



**UNFPA Submission to the
Independent Accountability Panel (IAP)
Call for Evidence and Contributions
For the 2017 IAP Report:
Accountability to Adolescents' Health and Human Rights**

**Progress and Challenges on the Every Woman Every Child (EWEC)
Commitments on Adolescents**

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Sexual and Reproductive Health Branch**

I. INTRODUCTION

The global development community has galvanized around adolescents' health and rights. The United Nations Secretary-General's updated *Global Strategy for Women's, Children's and Adolescent's Health (2016-2030)* has made adolescent health a new focus area, in light of the increasing recognition that promoting adolescents' health and well-being is not only important in itself, but also essential for creating healthier, more sustainable societies. Growing evidence and research have pointed to the great public health, economic and demographic benefits to be reaped when investments in adolescent health are made. Current and future generations of adolescent will thrive.

Since the revised Strategy was launched in 2015, over thirty national governments have made political commitments aimed to promote the health and well-being of adolescents in their countries. These political commitments represent a growing movement by governments and stakeholders to prioritize adolescent health through policy shifts and more robust programmes. Crucially, the commitments also provide a public basis for national constituents, particularly young people, to track and hold their governments to account for more intensified policy attention and action to their health and well-being.

This UNFPA submission to the International Accountability Panel (IAP) examines the extent to which these national governments have in place new or existing accountability mechanisms or platforms to monitor progress and challenges for carrying forward their political commitments to adolescents.

II. SURVEY AND METHODOLOGY

In May 2017, UNFPA reached out to twenty-eight of its field offices in low- and middle-income countries that were identified to have made an adolescent-related commitment for the *Every Woman Every Child (EWEC) movement*. These country offices were asked to respond to a short survey and describe the progress to date by national counterparts in fulfilling these commitments.¹ In consultation with the IAP Secretariat on the suggested lines of inquiry, the survey covered the following issues:

- The priority adolescent health areas highlighted within the EWEC political commitments;
- The existence of new or ongoing policies or large-scale programmes that address the adolescent priorities, and the available financial resources (if known) for these programmes²;
- Follow-up actions since the commitments were announced in September 2015 or afterwards, in particular policy and programmatic actions planned or underway;
- The existence of any specific accountability components or mechanisms embedded in such programmes and plans (e.g., through a monitoring and participatory review process toward fulfilling the EWEC commitment); and
- The range of stakeholders involved in developing and monitoring the adolescent-related components of the commitment.

Importantly, the survey did not ask about the types of strategies and interventions proposed or employed in the national plan or programme, and whether they are aligned with evidence-based practices. Nor did

¹ See Annex 1 for the survey completed by UNFPA country offices for the IAP Call for Evidence.

the survey cover issues of disaggregated data to inform and shape programmatic interventions. Disseminating strategic information that capitalizes on disaggregated data and available evidence would strengthen awareness of adolescents' situation and thereby provide a basis for monitoring change and promoting accountability. While these issues are key for the successful implementation of a robust national plan or programme addressing adolescent health, they were outside the purview of this analysis which aimed to focus on accountability mechanisms.

Eighteen out of twenty-eight UNFPA country offices responded to the internal survey (a response rate of 64 per cent). The geographic coverage spanned a few continents, with responses primarily from the Asia and Pacific region, Eastern and Southern Africa region, Latin America and the Caribbean, and the Western and Central Africa region.³

III. CORE FINDINGS

The following section describes core findings from the UNFPA country office survey for the IAP. These findings are clustered in two sub-sections: (1) the nature of the EWEC adolescent commitments and the corresponding national plans or programmes on adolescent health, as well as (2) the existence of accountability mechanisms and stakeholder engagement, especially by adolescents and youth, in defining and monitoring the commitment, national plan or programme (if one exists). Where relevant, specific country examples are highlighted.

In interpreting the findings, it is worth bearing in mind that the reporting period under consideration is less than two years at the time of the survey (e.g., since the EWEC commitments were announced in September 2015 at the launch of the Revised Global Strategy). Depending on whether the national plan or programme was already in existence at the time of the announcement, countries' progress in implementing and monitoring programmatic actions, as well as establishing accountability mechanisms, will vary considerably.

