Lessons learned from applying the Accelerated Action for the Health of Adolescents (AA-HA!) guidance for policy development in early adopter countries

SUDAN
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SUDAN
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<tr>
<th>Abbreviation</th>
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<tr>
<td>AA-HA!</td>
<td>Global Accelerated Action for the Health of Adolescents</td>
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<td>ADH</td>
<td>Adolescent Health</td>
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<td>AIDS</td>
<td>Acquired Immunodeficiency Syndrome</td>
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<td>CAH</td>
<td>Child and Adolescent Health</td>
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<td>EMRO</td>
<td>Eastern Mediterranean Regional Office of WHO</td>
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<td>FMOH</td>
<td>Federal Ministry of Health</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>H6</td>
<td>Partnership of UNAIDS, UNFPA, UNICEF, UN Women, WHO, World Bank</td>
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<td>MCA</td>
<td>Maternal, Newborn, Child and Adolescent Health Department</td>
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<td>MCH</td>
<td>Maternal and Child Health</td>
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<td>NCDs</td>
<td>Non-communicable Diseases</td>
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<td>RMNCAH</td>
<td>Reproductive, Maternal, Newborn, Child and Adolescent Health</td>
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<td>SDGs</td>
<td>Sustainable Development Goals</td>
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<td>SMOH</td>
<td>State Ministries of Health</td>
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<td>STIs</td>
<td>Sexually Transmitted Infections</td>
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<td>TB</td>
<td>Tuberculosis</td>
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<tr>
<td>UNESCO</td>
<td>United Nations Educational, Scientific and Cultural Organization</td>
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<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<tr>
<td>UNHCR</td>
<td>United Nations High Commissioner for Refugees</td>
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<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<td>WB</td>
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EXECUTIVE SUMMARY

Sudan is committed to the implementation of the Global Strategy for Women’s, Children’s and Adolescents’ Health (2016-2030), which aims to reduce unacceptable maternal, newborn, child and adolescent mortality in pursuit of its commitment to achieve the SDGs by 2030.

In view of this, Sudan’s Federal Ministry of Health (FMOH) launched the “Ten in Five” Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) Strategy 2016-2020 which received the highest political support at presidential level. However, of the 10 objectives articulated by the RMNCAH, not one explicitly describes specific interventions to address and improve adolescent health. Adolescents were deemed to benefit indirectly from a package of interventions designed to address more generally issues of equity, universal health coverage and vulnerable groups within the overall strategy.

In 2015, at the Sixty-eighth session of the World Health Assembly (WHA) in Geneva, Member States requested that WHO develop guidance on implementing global accelerated action for the health of adolescents as an imperative to address this neglected population group. The Global Accelerated Action for the Health of Adolescents (AA-HA!) Implementation Guidance document was presented during the Seventieth World Health Assembly in May 2017.

Following subsequent exposure to AA-HA! the FMOH embarked on the development of its own targeted adolescent health strategy which would improve the health and wellbeing of the country’s adolescents. The resulting National Strategy of Adolescent Health and Wellbeing 2018-2022 aims to further articulate the adolescent health component of the RMNCAH using the AA-HA! guidance and produce a doable, evidence-based, multisectorally-owned strategy, targeting adolescent health and appropriate to the Sudanese context.

The strategy development process was led by the Maternal and Child Health (MCH) department of the FMOH with technical assistance and guidance from the WHO/HQ and EMRO and participation of the UNFPA and UNICEF country offices in Sudan in 2017.

This report documents Sudan’s experience of using the AA-HA! guidance to develop the national adolescent health strategy. The report has been generated through in-depth interviews of key informants from the FMOH, participating sectors including the Ministry of Youth and Sport (MOYS), Ministry of Interior (MOI), Ministry of Security and Social Development (MSSD), representatives from Sudan’s State Ministries of Health (SMOH), H6 partners, academia, as well as a desk review of relevant policy and strategy documents and reports from two national consultative AA-HA! workshops.

The following are the main conclusions and recommendations regarding this process:

1. The AA-HA! guidance was a useful tool for developing a national adolescent health strategy and plan in Sudan. Comprehensive, systematic, and adaptable, it enabled the development of national capacities in planning and implementation, and motivated related sectors to carry out detailed analysis, prioritization and planning for adolescent health and sectoral interventions.

2. The AA-HA! guidance contributed to a better understanding of the benefits of investing in adolescent health and motivated national authorities, such as ministries of health and other national and international stakeholders, to fund related activities.

3. AA-HA! guidance offered direction with regard to identifying and analysing health priorities, offered a generic menu of evidenced based interventions suited to different ecological settings, and provided useful overall and cause-specific global and regional estimates for deaths and DALYs lost. All these helped the national team to better analyse, select and build consensus around national priorities, programming and interventions.

4. Following the AA-HA! guidance contributed to improving adolescents’ participation in national planning and the resulting adolescent health programmes and plans.

5. The AA-HA! guidance was suitable for use by programme managers at national and sub-national levels, including district managers, however it needs to be translated into locally-appropriate working languages, and should be accompanied by a facilitators’ manual together with 2 days orientation training on how to use it.
6. The existence of the adolescent health module within the One Health Tool helps national stakeholders to cost the national adolescent health programme.

7. It is recommended that Sudan collects good reference data on adolescents as evidence to support the planning of effective interventions. Furthermore, the establishment of a national adolescent observatory database would go a long way to ensuring such evidence is collected on a continuous basis and collated by different sectors and shared with all stakeholders.

8. It is recommended that WHO and FMOH continue to advocate and mobilize other H6 partners, UN Women, UNESCO, and the WB, to build and sustain the inter-sectoral momentum gained during this process, and to ensure full implementation of the adolescent health strategy.

9. The approach proposed in the AA-HA! guidance generated the level of political engagement necessary to commit to policy development/review with regard to adolescent health, and was therefore very useful.

Finally, when selecting national priorities, particular attention needs to be given to the contexts—geographical areas and settings— in such a huge and diverse country like Sudan. Programme managers will need to apply AA-HA! at sub-national levels to make sure they capture the specific adolescent health priorities in that area to be addressed.
INTRODUCTION

Country Background

The republic of the Sudan is a low-income country that extends over 1.886,068 km$^2$ with a population of approximately 41.5 million. The average life expectancy is 64.1 years$^1$ and the growth rate 2.41%. Around 36% of the population lives under the poverty line. As projected from 2008 Sudan’s census, the total youth population (15-24 years old) is 8,146,081, or 19% of the total population.$^4$

Adolescence – the transition from childhood to adulthood – is one of the most dynamic stages of human development. It is a time of marked physical, emotional, and intellectual changes, as well as changes in social roles, relationships and expectations. WHO defines adolescents as people between 10 and 19 years old.$^5$ As such there are 8,811,421 adolescents in Sudan (over 21% of the population), of whom 4,530,597 are male. Over half (51.8%) of all adolescents in Sudan are aged 10-14 years.$^6$

Maternal, newborn and under-five mortality remains high in Sudan with an estimated 311 maternal deaths per 100,000, 30 newborn deaths per 1000 live births and 70 under-five child deaths for every 1000 live births.$^7$ Birth rates for ages 15-19 years is 87/1000 adolescent women.$^8$ Approximately 10% of adolescent girls aged 12-14 years and 38% of those aged 15-19 years are married. Pregnancy and childbirth related complications are the leading causes of death among Sudanese adolescent girls aged 15-19 years.$^9$

Reproductive health and contraception knowledge are generally low, and nearly a third of all daughters born to young mothers (aged 15-19) are subjected to female genital mutilation. Life-skills are taught in schools, but 40 percent of out-of-school children are aged 12-13 years. This, coupled with poor school environments, means a considerable number of adolescents have little access to essential life-skills information and education. Access to water and sanitation is 68% in urban settings and just under 33% in rural areas, thereby increasing the risk of communicable diseases, such as water-borne diseases, to all population groups. Smoking is on the increase and other unhealthy practices such as those resulting in poor nutrition and/or obesity, are usually established during adolescence. The GHS 2012$^{10}$ reported that 39% of school going adolescents drink one or more carbonated soft sugary drink each day.

