring	UNICEF, World Health Organization, Global Fund, UN Women, and Gavi	https://www.healthdatacollaborative.org/fileadmin/uploads/hdc/Documents/Working_Groups/Community_Data/210305_UNICEF_CHW_Guidance_EN.pdf
Building block: Essential medicines/commodities		
Reproductive Health Supplies Coalition Youth Caucus Key Messages	Reproductive Health Supplies Coalition	https://www.rhsupplies.org/activities-resources/groups/youth-caucus/
Building block: Financing		
Financing for Results to Improve Adolescent Sexual and Reproductive Health and Wellbeing: Entry Points for Action	Global Financing Facility	https://www.globalfinancingfacility.org/sites/gff_new/files/GFF-Financing-results-improve-ASRHR_0.pdf

Resource	Organization	Link
Building block: Community		
Beyond the building blocks: integrating community roles into the health systems frameworks to achieve health for all	Publication in *BMJ Global Health*	https://gh.bmj.com/content/3/Suppl_3/e001384
Toolkits for adolescent SBC [social and behavior change], and community-based age and life-stage tailored programs (for very young adolescents and first-time parents)	Save the Children, Pathfinder International, The Challenge Initiative, KSuccess	https://tciurbanhealth.org/courses/adolescent-youth-sexual-reproductive-health-toolkit-demand-generation/lessons/social-behavior-change-for-youth-srh/ https://toolkits.knowledgesuccess.org/toolkits/meeting-ftp-needs https://toolkits.knowledgesuccess.org/toolkits/very-young-adolescent-sexual-and-reproductive-health-clearinghouse
Social Norms Exploration Tool	Passages	https://www.alignplatform.org/resources/social-norms-exploration-tool-snet
Youth Programming Assessment Tool (for youth-serving civil society organizations)	FHI360	https://ypat.fhi360.org/
Making Every School a Health-Promoting School	World Health Organization	Global standards and indicators: https://www.who.int/publications/i/item/9789240025059 Implementation guidance: https://www.who.int/publications/i/item/9789240025073 Country case studies: https://www.who.int/publications/i/item/9789240025431
Prioritization and action planning		
SMART advocacy toolkit	Jhpiego	This advocacy toolkit was developed for family planning services, but is appropriate for advocacy within any part of the health system. https://www.advancefamilyplanning.org/advocacy-portfolio

ANNEX 2: HEALTH SERVICES AND INTERVENTIONS ADDRESSED IN WHO GUIDELINES



Source: Reproduced from *Health for the World's Adolescents: A second chance in the second decade*, World Health Organization, page 9, Figure 4, Copyright (2014). Accessed September 27, WHO_FWC_MCA_14.05_eng.pdf.

ANNEX 3: KEY CONCEPTS AND DEFINITIONS

Throughout this document, several terms and concepts are referenced, and are defined as follows.

Concept	Definition
Adolescent age/life-stage tailored	Adolescent health approaches need to be systematically tailored to address the needs of diverse adolescents, which may include special attention to: • Age ranges of 10–14 and 15–19 • Partnership/marital status (single, with a boyfriend or girlfriend, married/in-union) • Parenthood status (not pregnant or parenting, pregnant, with one or more children)
Comprehensive sexuality education	A curriculum-based process of teaching and learning about the cognitive, emotional, physical, and social aspects of sexuality that aims to equip children and adolescents with knowledge, skills, attitudes, and values that will empower them to realize their health, well-being, and dignity; develop respectful social and sexual relationships; consider how their choices affect their own well-being and that of others; and understand and ensure the protection of their rights throughout their lives.[u]
Gender sensitive	Approaches that take into account the impact of policies, projects, and programs on men, women, boys, and girls and try to mitigate the negative consequences thereof.
Gender transformative	Approaches that create opportunities for individuals to actively challenge gender norms, promote positions of social and political influence for women in communities, and address power inequities between persons of different genders.
Health-promoting school	A school that consistently strengthens itself as a safe, healthy setting for teaching, learning, and working.
Intersectionality	The interconnected nature of an individual's membership in multiple social groups (i.e., social categorizations of age, gender identity, disability, geographic location, ethnicity, race, social class, wealth status), which may create overlapping systems of disadvantage and vulnerability for some adolescents.
Positive assets	Assets are the resources, skills, and competencies that young people need to grow up into healthy, caring, and responsible adults. Assets can include body literacy and knowledge, positive values, positive self-identify, commitment to learning, and self-control.
Service delivery point (SDP)	Any location at which health services may be provided to adolescents. An SDP can be a public, private, or nongovernmental facility at the primary, secondary, or tertiary level; community-based such as outreach services or a community health worker; or a pharmacy or drug shop.

[u] UNESCO. International Technical Guidance on Sexuality Education: An Evidence-Informed Approach. Geneva; 2018. http://unesdoc.unesco.org/images/0026/002607/260770e.pdf.

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