The EWEC Adolescent Commitments and Corresponding Programmes

Sexual and reproductive health issues are priority health issues for adolescents in the EWEC commitments. The political commitments highlighted a number of critical adolescent sexual and reproductive health concerns: preventing adolescent pregnancy, addressing unmet need for family planning, reducing maternal mortality, tackling gender-based violence, and preventing STIs including HIV. India notably described a comprehensive adolescent health package that covers not only sexual and reproductive health, but other concerns such as mental health, nutrition, non-communicable diseases, and substance misuse. Mexico in particular has committed to address the high rates of adolescent pregnancy in the country, especially those among very young adolescents (ages 10-14 years old). Malawi had indicated a specific commitment to promote girls' education and reduce teenage pregnancies, recognizing that educating girls has positive effects on sexual and reproductive health and other outcomes. For Ethiopia, the Government has translated the EWEC commitment into different strategic documents, including: The Ministry of Health Reproductive Health Strategy (2016-2020), the National

³ See Annex 2 for the list of UNFPA country offices that received and responded to the internal UNFPA survey.

Adolescent and Youth Health Strategy (2016-2020), and the Plan to Eradicate Harmful Traditional Practices by 2025 and Eradication of Fistula by 2020.

In terms of priority interventions, governments also indicated plans to improve access to and the quality of sexual and reproductive health services including contraceptives for adolescents and youth, comprehensive sexuality education, life skills, counseling, as well as strengthening outreach and home visits. Governments such as Ethiopia prioritized actions in terms of accessibility of sexual and reproductive health information and services, eradicating child marriage and female genital mutilation, and addressing other factors such as access to formal education and vocational skills.

In addition, governments more broadly committed to promote mobilization and behavioral change efforts that support adolescent health and well-being. Sierra Leone in particular committed to have women, men and youth be represented in village committees across their chiefdoms and raise awareness about sexual and reproductive health. While the Philippines did not single out any specific adolescent health concerns in its political commitment, the Government committed to end preventable deaths among women, children, and adolescents with a particular focus on marginalized and vulnerable groups.

Most countries reported the existence of large-scale national programmes or plans to carry forward the adolescent-related EWEC commitments. The vast majority of country offices surveyed noted that large-scale national programmes and plans have been developed to implement the commitment on adolescents (sixteen out of eighteen countries, or 88.9 per cent). Some of these programmes were already in existence and underway, and in essence, are serving as the primary government action toward fulfilling their respective EWEC commitments (e.g., India and its RSKS programme which launched in 2014, or Sri Lanka and its National Strategic Plan on Adolescent Health 2013-2017). Similarly, Sierra Leone already had in place the National Strategy for the Reduction of Teenage Pregnancy (2013-2015), which is currently being revised as a five-year strategy (2017-2021) to include more components such as child marriage prevention, a more enabling legal environment for adolescents, comprehensive “age-appropriate information and education”, and community engagement and youth participation. On the other hand, some countries such as Kenya initiated a new process in light of the impetus afforded through the updated Global Strategy to make a renewed or accelerated commitment to adolescent health. Rather than a standalone strategy, Mauritania indicated that adolescent health is integrated within its National Strategic Plan on Sexual and Reproductive Health (2016-2020), which addresses the need to improve information and service delivery for adolescents and youth.

Some countries reported a lack of budget and financial resources to implement the national plan or large-scale programmes. Nine out of the sixteen country offices reported that the national plan or programme was supported by an accompany budget, which calls into question the ability to carry forward the government’s ability to carry forward its EWEC commitment on adolescent health. If there could be a ‘silver lining’ in this scenario, it is that six of the nine country offices noted that some significant resources have been allocated for the national plan or programme. Sources of funding included both domestic resources from health and other sectors, primarily from developmental partners.

In addition, the range of financial resources that was reported among the countries was quite wide, from as little as \$20,000 to \$60 million USD. Countries that reported the lack of a budget noted that resource mobilization remains a formidable challenge. At the same time, countries may be faced with inadequate

institutional capacity and human resources to execute and utilize the significant resources in an accelerated manner.

Most but not all national programmes and plans for adolescent health included monitoring and evaluation plans. Although sixteen country offices reported that national programmes for adolescent health are in place, twelve programmes were reported to have an accompanying monitoring and evaluation plan with a results framework and indicators. Malawi's National Youth-Friendly Health Services Strategy (2015-2020) is one such example that articulates a clear plan to monitor the five components of the Strategy (e.g., policy engagement, service delivery, coordination and collaboration, mobilization of young people, and resource mobilization) with baselines, indicators and targets. For example, the monitoring and evaluation plan details out specific activities to measure results in service delivery that addresses capacity development of service providers, supportive supervision, service coverage, utilization and quality. On the other hand, Madagascar is among the few countries that have a national plan or programme defined, yet currently lacks a monitoring and evaluation plan at the time of the survey. However, Madagascar noted that the Ministry of Health's Department of Reproductive Health plans to convene stakeholders in 2017 in order to develop strategic documents such as the monitoring and evaluation plan and jointly define and monitor results.