However, despite these considerable challenges, adolescent specific health services are virtually non-existent in Sudan, and general health services are not specifically tailored to address adolescent’ needs due to gaps in human resources availability and capacity, coupled with the lack of specific guidelines and management protocols. In addition, data on adolescent health are insufficient for measuring the relevant adolescent health indicators. In general, adolescent issues and health needs have been overlooked for a long time.

In 2008, the WHO/CAH urged the FMOH to develop a national policy for adolescent health. However, due to inadequate political commitment at that time and the high turnover of staff within the FMOH, the process ended in 2010, with just a situation analysis drafted, as well as the identification of some broad policy issues. This draft strategy was not further developed or submitted for national endorsement even within the FMOH.$^{11}$ Subsequently adolescent health interventions were limited to school health under the Health Promotion Programme and the Reproductive Health (RH) Programme.

The Government of Sudan credits the health of women, children and adolescents as key to progress in all development goals. It acknowledges that investing more in the health of these groups will help build more peaceful, productive societies and reduce poverty.

Based on its commitment to the Global Strategy of Women, Children and Adolescent to achieve the SDGs by 2030, the MCH department of the FMOH.

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1. EMRO Framework for health information systems and core indicators 2017. www.emro.who.int/docs
2. www.worldpopulationreview.com
3. National Health sector policy 2017-2030
4. Central Bureau of Statistics (CBS), Sudan, 2018 population projections
5. UNAIDS & WHO: Global standards for quality health-care services for adolescents 2015
6. CBS, Sudan: Population Projections for 2018
7. EMRO Framework for health information systems and core indicators 2017. www.emro.who.int/docs
8. CBS Sudan: Multiple Indicator Clusters Survey (MICS) 2014
9. www.youthpolicy.org/Sudan’s profile
10. https://www.who.int/ncds/surveillance/gshs/2012_Sudan_GSHS_FS.pdf
11. FMOH: Adolescents health situation analysis and policy issues, Sudan-2010
launched the “Ten in Five” RMNCAH Strategic Plan for 2016-2020 under the auspices of His Highness Omer Ahmed El Bashir, the President of the Republic of Sudan, in September 2015.

Ten strategic objectives to be achieved in five years by 2020 were outlined in the RMNCAH plan. However, apart from one objective specifically focused on newborns and another on nutrition, all the other components of the plan were to be addressed implicitly but non-specifically as a package of general services. For example, the first objective of the RMNCHA plan allegedly includes adolescent services along with all other services designed to address equity, achieve universal coverage and primary health care, and meet the needs of vulnerable groups:

However, adolescent health is not articulated, and as a consequence today’s adolescents – the country’s key asset and resource with the potential to contribute to their families, communities and society at large – risk being further overlooked as a group in need of targeted health services.

In recent years several international conferences and publications focusing on adolescents and youth have generated awareness and interest about adolescent health in Sudan. At the Sixty-eighth session of the World Health Assembly (WHA) that took place in Geneva 18–26 May 2015, Member States requested that WHO develop guidance on implementing accelerated action for adolescent health. The Global Accelerated Action for the Health of Adolescents (AA-HA!) was presented during the Seventieth World Health Assembly in May 2017.

Further exposure to the AA-HA! guidance and the sensitization that took place during a regional inter-country AA-HA! workshop, in Cairo, March 2017, resulted in both the MCH and CAH departments of WHO/EMRO and the FMOH acknowledging the alarming gaps in the adolescent health component of the RMNCAH strategy. The FMOH decided to develop a comprehensive national strategy for adolescent health and Sudan became one of the very early adopters of the AA-HA! initiative.

**Objectives of this report**

This report documents Sudan’s experience in developing a comprehensive adolescent health strategy in order to assess the relevance and usefulness of AA-HA! guidance, and determine if modifications are needed to improve the process. A number of assumptions were made regarding the difference AA-HA! guidance could make to policy and strategy development; the objectives of the case-study are to measure Sudan’s experience against many of these assumptions, as appropriate.

**Assumptions about AA-HA!**

1. Using the AA-HA! guidance will lead to a more comprehensive, more evidence-based adolescent health and development strategy and programme plan
2. The comprehensiveness of the AA-HA! guidance across priorities, and the provision of global and regional estimates for deaths and DALYs lost, help national teams to realize gaps in national priorities and data (e.g. for neglected issues such as drowning, mental health, cyber violence), and will lead to a broader strategy and plan than would otherwise have been proposed
3. The provision of the menu of evidence-based interventions within the AA-HA! guidance contributes to a better-informed, more evidence-based policy document (e.g. focusing only on evidence-based approaches)
4. The ecological approach helps to analyse and plan not only based on deaths and DALYs lost but also related to behaviours and health determinants, and to plan interventions at various ecological levels
5. The Adolescent Health in all Policies Approach (AHiAP) described in the AA-HA! document empowers the FMOH to be more effective in bringing together other sectors, and to steer intersectoral efforts, as well as to include actions by other sectors in the resulting strategy and action plan
6. The perceived usefulness of the approach proposed in the AA-HA! guidance and of its recommendations generates the level of political engagement necessary to commit to policy development/review
7. The AA-HA! guidance contributes to a better understanding of the likely benefits from investing in adolescent health, and the national
stakeholders are more inclined to fund related activities with domestic and or partner funds (as opposed to asking WHO to pay for expenses related to adolescent health activities)

8. After a brief national capacity building workshop, the AA-HA! guidance is a self-explanatory document that enables the national adolescent health task force team to apply the AA-HA! systematic process independently, without further external support. A facilitator manual based on AA-HA! is important to support this process.

9. The existence of the adolescent health module within the One Health Tool (OHT) helps national stakeholders to cost the national implementation plan for the adolescent health programmes.

10. AA-HA! contributes to explicitly including actions towards improving adolescent participation in national planning and the resulting adolescent health programmes.

The H6 plus UNESCO partnership brought about by AA-HA! is being maintained at the country level.

Methods & Materials

Consultant

WHO recruited a national consultant, Dr Sumaia Mohamed Alfadil, to undertake the case study. Dr Alfadil is an associate professor of community medicine at Nile College for Medical Sciences with expertise in maternal, child and adolescent health and health system development.

The case study was generated from in-depth interviews (in-person and voice recordings) with key informants and a desk review of national strategy documents (see below) related to adolescent health.

Key Informants (refer to Annex 1)

Key informants included members of the national Technical Working Group (TWG) established by the FMOH to develop the adolescent health strategy; MCH department staff engaged in utilization of the AA-HA! some H6 partners and government related sectors such as MOYS, SMOHs, academia, participants in the EMRO regional AA-HA! workshop March 2017, and participants and facilitators involved in the first and second national AA-HA! workshops in June 2017 and December 2017 respectively.