Accountability and Stakeholder Engagement

Among the countries that responded, adolescents and youth were less likely to have been engaged in developing the EWEC commitment compared to other stakeholder groups. To that end, the countries reported a diverse range of stakeholders that were engaged or consulted to develop the commitment. As anticipated, across the majority of countries, the Ministry of Health was involved or led the process, with Ministries of Youth, Education and Gender indicated as other line ministries that played a contributing role. However, only ten out of the eighteen countries reported that adolescents and youth were among the stakeholders involved in developing the commitment, the lowest proportion of a stakeholder group compared to other entities. On the other hand, civil society organizations and other UN entities were more likely to have been engaged in developing country-level commitments, compared to adolescents and youth.⁴

From an accountability perspective, other stakeholders appear to have been better represented overall in the process, but the depth and scope of youth-led organizations' true representation and engagement were not described. Further enquiry into the depth, scope and range of adolescents and youth's leadership and involvement, and the diversity among the youth representatives who engaged in the process, would be needed.

On the other hand, adolescents and youth were just as likely to be involved in developing the national plan or programme on adolescent health as other relevant stakeholders. A key finding from the survey results shows there was wide stakeholder engagement that included key line ministries, adolescents and youth, UN entities, and civil society groups across twelve out of sixteen countries (or 75 per cent). So while in some countries adolescents and youth were not involved in defining the EWEC commitment itself, their participation in principle would be more substantive by engaging in a process of defining key priorities

⁴ Thirteen out of eighteen countries reported civil society engagement, while fourteen out of eighteen countries noted other UN agencies were involved in shaping the EWEC commitments.

and strategies for a national plan or programme. Similar to the above, whom among adolescents and youth were involved, the methods employed to facilitate their engagement, their level involvement and contributions toward this process, and other critical factors for meaningful participation in a national plan or programme development process, were not investigated through this global survey, though would merit follow-up in select countries where young people were systematically engaged from the onset and throughout implementation.

Since the political commitments were announced, the majority of countries have not done any monitoring report or participatory review process on their EWEC adolescent commitments. Fifteen out of eighteen of the reporting countries noted that no monitoring report nor participatory review process has taken place to track results (or 83.3 per cent of the reporting countries). Not surprisingly, those national plans or large-scale programmes without financial resources have not done any participatory review process to date.

On the other hand, India is one of three countries that have reported that such a process has taken place (the other two countries are Mexico and Sri Lanka). India reported that although formal monitoring processes are still being institutionalized, the Ministry of Health does undertake an annual review of the national adolescent health programme (RKSK), which operates at a large scale (213 of 640 districts covered in India). To date, some key results include: the recruitment of 182,000 peer facilitators to do outreach and sensitization among adolescents; 7250 adolescent-friendly health clinics established; 31.5 million adolescents in schools receiving weekly iron and folic acid supplementation; and 27 million adolescent girls reached through the menstrual hygiene scheme. Moving forward, the Government of India plans to put greater emphasis on schools, provide more structured mentorship and capacity development to the peer facilitators, offer more helplines, and institutionally improve the youth-friendliness of existing health services.

Formal accountability mechanisms have not been fully established in most of the reporting countries at the time of this survey, though some examples exist. Despite global political momentum to move the adolescent health agenda, only a third of the reporting countries (six out of eighteen countries) reported any specific accountability components embedded in their respective national plans or programmes. Again, this could be due to the fact that many countries have not yet fully designed or implemented their proposed plans, or lack the requisite resources to do so.

Among the six countries⁵ that reported on having accountability mechanisms embedded within the national plan or large-scale programme, the commonly-cited examples include technical working groups or other types of monitoring mechanisms led by the responsible unit within the Ministry of Health and with other relevant entities involving youth, education, and gender. Such groups could have oversight of the programme strategy's implementation. They are also expected to convene regularly (e.g., on a quarterly basis) and include the broad range of stakeholders engaged in the development of the national plan or strategy mentioned previously, as well as other groups such as academia (Mexico) and the media (Ethiopia). In Afghanistan, other government bodies such as the Afghan Youth Parliament and the President's Office are reportedly involved. Both Kenya and Malawi have noted that

⁵ These six countries include: Afghanistan, Ethiopia, Kenya, Malawi, Mauritania, and Mexico.

Mexico is one of the few countries that reported having an accountability mechanisms embedded in its plan. To provide oversight and accountability to the National Strategy to Prevent Adolescent Pregnancy (ENAPEA), the Government of Mexico has set up an inter-sectoral committee and technical working groups involving multiple entities (line ministries, government units such as the Mexico Institute of Youth, relevant UN agencies, and civil society) to design, monitor and coordinate actions. Specific sub-committees are also charged to address issues such as monitoring and evaluation, as well as the differentiated needs and strategies to prevent pregnancy among girls below age 15.

None of the countries reported any independent assessments by a third party in monitoring implementation of the EWEC adolescent commitment. Nonetheless, national and sub-national level participatory review meetings or independent assessments by a third party or by adolescent and youth constituents (e.g., as citizens or as members of youth-led networks and organizations) can still be put in place in the medium-term. These approaches can be further backed and strengthened by more established coordination or accountability mechanisms, such as those cited by the six countries.

IV. CONCLUSION AND RECOMMENDATIONS

This UNFPA submission reviews the extent to which countries have followed through on the commitments they have made to adolescents under the auspices of the *Every Woman Every Child* movement. It also reviews whether countries have established a national plan or large-scale programme in relation to their commitment and have established accountability mechanisms to monitor progress and challenges. Such programmes are more likely to be relevant and successful when key stakeholders participate in the design, implementation and monitoring of the said programmes. Stakeholder engagement also lends to stronger ownership and accountability, especially for and by those whose lives and interests are most at risk.

As mentioned previously, the actual reporting period for actions since the EWEC announcements were made in September 2015 is relatively short. Consequently, some of the planned activities for monitoring and accountability are still being planned or have yet to be implemented from national to sub-national levels, let alone at scale. While the survey has allowed for an overview of key priorities and issues in terms of programme implementation, monitoring and accountability, the reporting period does limit the depth and scope of the analysis. It would therefore be worthwhile to revisit progress and further challenges within the next two years, which would be at the mid-way point for some of the national plans or large-scale programmes and thus serve as a useful benchmark for holding national governments with partners accountable to their 2015 commitments.

Nonetheless, there are key recommendations that merit attention while countries plan or implement their EWEC commitments on adolescent health:

- ***Advocate for dedicated and sustained financial resources to back the EWEC commitments, ideally from the onset.*** National plans and programmes clearly cannot be well-implemented nor monitored without adequate and predictable funding. Those for adolescent health tend to be particularly unfunded or underfunded for various reasons. True accountability therefore would require consistent actions to advocate and monitor for dedicated and sufficient resources within budgets to carry forward the commitments. Accountability mechanisms should also be costed and budgeted.

- **Clarify distinctions between monitoring and accountability mechanisms, and establish both mechanisms to support implementation and quality assurance.** As stated above, while certainly different oversight and monitoring mechanisms serve an accountability function (e.g., to ensure actions are carried forward), there is much room to expand beyond existing mechanisms such as technical working groups. Governments and stakeholders can incorporate more social accountability platforms and other spaces for participation that systematically engage adolescent and youth and other constituents as essential for a well-functioning health system. Moreover, new technologies and models can be explored as innovative platforms to monitor implementation and deliver feedback in real-time and the real (or anonymous) voices of adolescents and youth themselves. The idea is to build a culture of accountability but also collective learning and quality improvements with adolescents and key partners to strengthen programmes.
- **Support regular and sustained engagement by adolescent constituents themselves in monitoring the fulfilment of the EWEC commitment.** While countries reported adolescents and youth being involved in the development of the commitment and national plan or programme to address the adolescent health, it is less known the extent to which adolescents participated in monitoring and providing regular and routine input into these programmes. Tokenistic and one-off engagements should be avoided. More exploration is needed to examine the extent to which their perspectives were taken into account and used for programme development and quality assurance.
- **Across all countries, incorporate and strengthen monitoring and accountability mechanisms beyond the national level and particularly at the district and county levels.** Countries that reported the existence of coordination units and technical working groups should be encouraged to also put in place decentralized accountability mechanisms. This could involve establishing participatory structures and engaging community constituents particularly adolescents and youth to provide ongoing and transparent feedback on progress. These accountability mechanisms can consolidate the varied experiences by adolescents in accessing relevant health information and services, and the interactions they experience with adult providers and educators, and in turn inform and guide decision-making and interventions at clinics, schools, municipalities, provincial and national levels. These will not replace the needed technical and oversight functions performed at the national level, but will serve as complementary and critical mechanisms for tracking progress, trouble-shooting, and ensuring responsibilities and accountability.

The EWEC movement indeed motivated governments to develop adolescent health strategies, though work is still needed to ensure adequate financing, to monitor and evaluate for results, and to engage stakeholders systematically so as to hold governments accountable to their commitment. For countries that regarded existing programmes as fulfilling their EWEC adolescent commitments, governments would be encouraged to put in place such mechanisms during implementation rather than retrospectively. The practice of consistent and systematic engagement by adolescents in processes that will affect their health and well-being, and providing the accountability platforms with other relevant stakeholders toward that end, will ultimately create a citizenry that will not only survive preventable deaths, but will thrive and transform their societies.