Desk review

The differences between various drafts of the national adolescent health strategy, before and after the regional AA-HA! workshop in Cairo, as well as before and after the national AA-HA! workshops in Khartoum, were reviewed in order to understand how the application of the AA-HA! guidance influenced the evolution of the content of the strategy (refer to Annex 3).

To understand how the AA-HA! guidance influenced the process of strategy development (e.g. stakeholder engagement, youth participation etc.), a comparative analysis of the process of development of the National Strategy of Adolescent Health and Wellbeing 2018-2022 and the process of developing the adolescent health component of RMNCAH 2016-2020 was undertaken (refer to Annex 2).

The findings of focus group discussions, conducted by FMOH with adolescents, parents, and healthcare providers as part of the strategy development process, were included as part of the desk review (refer to page 16).

The following documents were reviewed:

2. The Global Strategy for Women’s, Children’s and Adolescents’ Health (2016-2030)
3. FMOH Sudan: The Ten in Five RMNCAH strategy 2016-2020
4. FMOH: Adolescent Health Policy 2010
5. FMOH: First draft of the adolescent health strategy 2017, developed before the regional AA-HA! workshop (based on initial briefings from 2010).
6. FMOH: Report & power point presentation of the focus group discussion with adolescents 2017
7. FMOH: Five S Strategy of Adolescent Health June 2017 (Second draft of the adolescent health strategy, developed after the regional AA-HA! workshop and before the first national AA-HA! workshop)
9. FMOH & Global Fund: National workshop for production of Interventions and Activities for Adolescent Health Strategy, Sudan-Khartoum- 4-5 December 2017
11. Sudan National Health Policy 2017-2030
SUDAN’S EXPERIENCE IN APPLYING THE AA-HA! GUIDANCE FOR STRATEGIC PLANNING

Overview of the process undertaken to develop the National Adolescent Health and Wellbeing Strategy of Sudan, 2018-2022

The figure below illustrates the key steps in the development of the Adolescent Health Strategy:

This process is described in some detail below.

**Mobilizing political support for a national adolescent health strategy**

The AA-HA! process of developing a national adolescent health strategy garnered high political commitment, as evidenced by the involvement of His Excellency the Federal Minister of Health and the Undersecretary of Health, who reached out to Undersecretaries in other government sectors, thereby securing quite diverse participation in the two AA-HA! national consultative workshops (June and December 2017) which were also attended by participants from national and sub-national levels.¹² ¹³

The FMOH continued to advocate for the development of a robust adolescent health strategy, met with stakeholders from relevant sectors at different stages of the process, and mobilized the country offices of WHO, UNFPA and UNICEF who actively participated in the regional and national AA-HA! workshops and the TWG.

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¹² FMOH and WHO: Report of the first National AA-HA! consultation workshop June 2017
Establishing a national technical working group

On 10th of April 2017, a small technical working group was established composed of the staff of the FMOH’s MCH Department (MCH includes: Child and Adolescent Health (CAH), Extended Programme of Immunization (EPI), Reproductive and Maternal Health (RH) and Nutrition Programmes), Non-communicable disease (NCDs), UNFPA, UNICEF, WHO and three representatives from academia. The main objective was to update the situation analysis of 2010 and outline strategic directions for a national adolescent health strategy that would be elaborated further in a regional consultative workshop.

Although stakeholders from other sectors, such as the Ministries’ of Interior (MOI), Security and Social Development, Education etc., were not invited to join the TWG, individual meetings took place with these sectors to encourage ownership of the initiative to develop a national adolescent health strategy and update the situation analysis of 2010 with additional relevant sectoral data, in preparation for the regional inter-country AA-HA! workshop in Cairo. The draft adolescent health strategy that was prepared prior to the regional inter-country AA-HA! workshop was generic, lacked data and did not prioritise interventions or analyse determinants.

Five members of the TWG (two from MCH and one each from UNFPA, UNICEF and WHO country offices) along with an NGO (Coordinator of the Network of Adolescent and youth of Africa & representative of Sudan Fertility Care Association) participated in the regional inter-country AA-HA! workshop in March 2017. The updated 2010 draft strategy that was consolidated before the regional meeting was further developed during the workshop by the TWG to include all priorities listed in the AA-HA! guidance.

In June 2017, the MCH welcomed technical assistance from WHO EMRO and HQ who conducted a one-day facilitation training for the TWG so that they could lead the process of improving and developing the draft national Adolescent Health Strategy during a national two-day AA-HA! consultation workshop that was held immediately afterwards.

Generating funding to support the development of the national adolescent health strategy in Sudan

Improving services for adolescents was recognised by the Global Fund as vital to strengthening the health system in Sudan and the FMOH was able to fund all AA-HA! related activities with finances available from Global Fund Projects. In addition, it was perceived that good advocacy would help generate additional funding, and representatives from other sectors confirmed that they would support interventions related to their mandate.

20-21 March 2017: WHO/UNAIDS/UNFPA/UNICEF joint regional meeting on AA-HA! – Cairo

Objectives:

1. Share key adolescent health elements of the Global Strategy for Women’s, Children’s and Adolescent Health and the Global Accelerated Action for the Health of Adolescents (AA-HA!): guidance to support country implementation;

2. Introduce and use the AA-HA! guidance in developing/ updating national adolescent strategies and plans;

3. Determine areas for action in adolescent health programming in Member States and for United Nations agencies and other relevant stakeholders, based on the AA-HA! guidance, and discuss its implications on existing adolescent and school health programmes in the Region

Participants and Proceedings:

The meeting was attended by a total of 50 participants, including participants from 10 countries of the Eastern Mediterranean Region, together with experts from regional and international organizations, academic institutions, nongovernmental organizations, youth organizations and WHO, UNAIDS, UNICEF and UNFPA staff members from headquarters, regional and country offices.

Outcomes from the Regional workshop:

Each country identified key next steps and activities to be implemented, including:

- advocating for use of the Global Accelerated Action for Health of Adolescent (AA-HA!) Implementation Guidance with decision-makers, donor agencies and technical partners;
- reactivating/developing a national taskforce for adolescent health in line with the implementation guidance;
- conducting national orientation meetings for consensus on, and communication of, the implementation guidance;
- holding national workshops for adolescent health implementation planning and measurement;
- strengthening the skills of health providers to address adolescent health and well-being and identifying champions at country and district levels.
20 June 2017 – Khartoum: Workshop to train national facilitators in the application of the AA-HA! guidance:

Objectives:
1. Build competencies of the national experts in applying the AA-HA! guidance for national priority-setting, programming, monitoring & evaluation.
2. Plan the subsequent two days (June 21-22) national AA-HA! consultation workshop for a larger group of stakeholders

Proceedings of the facilitation workshop

WHO facilitators took the participants through the contents of the AA-HA! guidance. Facilitators and TWG agreed on the expected outcomes, methods and materials to be used during the June 21-22 national workshops and the necessary group work that would enrich the first draft of the adolescent strategy developed by the TWG. Small working groups were identified to work on the five following areas:

- Needs assessment
- Landscape analysis
- Priority setting
- Adolescent health programming
- Monitoring & evaluation (M&E)

A scoring system was proposed to select the top national priorities for adolescent health in Sudan and facilitators prepared simplified notes extracted from the AA-HA! guidance.

21-22 June 2017 – Khartoum: First national AA-HA! workshop

Objectives
1. To have a common understanding among key stakeholders on national priorities for adolescent health in Sudan.
2. To agree on a priority package of interventions, in health as well as other key sectors.
3. To develop a road-map for the finalization of the national adolescent health strategy.
4. To develop a road-map for the implementation of the national adolescent health strategy.

Participants

The workshop was attended by representatives from a variety of sectors and departments including FMOH, Ministries of Labour, Interior, Economic and Finance, Youth and Sports, Youth representatives of the National Parliament, National Humanitarian Commissioner for Refugees and the National Council of Child Welfare, National health insurance Fund as well as representatives of SMOH (Khartoum, Ghadarrif, and Gezira). Representatives from academia and sections related to child health, protection and adolescents from UN agencies- UNFPA, UNICEF, WHO – also took part, as well as Professional Organizations such as Sudan Associations of Paediatrics and Association of Obstetrics and Gynaecology.

Proceedings of the workshop

The Director of MCH described the current situation of adolescent health in Sudan and expected outcomes of the workshop. WHO facilitators presented the global and regional situation of adolescent health and introduced the AA-HA! guidance as a tool for developing the national strategy.

Participants were divided into five groups, one for each section of the AA-HA! guidance which they used to consider the existing information in the first draft of the strategy, amend where possible, or recommend further information be sought by the TWG drafting committee.

Due to time limitations the groups completed the needs assessment, landscape analysis, priority setting and outlines of key areas for programming, but were unable to finalise the detailed interventions /activities required or an M&E framework.

Outcomes of the first national workshop:

At the end of the workshop, participants agreed on five broad national priorities and further proposed to support the strategy draft with more reliable country specific indicators. They also agreed to hold another workshop and engage more partners – from other sectors and from the state ministries of health – to provide more information in certain issues, fill gaps, and work on sub-areas within each priority relevant to Sudan.

National priority areas as identified during the first national AA-HA! workshop:
1. Unintentional injuries
2. Violence
3. Non-communicable diseases and malnutrition
4. Mental health, substance use and self-harm
5. Sexual and Reproductive Health (SRH)

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14 FMOH & WHO: Report of the AA-HA! consultation workshop 20th-22nd June 2017
Focus group discussions with adolescents.

Adolescents were not included as members of the TWG, but eight (8) focus group discussions (FGDs) were conducted by the FMH prior to the first national AA-HA! workshop to gain inputs into the national adolescent health strategy. These took place in June 2017 between different adolescents, parents and health care providers. Five groups of adolescents were established: two male groups, two female groups, and one group of adolescents who had no parents. In addition, two groups of parents (not of the participating adolescents) and one group of general medical practitioners took part.

A total of 45 male adolescents, 30 female adolescents, five fathers, 25 mothers, and seven male and eight female medical practitioners were involved in the FGDs. Adolescents were asked to identify what, in their view, are the most important health issues and their inputs were used to strengthen the needs assessment, national priorities and programming for adolescents.

Most adolescents said that health services were accessible and that they were either accompanied by their families, or by police in case of homeless adolescents.

Meetings with inter-sectoral bodies.

Meetings were held with many of the sectors described below, and all were included in invitations to the first national AA-HA! June 2017 workshop:

Youth Union of the National Parliament, Ministry of Justice, Ministry of Labour, Association of Women Employees, private sector, civil society, the National Council for Child Welfare (NCCW), WFP (provides food aid in humanitarian settings), UNHCR (provides services to refugees in states bordering countries like Eritrea, South Sudan etc) National High Commission for Refugees (a government department that governs and coordinates the humanitarian work of internal agencies in Sudan), and representative of students affairs in the Ministry of Higher Education etc.

Even wider participation was sought for the second national AA-HA! consultation workshop in December 2017. This was due to the recognition that more inputs were needed from certain departments of a single sector, such as the Ministry of Interior, where representatives from departments of health services, road traffic and the control of drugs provided valuable insights. In addition, four more representatives from the NCCW, as well as child health programme managers from 14 of the 18 State Ministries of Health, and the Fertility Care Association, took part in the workshop.


Objectives

1. To expand the participation of more stakeholders including SMOH
2. To refine the priorities set during the first workshop, proceed with identification of detailed activities, and develop an M&E framework.

Participants, Proceeding and Conclusions of the second workshop

Participants of this workshop represented the various states of Sudan and included a larger number of MCH national teams and departments of relevant related sectors. Proceedings followed the same track as the first workshop and participants were divided up according to the five priority areas, working on sub-areas within each priority selected, and used a scoring system to identify evidence-based needs. For example, within Sexual Reproductive Health (SRH), which was selected as a priority in the first workshop (June 2017), early pregnancy and Female Genital Mutilation (FGM) were considered to be top priority sub-areas.

“ We are grateful for Sudanese doctors: they help us, they pay for our drug, they treat us with passion and dignity and they stand by us ”.

Homeless adolescent
Peer review by WHO and finalization of the strategy

The Adolescent Health Strategy has received peer review by WHO in June 2018 and is undergoing revision by FMOH, before proceeding to be officially cleared by the Council of the Undersecretary of Health. This will be followed by final endorsement facilitated by FMOH toward the end of 2018.

Official endorsement of the strategy

Changes in leadership within the FMOH have delayed the last stages of the finalization and endorsement of the Adolescent Health Strategy. However, the FMOH confirms that an endorsement workshop is expected to be organised before the end of 2018 to which stakeholders will be invited, including H6 partners, and the strategy will be integrated into the overall National Health Sector Strategic Plan under the “one plan, one budget, one M&E framework” principle.
KEY FINDINGS FROM THE APPLICATION OF THE AA-HA! APPROACH IN SUDAN

1) AA-HA! Understanding gaps in adolescent health issues, and consequent gaps in priority interventions.

The AA-HA! guidance provided an in-depth analysis of the broader problems facing adolescents which were supported by the estimates of global and regional deaths and DALYs indicators, such as drowning, which has been deficient in the Sudan’s needs assessment.

“The checklist provided in the AA-HA! guidance ensured systematic discussion of all possible interventions and helped participants identify possible gaps and review their importance. (refer Annex 5).”

Key informants

To agree on the top priority evidence-based interventions and to set national priorities and programming, a scoring system was used, assisted by a sub-set of criteria, against which interventions and activities were prioritized (see Table 1 below).

Issues that commanded little consensus from partners and participants were removed, such as malaria, TB, diarrhoea, etc. In fact, communicable diseases were totally removed from the final draft of the national Adolescent Health Strategy despite there being a high burden of communicable diseases in the country. It is likely that, due to the absence of age-disaggregated data, there was no evidence to suggest that these diseases were directly responsible for deaths or disabilities among adolescents in particular. The lack of age-disaggregated data for adolescents was noted by not only Sudan but other countries in the region. Sudan recommended this gap be highlighted for future attention and action.

Some states, such as Darfur & Kordofan (north, south and west), which are conflict prone areas and far from natural water bodies, found that the prevention of drowning was not relevant to their context, whereas violence was determined as a high priority. Such specificity will need to be addressed, not only when selecting national priorities, but during implementation of the adolescent health strategy in different parts of the country. It will be necessary for programme managers to use AA-HA! at sub-national levels, where the context differs in such a huge and diverse country like in Sudan.