ANNEX 1: Google Survey - Call for Evidence for the 2017 IAP on Adolescents

Name of Respondent: Last Name, First Name

Contact Email:

Duty Station:

UNFPA Region:

Developing the Every Woman Every Child (EWEC) Commitment on Adolescents

1. The below lists key components that could be covered within the EWEC commitment on adolescents. Check those that apply to the EWEC national commitment in your country.
 - Date of the commitment
 - Responsible Government Unit for the commitment
 - The expected goal and/or outcomes
 - Any adolescent groups of focus (e.g., very young adolescents ages 10-14, married adolescents, pregnant adolescents, etc.)
 - Any specified geographical coverage of the commitment
 - Specific adolescent health issues prioritized in the commitment
 - Other adolescent-related issues prioritized in the commitment (e.g., education, protection)
2. Based on your checked options, briefly describe the EWEC national commitment as it relates to adolescents in your country. *You can cut and paste the official commitment here and highlight the adolescent issues, and supplement with any other important information about the commitment.*
3. Which stakeholders were involved in developing this commitment? Check all that apply:
 - a. Adolescents (10-19 year olds) and youth (15-24 year olds)
 - b. Civil society groups
 - c. Ministry of Health
 - d. UN agencies
 - e. Other:
If other Ministries besides Health or other stakeholders were involved, please name them

Implementing the Commitment through a National Plan or Programme

4. Has a national plan or large-scale programme for adolescent health been developed to implement the commitment? YES/NO
5. If YES, please name the national plan or programme, highlight the main objectives and features of this plan or programme, and attach a pdf or link to the existing plan.
6. If the Government has developed a national plan or programme, does it have a monitoring and evaluation plan, with a results framework with indicators? YES/NO
7. If YES, which stakeholders were involved in developing the national plan? Check all that apply.
 - a. Adolescents (10-19 years old) and youth (15-24 years old)
 - b. Civil society groups

- c. Ministry of Health
- d. UN agencies
- e. Other:
If other line ministries besides health (e.g., education, gender, etc.) or other stakeholders were involved, please name them.

8. Does this national plan have a budget? YES/NO
9. If YES, what is the total amount allocated for implementing the adolescent-related activities? If NO, skip to the next section, “Monitoring and Participatory Review Processes”.
10. If YES, what is the funding source? This could be domestic resources from the health sector, other sectors, or other sources.
11. Does it represent a significant increase of domestic resources for adolescents (prior to 2015)? YES/NO

Monitoring and Participatory Review Processes

12. Has there been any monitoring report or participatory review processes to date that have tracked results? YES/NO
13. If YES, kindly share the results achieved, or any remedial actions taken based on any findings to improve programme delivery.
14. Are there any specific accountability components embedded in this plan? This could be social accountability by civil society and youth groups (e.g., at community, sub-national and national levels) to provide an independent assessment and feedback on service delivery, or formally via parliamentary or participation in oversight of government sectors involved in fulfilling the EWEC commitment. YES/NO
15. If YES, please explain below.
16. If you would like to add any further comments, please note them in the space below.

Thank you for responding to this questionnaire. Your responses will be used for a UNFPA submission to the IAP.

ANNEX 2: List of Countries that Made Adolescent-Related EWEC Commitments*

Asia and Pacific Region				
Country	UNFPA Country Office Responded to Survey	National Plan or Large-Scale Programme to Address EWEC Adolescent Commitment	Monitoring and Evaluation Plan	Accountability Components in the National Plan or Large-Scale Programme
Afghanistan	X	X	X	X
China	X			
India	X	X	X	
Pakistan	X	X		
Philippines	X	X	X	
Sri Lanka	X	X	X	
East/Southern Africa				
Burundi				
Comoros				
DRC				
Eritrea				
Ethiopia	X	X	X	X
Kenya	X	X	X	X
Lesotho				
Madagascar	X	X		
Malawi	X	X	X	X
Mauritius				
Rwanda	X			
Latin America/Caribbean				
Colombia				
Costa Rica	X	X	X	
Mexico	X	X	X	X
West/Central Africa				
Angola	X	X	X	
Benin				
Cote d'Ivoire	X	X		
Liberia				
Mauritania	X	X	X	X
Sao Tome e Principe				
Sierra Leone	X	X	X	
Togo	X	X		

*List of Countries from the EWEC meeting on Adolescent Health (March 2017)

X = Yes, Blank = No