2) AA-HA! – adhering to an evidence-base and setting national priorities.

In view of the gaps in knowledge about specific national indicators and interventions, the list of evidence-based interventions provided in the AA-HA! guidance helped the FMOH and stakeholders select national priority interventions relevant to Sudan’s context.

“we used to ask sectors what information they have about adolescents, after AA-HA! we asked them about specific indicators and interventions”.

Key informants

Many key informants confirmed having the AA-HA! list of evidence-based interventions provided an easy framework to follow for setting priorities.

“We developed the first draft by collecting information from the departments within the FMOH or other sectors that we thought are related to adolescents; after having the AA-HA! in hand we were confident in re-approaching the relevant sectors and departments”.

“We used to ask sectors what information they have about adolescents, after AA-HA! we asked them about specific indicators and interventions”.

Some described the lists as providing “a reminder that if you follow, you will not miss any important interventions or activity”.
### Table 1: An example of Prioritization of actions: NCDs, Nutrition and Physical Activity group

<table>
<thead>
<tr>
<th>Proposed Intervention/ecological level</th>
<th>Feasibility</th>
<th>Affordability</th>
<th>Potential impact</th>
<th>Potential to go to scale</th>
<th>Likelihood for political support</th>
<th>Equity</th>
<th>Total score</th>
</tr>
</thead>
<tbody>
<tr>
<td>National nutrient labelling system</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>11</td>
</tr>
<tr>
<td>Urban planning policies</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>18</td>
</tr>
<tr>
<td>Interventions in schools and public facilities</td>
<td>4</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>19</td>
</tr>
<tr>
<td>Nutrition and physical activity literacy campaigns</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>24</td>
</tr>
<tr>
<td>Improve access to healthy food and environment in schools and other public institutions</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>24</td>
</tr>
<tr>
<td>Improve access of healthy food</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>18</td>
</tr>
<tr>
<td>Campaigns to raise awareness of adolescent nutrition and physical health</td>
<td>5</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>25</td>
</tr>
<tr>
<td>Physical and nutrition education in school curricula and for community organizations</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>24</td>
</tr>
<tr>
<td>Regular, structured sports activities</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>18</td>
</tr>
</tbody>
</table>

Source National AA-HA! workshop 4-5 December 2017 Group Work 1

The highlighted areas above were selected as priority actions.

Adolescents participating in the FGDs identified the following health issues as main problems encountered by their peers: smoking, using drugs, stress and psychological problems, asthma, nutritional deficiency (mainly vitamin deficiency) and verbal and physical violence. Violence was also experienced in school, particularly by teachers and peers. Many of these issues were included in the final Adolescent Health Strategy, including smoking, violence, mental health and substance abuse.

Applying the multi-sectoral approach described in Adolescent Health in all Policies Approach of the AA-HA! guidance captured priorities for adolescent health normally outside the mandate of the MOH, such as violence and unintentional injuries.

An example of a more focused approach in selecting priority interventions was the consensus on focusing on prevention of early pregnancy and FGM as sub-areas of sexual and reproductive health (SRH), which was discussed extensively; while voluntary medical male circumcision, also recommended as an intervention in the AA-HA! guidance, was not discussed as it is accepted as a routine cultural and religious practice among almost all Sudanese communities.

“AA-HA! was helpful in listing all possible evidence-based interventions, but they were not all appropriate to our context, so we had the chance to select what suits us…”

“...as part of the academic sector and under our social accountability principles towards communities, we can assist in promoting some interventions at community level such as health promotion and awareness raising.”

### 3) Application of the AA-HA! ecological analysis

AA-HA! also provided an ecological analysis which helped to assess at which levels interventions could be delivered, for example at school or community level, and at what scale they could be...
implemented; this enabled the TWG to be more focused in selecting fewer interventions. Evidence generated either from related sectors, such as from reports from the road traffic department, or by consensus reached during the two national AA-HA! consultative workshops (June and December 2017), supported the inclusion of these interventions.

Respondents confirmed that the AA-HA! guide was very systematic in detailing the underlying causes for adolescents’ problems and therefore helpful in pointing to different types of interventions and programming that a country could choose from.

One respondent cited legislation as an example of structural and environmental levels to be considered:

“Restriction of alcohol to minors is listed as a possible intervention in the AA-HA! guidance, but, as alcohol is forbidden by law for any citizen, of any age, at any time, this intervention is not appropriate in our context. However, as we also know that it may well be sold under the table, we identified enforcement of the law and community awareness raising programmes as a priority for this specific context”.

Another good example of how AA-HA! guidance helps refine priorities based on an analysis of the social determinants of health and the ecological approach, was the selection of the prevention of early pregnancy. The prevention of early marriage as a direct underlying cause of early pregnancy is already supported by the Child Act 2010. However, despite this and appreciating that prevention of early marriage might not be acceptable to many communities, for cultural reasons as well as poverty, the group still selected prevention of early pregnancy as a priority action.

5) Political Engagement and Governance

High level commitment to developing a national Adolescent Health Strategy has been highlighted at critical stages throughout the process, and the involvement of Undersecretaries of various Ministries (the second tier of hierarchy, after the Minister) doubtless created momentum and provided motivation to the different sectors.

The participation of the Youth Union of Parliament was also regarded as an extremely important step to ensure political engagement and sensitization of policy makers.

In addition, key informants and participants also recommended ways in which the process of development of the national adolescent strategy could be improved, including modifications to the composition and function of Technical Working Groups (TWG) and other processes:

• The adolescent health TWG should include other stakeholders from other sectors, either as permanent members or invited when required.
• The TWG should take the lead in maintaining the coordination for implementation of the strategy. Reporting and periodic meetings should be established and maintained to sustain the momentum gained through the process of developing the national Adolescent Health Strategy and to follow-up on its implementation.

• Timelines for finalization of the strategy should be clearly defined.

• To ensure effective programming and strengthen capacity and profile, the FMOH Child health programme should include a dedicated unit for adolescent health and recruit a full-time coordinator.

**Facilitator Selection and Training**

Key informants agreed that the training was very useful and had helped steer the participants step-by-step through the different sections of the guidance; this helped generate more evidence on setting national priorities, national programming and identifying activities. However, they recommended extending the training of facilitators to two days, so they could be more familiar with AA-HA! Guidance.

It was advised that the selection of facilitators should not be limited to the members of the TWG but should be based on the merits of having good facilitation skills. It was observed that some TWG members who had no previous facilitation skills found it difficult to facilitate the workshop with only one day’s training in a new subject.

**National AA-HA! workshops**

It was recommended that national AA-HA! workshops take place over at least three days with materials shared with facilitators two weeks in advance to enable them to be more familiar with the process.

In addition, workshops should be cascaded to state and district levels to ensure micro-planning and a bottom-up approach, particularly since the opportunity to strengthen district health systems is currently supported by the Global Fund.

**AA-HA! guidance document**

The AA-HA! guidance document was much appreciated with the following recommendations:

• add a tool for navigation within the document

• translation into local languages and the development of a facilitator’s manual, especially for use at sub-national levels

• comprehensive training of good facilitators as a prerequisite to applying AA-HA! guidance to other programme planning, especially at the state and district levels

A respondent from one of the states and who participated in one of the AA-HA! workshops said:

**“for us the most important implementation level are the localities (districts), so it’s very important to engage them in planning. States’ Governors have a great leadership role to ensure that the strategy and plans will be implemented”**

6) Generating Funding

The costs of activities to undertake the process of developing the national adolescent health strategy, including participation of Sudanese delegates at the regional AA-HA! workshop, and in country meetings and consultations, was approx. 15,000 US dollars. To cost the implementation plan and mobilize resources for it, the MCH is planning to use the adolescent health module of the “one health tool”. However, due to limited local capacities, the costing exercise will require WHO support. Once costed it is expected that discussions with the Ministry of Finance, other ministries, partners and stakeholders will take place to decide how the various elements of the plan will be funded.

**7) AA-HA! process and tools are enablers to build national capacity**

The AA-HA! guidance was considered to be a useful tool for the development of a national strategy, and also served as a vehicle for capacity development in adolescent health. Observations on the workshops, facilitation and the AA-HA! guidance document were constructive.
Adaptability of the AA-HAI

The AA-HAI approach was considered very adaptable for use in the development of other strategies. The step by step process could be modified to suit other programmes and, particularly the section that covers DALYs and evidence-based interventions, was applicable to other health issues.

8) Adolescent participation

Adolescents were not included as members of the TWG, however, their contribution to the national strategy of adolescent health and wellbeing was enabled through eight (8) focus group discussions (FGDs) between different adolescents, parents and health care providers. In addition, representatives from the Youth Union of Parliament took part in the AA-HAI national workshops, thus sensitizing one section of the Sudan Parliament, which will ultimately be responsible for the final national approval and endorsement of the strategy.

The MCH appreciated that in future adolescents and representatives of other key sectors should be included in the TWG.

9) The national H6 plus UNESCO partnership mobilised by AA-HAI is being maintained.

All key informants confirmed that apart from WHO, UNICEF and UNFPA, who are regularly engaged in MCH activities, none of the other H6 partners participated in the process of developing the Adolescent Health Strategy. However, MCH advised that H6 partners are part of the overall health sector “One plan-one budget, one M&E framework” approach and not only will the national Adolescent Health Strategy be consolidated into one overall country plan, H6 partners will be included in that essential alignment process and the WCO is planning to include them in future meetings concerning the Adolescent Health Strategy and its implementation.

In addition, additional country partners, WFP and UNHCR, were both engaged in developing the Adolescent Health Strategy as both deal with the internally displaced and refugees, which clearly include adolescents.

It was concluded that the FMOH, as the main owner of the Adolescent Health Strategy, should continue to lead the mobilization of all partners in all relevant sectors to support the finalisation and implementation of the adolescent health strategy.

10) Setting the Monitoring and Evaluation (M&E) framework

The FMOH, with support of the WCO, has set a framework for M&E based on programming areas and guided by the AA-HAI logical planning framework. All national plans have to be endorsed by the National Council of the Strategic Planning which provides special planning formats with which this strategy will be aligned.
### Annex 1. List of Key Informants

<table>
<thead>
<tr>
<th>S.N</th>
<th>Name</th>
<th>Affiliation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Dr Nada Jafar</td>
<td>Director MCH/FMOH</td>
</tr>
<tr>
<td>2</td>
<td>Dr Manal Hassan Taha</td>
<td>Director Child &amp; Adolescent Health/FMOH</td>
</tr>
<tr>
<td>3</td>
<td>Dr Manal Sayed Fadul</td>
<td>ADH coordinator/FMOH</td>
</tr>
<tr>
<td>4</td>
<td>Mrs Eman Hago Ibrahim</td>
<td>AYRH/FMOH/member of the TWG</td>
</tr>
<tr>
<td>5</td>
<td>Dr Dalya Idris Hassan Etayeb</td>
<td>Quality officer/MCH/workshop participant</td>
</tr>
<tr>
<td>6</td>
<td>Dr Hiba Hussein Ibrahim</td>
<td>ADH focal person/WCO</td>
</tr>
<tr>
<td>7</td>
<td>Dr El Sheikh Ali</td>
<td>HIV officer/WCO/ADH/TWG</td>
</tr>
<tr>
<td>8</td>
<td>Mr Eljaile Ahmed Mohamed</td>
<td>Youth programme analyst UNFPA/member of the TWG</td>
</tr>
<tr>
<td>9</td>
<td>Mrs Amani Elamin Daifallah</td>
<td>ADH programme/Ministry of Youth/participant of the consultation workshops using AA-HA!</td>
</tr>
<tr>
<td>10</td>
<td>Dr Abeer Khalid Alagabany</td>
<td>ADH focal person/UNICEF/Member of the TWG</td>
</tr>
<tr>
<td>11</td>
<td>Dr Sara Lavinia Berair</td>
<td>Associate professor of community medicine/Elnelain university &amp; member of the TWG</td>
</tr>
<tr>
<td>12</td>
<td>Ms Amal Hassan Eid</td>
<td>IMCI focal person, Sinnar SMOH/workshop participant</td>
</tr>
</tbody>
</table>

### Annex 2. Comparative analysis between the development of the National Strategy of Adolescent Health and Wellbeing 2018-2022 & the development of the adolescent health component of RMNCAH plan 2016-2020

<table>
<thead>
<tr>
<th>Stage in the process</th>
<th>Developing the adolescent health component of the RMNCAH plan 2016-2020</th>
<th>Developing the National Strategy of Adolescent Health and Wellbeing 2018-2022</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capacity building for the national team/task force to develop the draft</td>
<td>Not done</td>
<td>One day Training of the TWG on AA-HA! guide</td>
</tr>
<tr>
<td>Securing high level commitment</td>
<td>Highest Presidential Level through the National Health Coordination Council</td>
<td>Orientation to H/E Minister and Undersecretary of Health</td>
</tr>
<tr>
<td>UN agencies involved in situation analysis</td>
<td>WHO, UNICEF and UNFPA were involved</td>
<td>WHO, UNICEF and UNFPA were involved</td>
</tr>
<tr>
<td>UN agencies involved in prioritization</td>
<td>WHO, UNICEF, UNFPA, UNHCR and WFP were involved</td>
<td>WHO, UNICEF, UNFPA and WFP were involved</td>
</tr>
<tr>
<td>UN agencies involved in producing/revising the draft</td>
<td>WHO, UNICEF and UNFPA were involved</td>
<td>WHO, UNICEF and UNFPA were involved</td>
</tr>
<tr>
<td>Stage in the process</td>
<td>Developing the adolescent health component of the RMNCAH plan</td>
<td>Developing the National Strategy of Adolescent Health and Wellbeing 2018-2022</td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td>---------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Involvement of sectors other than health in situation analysis</td>
<td>Could Not be traced in RMNCAH document</td>
<td>Ministries of: General education, Interior, Social Protection and Welfare and Ministry of Youth and Sport</td>
</tr>
<tr>
<td>Involvement of sectors other than health in prioritization</td>
<td>Could Not be traced in RMNCAH document</td>
<td>Ministries of: General education, Interior, Social Protection and Welfare, Justice, Private sector, Women Employees, Labour, 14 State Ministries of Health, Civil Society Organizations</td>
</tr>
<tr>
<td>Involvement of sectors other than health in producing/revising the drafts</td>
<td>WHO, UNFPA and UNICEF</td>
<td>WHO, UNFPA and UNICEF</td>
</tr>
<tr>
<td>Involvement of State (sub-national) level representatives in SA</td>
<td>Documentation could not be traced, but the States were invited to a dissemination and endorsement ceremony</td>
<td>States were engaged in the process of revising the draft situation analysis, selecting priorities interventions, programming through an in-depth consultative process and developing activities</td>
</tr>
<tr>
<td>Involvement of State level representatives in prioritization</td>
<td>Not documented</td>
<td>CSOs such as Mojadidon organization, Academia, Family Care Association, Sudanese Association of Paediatricians, Sudanese Association of Obstetricians and Gynaecologists, Women Union, Youth Union and Enterprises Union were engaged in revising the situation analysis and were heavily engaged in prioritization, programming and activity development process</td>
</tr>
<tr>
<td>Involvement of State level representatives in producing/revising the drafts</td>
<td>Not documented</td>
<td>Academia, Family Care Association, Sudanese Association of Paediatricians, Sudanese Association of Obstetricians and Gynaecologists, Women Union, Youth Union and Enterprises Union were engaged in revising the situation analysis and were intensively engaged in prioritization, programming and activity development process</td>
</tr>
<tr>
<td>Involvement of CSOs in situation analysis</td>
<td>Not documented</td>
<td>Association of women employees</td>
</tr>
<tr>
<td>Involvement of CSOs in prioritization</td>
<td>Not documented</td>
<td>Mojadidon organization</td>
</tr>
<tr>
<td>Involvement of CSOs in producing/revising the drafts</td>
<td>Not documented</td>
<td>Youth Union of the National Parliament</td>
</tr>
<tr>
<td>MOH departments involved</td>
<td>PHC, MCH (CAH, RH, EPI, Nutrition), health promotion, Policy and Planning, International Health, Human Resource Development</td>
<td>PHC, MCH (CAH, RH, EPI, Nutrition), health promotion, School Health, NCDs, health information systems, emergency health action</td>
</tr>
</tbody>
</table>
Stage in the process | Developing the adolescent health component of the RMNCAH plan | Developing the National Strategy of Adolescent Health and Wellbeing 2018-2022
---|---|---
Lead unit/department | MCH | MCH/CAH
Adolescent/young people involvement | Not documented | Five groups of males, females and homeless adolescents. Along with representatives of Youth of the Parliament
Costs of the process | Cost of Adolescent component in RMNCAH is not specified, despite the fact that other components were specified | Costs of regional and national AA-HAI workshops and training, meetings with TWG, FGDs, finalisation of drafting, approval and endorsement, TBC.
Human resources of the department and timelines undertaken to complete the process | Cost of the process of developing the strategy is not documented | Duration of process, changes in FMOH personnel, and delays in completing the strategy makes it difficult to assess the overall resources and timeline, but estimated 2-year period of actual effort to final strategy.

Annex 3. Comparison of the content and quality of first and final drafts of the national adolescent health strategy

<table>
<thead>
<tr>
<th>This column lists all sections and subsections from the final draft, with short comments against each in the next 2 columns, and example is provided below</th>
<th>Pre-joint regional AA-HAI workshop draft of strategy March 2017</th>
<th>Final draft of the National Strategy of Adolescent Health and Wellbeing 2018-2022</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>Refers to global overview of adolescent health, country geo-demographic and socio-economic profile, background related to adolescent health key indicators and problems, noting gaps in information, leading the reader from the stage of developing the adolescent health policy 2008. The introduction also highlights the health system framework addressing the six blocks. It confirms that there is a focal person for adolescent health within the FMOH, and that the school health strategy addresses adolescents within schools</td>
<td>No introduction per se, instead starts with a situation analysis which introduces the country demographic and socio-economic overview, and the rational for national commitments to adolescent health strategy development</td>
</tr>
<tr>
<td>Context and Rationale for the strategy</td>
<td>Well formulated stand-alone rationale that was linked to country commitment to achieving the SDGs; references the 25 years national strategic plan, the large adolescent population that requires special attention, and the importance of addressing risk factors early at this phase of development; also, the need to analyze factors related to other sectors and the need for developing relevant policies</td>
<td>Rational is not explicitly written but the reader can understand from the background describing adolescent health problems, the country commitment to the new Global Strategy for Women’s Children’s, and Adolescents’ Health (2016-2030) to achieve the SDGs. The arguments from the rights perspective and economic benefits are articulated.</td>
</tr>
</tbody>
</table>
This column lists all sections and subsections from the final draft, with short comments against each in the next 2 columns, and example is provided below

<table>
<thead>
<tr>
<th>Pre-joint regional AA-HA! workshop draft of strategy March 2017</th>
<th>Final draft of the National Strategy of Adolescent Health and Wellbeing 2018-2022</th>
</tr>
</thead>
<tbody>
<tr>
<td>Situation analysis</td>
<td>1/ Situation analysis provides firstly a short overview of the country profile with emphasis on issues related to adolescents, commitment to the SDGs and the policy context for having an adolescent health strategy based on the global strategy for women, children and adolescents and Sudan RMNCAH strategy</td>
</tr>
</tbody>
</table>

Subsections of the situation analysis.

1-1-Nutrition and Physical Health:
   The analysis provides numbers of communicable diseases and NCD per ages 5-14 and 15-24 and details on feeding practices focusing on types of dietary intake. Information on physical activity is lacking.

1-2-Mental Health
   Provided indicators on children and adolescent mental disorders as percentage of total cases from public health facilities and community based traditional settings. It provides information on adolescents who demonstrated an intention to commit suicide and the reasons behind their intention.
<table>
<thead>
<tr>
<th>Situation analysis</th>
<th>Pre-joint regional AA-HAI workshop draft of strategy March 2017</th>
<th>Final draft of the National Strategy of Adolescent Health and Wellbeing 2018-2022</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-3-Substance use: alcohol and drugs</td>
<td>Pointed to indicators on adolescent who are alcohol and drug users. Elaborated more on tobacco use.</td>
<td>1-3-Substance use: alcohol and drugs Pointed to indicators on adolescent who are alcohol and drug users. In the deficiency of recent updates on adolescents the analysis pointed to the overall case’s notification provided by ministry of interior and the scale of production of cannabis in the country as a risk factors that will increase abusers.</td>
</tr>
<tr>
<td>1-4-Reproductive and Sexual Health</td>
<td>1-4-1-Early Pregnancy Described indicators on early marriage before the 18 years old and cases of abortion as well as maternal death among young females aged 15-20 years compared to total maternal death as proxies for early pregnancy.</td>
<td>1-4-Reproductive and Sexual Health 1-4-1-Early Pregnancy Proxy indicators for early pregnancy were derived from high early marriage indicators and increased prevalence of maternal deaths in the 15 to 20-year age groups. Information on abortions provided in pre-Cairo situation analysis was deleted</td>
</tr>
<tr>
<td></td>
<td>1-4-2-FGM Information on FGM was the same as of the final draft of the strategy but more analysis has been provided regarding age at which females were subjected to FGM</td>
<td>1-4-2-FGM Information is provided denoting diversity of figures from the different sources as well as differences between states</td>
</tr>
<tr>
<td>1-5-Violence</td>
<td>Provided a detailed background disaggregated by sex and type of violence with other criminal data dated 2008</td>
<td>1-5-Violence Analysis reported different types of violence generated from rapid assessment and school health situation analysis dated 2010 and 2016 but without providing statistics except for rape, which was generated later, after the consultation workshops.</td>
</tr>
<tr>
<td>1-6-Unintentional Injuries</td>
<td>Statistical data was provided on RTA trends while no mention to drowning. Note: Analysis provided on communicable and non-communicable diseases namely HIV/AIDS, Malaria, TB; however it was not age specific except for scarce information on HIV affecting children (not aggregated by age so as to delineate those of 10 years or more).</td>
<td>1-6-Unintentional Injuries Reflected trends of traffic accidents before and after interventions on RTA control. It provided registered cases on drowning for the years 2015, 2016 and 2017. Note: Analysis of communicable and non-communicable diseases namely HIV/AIDS, Malaria, TB and Hepatitis has been deleted.</td>
</tr>
<tr>
<td>Section</td>
<td>Pre-joint regional AA-HA! workshop draft of strategy March 2017</td>
<td>Final draft of the National Strategy of Adolescent Health and Wellbeing 2018-2022</td>
</tr>
<tr>
<td>---------</td>
<td>---------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Landscape analysis</td>
<td>The analysis discussed existing risky behaviours and the legislation targeting them, as well as the facilities serving specific groups of adolescents under difficult circumstances (homeless, delinquents etc.). It also highlighted partners under relevant areas. Examples: Ministry of Interior, National NGOs like Sabah and Maather, Ministry of Security and Social Development and NCCW etc.</td>
<td>The situation analysis of the above thematic areas has been generated following series of meetings of the TWG and the two consultative workshops on developing national priorities. Under each area analysis has been provided as to what interventions/strategies/legislations are currently being implemented or are newly developed or, do not exist. Examples:</td>
</tr>
<tr>
<td>1/ Nutrition and Physical activity</td>
<td>The landscape analysis concluded that the focus on nutrition interventions has been on mothers and children with little on adolescents, while collaboration between MOH and ministry of general education working on physical activity exists.</td>
<td></td>
</tr>
</tbody>
</table>
| 2/ Reproductive and Sexual Health | 2-1-Early Pregnancy  
2-2-Strategies to support prevention of child marriage coordinated by National Council of Child Welfare (NCCW) aimed at enacting policies and enacting legislation for setting a minimum age for marriage | |
<p>| 3/ Mental health | The NCCW has developed psychosocial support manual for children and adolescent in emergency settings. Coordination among partners and legislations were identified as gaps under landscape analysis | |
| 4/ Violence and 5/ Un-intentional injuries | The analysis shed light on intervention strategies, laws and legislation on both violence and on the outcomes following enforcement through a national strategy on road safety | |
| Ecological analysis | Has been well reflected quoted from different sources namely rapid assessments in which adolescents were engaged 2010 and localized survey of Khartoum 2013 | This has been well reflected in areas such as in violence in schools, views of adolescents towards personal violence, religious and community pressures reasons for early marriage etc. |</p>
<table>
<thead>
<tr>
<th>This column lists all sections and subsections from the final draft, with short comments against each in the next 2 columns, and example is provided below</th>
<th>Pre-joint regional AA-HA! workshop draft of strategy March 2017</th>
<th>Final draft of the National Strategy of Adolescent Health and Wellbeing 2018-2022</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Setting national priorities</strong></td>
<td>The report provided overall analysis of all issues; however, it was not clear how the planning team had managed to select certain priorities over others. It should be noted that the final shape of this early draft included only a situation analysis and some very broad policy statements.</td>
<td>The final draft strategy reflected the above five priorities based on the prioritization criteria set by the AA-HA! and applied during the two consultation workshops. Criteria included: magnitude of the problem, affected adolescents, potentialities for scaling up, financial support etc. The information was extracted by the consultant from the workshop reports.</td>
</tr>
<tr>
<td><strong>National Programing: Strategic objectives</strong></td>
<td>Ended with the following: Policies should be directed towards:  • Governance, effective integration and collaboration both inter and intra-sectoral.  • Promotion of safe and supportive environment for adolescents’ health through schools, families, and youth centres, etc.  • Advocacy on rights, availability of needed services and information at facility and community level for adolescents among decision makers and political leaders.  • Raising awareness health seeking behaviour among adolescents at community level.  • Creation of an adolescent health information system for programme planning, monitoring and evaluation.</td>
<td>Provided well-articulated framework built around six strategic objectives, products and activities including targets to be achieved by year. It addresses: governance, adolescent services that ensures UHC, adolescents’ rights and equity, financial protection, promote healthy behaviour and support research to design and assess evidence-based interventions</td>
</tr>
<tr>
<td><strong>Products and activities</strong></td>
<td>Not available</td>
<td>Products and activities reflected the different interventions extracted from AA-HA! list and by relevant levels of ecological analysis. Stakeholders responsibilities of certain targets and activities have been reflected in the strategic framework</td>
</tr>
<tr>
<td><strong>M&amp;E</strong></td>
<td>Not available</td>
<td>Despite the gap in many baseline indicators but Targets were set for each year</td>
</tr>
</tbody>
</table>
### Annex 4. National Policies, legislation and strategic frameworks, relevant to child and adolescent health and development

<table>
<thead>
<tr>
<th>Policy level</th>
<th>Legislation level</th>
<th>Strategies and frameworks</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Health Policy, 2017-2025</td>
<td>Child protection Law 2011</td>
<td>“10 in 5” strategy 2016-2020</td>
</tr>
<tr>
<td>National Food and Nutrition policy 2017</td>
<td>Mental Health law 2016</td>
<td>SBV within current education system framework</td>
</tr>
</tbody>
</table>


### Annex 5. Examples of prioritization of key issues discussed in the situation analysis

<table>
<thead>
<tr>
<th>Key issues discussed in the AA-HA! section 2</th>
<th>Discussed in the situation analysis</th>
<th>Reflected in selected priorities</th>
<th>Reasons for not prioritizing if discussed in the situation analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Road injuries</td>
<td>Yes</td>
<td>Yes</td>
<td>Low feasibility, high costs, or other</td>
</tr>
<tr>
<td>Drowning</td>
<td>Yes, but deficient data</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Burns</td>
<td>No</td>
<td>No</td>
<td>No evidence available</td>
</tr>
<tr>
<td>Interpersonal violence</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Collective violence</td>
<td>Implicitly understood from cases of kidnapping committed by adolescents</td>
<td>No</td>
<td>Not enough evidence</td>
</tr>
<tr>
<td>Legal intervention</td>
<td>No</td>
<td>No</td>
<td>No evidence</td>
</tr>
<tr>
<td>AIDS</td>
<td>Yes</td>
<td>To some extent only within SRH package (awareness raising)</td>
<td>No disaggregated data about prevalence. Data available is about knowledge and risky behaviours among of adolescent</td>
</tr>
<tr>
<td>Other STIs</td>
<td>Yes</td>
<td>As above</td>
<td>As above</td>
</tr>
<tr>
<td>Nutrition and physical activity and the link with NCDs</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Mental Health; Substance Use, and Self-Harm</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Neglected communicable diseases such as Schistosomiasis and Leishmaniasis</td>
<td>Yes</td>
<td>No</td>
<td>Not enough evidence and is limited to certain geographic areas</td>
</tr>
</tbody>
</table>