New International Development Policy: Submission from the Centre for Adolescent Health

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This submission has been prepared by academics and early career researchers at the Centre for Adolescent Health and from its NHMRC funded Centre for Research Excellence on Driving Global Investment in Adolescent Health.

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About us

The **Centre for Adolescent Health** (https://www.rch.org.au/cah/) is Australia's largest academic centre in adolescent health. We are a WHO collaborating centre for adolescent health and have strong links to UN agencies (WHO, UNICEF, UNESCO, World Bank). Internationally recognised for our research and technical knowledge, education and ideas generation, we are physically based in Melbourne at the Children's campus, hosted by the Royal Children's Hospital, the Murdoch Children's Research Institute (MCRI) and the University of Melbourne's [UOM] Department of Paediatrics. We are Australia's leading provider of education and training on adolescent health and host a masters/diploma/graduate certificate in adolescent health and wellbeing through the University of Melbourne (https://www.rch.org.au/cah/education_training/Postgraduate/). We also provide non-accredited orientation courses and have trained many clinical professionals in adolescent medicine who now lead services across Australia as well as internationally.

The Centre for Adolescent Health hosts an NHMRC funded **Centre for Research Excellence (CRE)** called ***Driving Global Investment in Adolescent Health*** (https://adolescentsourfuture.com/cre-in-global-adolescent-health/). Led by Professor George Patton, the Centre for Research Excellence unites around 40 researchers nationally and internationally to focus on the health, development and wellbeing of 10-24 year olds. The CRE is designed to lay some of the technical foundations to drive policy and development and establish the evidence for what strategies are most effective, particularly in low-resource settings, and in priority neglected areas such as mental health, injuries and violence and non-communicable disease (NCD) risks. We have an international focus (our priority countries are Indonesia and China) and also focus nationally on neglected and stigmatised populations (Indigenous Australian adolescents, adolescents in youth justice settings).

Foreward

Adolescence is a profound period of human growth and development in which the assets and capabilities that underpin future adult health and wellbeing, social relationships, parenting and employment are established. In this way, on top of the earlier years of childhood, adolescence stands out as a life phase that should ideally underpin international development agendas.

Investments in later childhood and adolescence can reverse early-life deficits and have the potential to bring a triple dividend of reduced death and disability in adolescence; healthier trajectories across the life-course; and the best possible start to life for the next generation.[1] Yet adolescence has been neglected; it is estimated that between 95-99% of all research in the 0-19 year age group focusses on 0-4 year olds. With decades of investment in the early years, we have barely begun to invest in later childhood and adolescence. The most significant barriers to investment are technical, in terms of defining priority health needs and populations and understanding what responses will be most cost-effective in a given context. Emphasis on the proposition that harms in early life are irreversible are not only weakly supported by the evidence but contribute to underinvestment in adolescence.

The importance of investing in healthy adolescent development is increasingly appreciated in global policy such as the 2030 Every Woman Every Child Global Strategy for Women's, Children's and Adolescent's Health, and the Global Accelerated Action for the Health of Adolescents (AA-HA!). Both of these policies highlight the need for investing in actions that promote healthy adolescent development in every country.[2,3]

We welcome the efforts of the Australian Government to promote healthy human development in our region. We look forward to seeing how this new International Development Policy can provide a framework for Australia to partner with our neighbours in the Pacific and Southeast Asia on shared

priorities, especially around the SDGs. In this submission, we aim to provide some insights about how best to support these human capabilities by bringing attention to four policy opportunities:

- Age – there is a need to extend the age range of investments from a predominant focus on 0-5-year-old children to be inclusive of adolescents (0-24 years).[4]
- Health topics – there is a need to extend from current investments on health security to a wider set of health risks and disorders (e.g., risks for non-communicable diseases/ mental health/injuries).
- Settings for health – beyond health services, there is the need to appreciate the value of families and schools to promote healthy child and adolescent development, and particularly consider how the health and education sectors can collaborate in more integrated ways.
- Data for decision making – there is a need to update both data systems which collect data and indicators which report progress, to be inclusive of age, risk factors, disease outcomes, and social determinants to better reflect priority areas in our region. This is essential to transparent and accountable priority setting and monitoring and evaluation.[5]

We also provide comments on the need to invest in capacity building around adolescent health, as outside Australia and New Zealand, no country in the Asia Pacific region has anything close to critical mass in technical expertise in adolescent health and development, adolescent health services, or adolescent health promotion.

What key trends or challenges will shape Australia's engagement in our region and globally over the next five to 10 years?

The Asia Pacific region is remarkably young. While Australia's median age is 37 years, the median age in our neighbours is much younger, being 19.6 years in the Solomon Islands, 22.4 years in Papua New Guinea and 29.7 years in Indonesia. How countries educate and employ the largest cohort of adolescents in our region has significant implications for the future health of individuals and the national wealth of countries. Yet globally, and in our region, adolescents have not experienced the same health gains seen in younger children and maternal health.[6,7] Despite representing 1.8 billion people worldwide, or 30% of the population across our region,[8] and adolescents receive a fraction of the development assistance for health, disproportionate to their disease burden.[9]

Australia's international development health programs in the Indo-Pacific have focussed on infectious diseases (notably HIV, tuberculosis and malaria), building health workforce and infrastructure capacity, increasing access to primary education, maternal and child health, and preventing gender-based violence. The delivery of these health initiatives has predominantly focussed on women, 0-5-year-old children and adults, with little focus on adolescents. In the MDG era, for example, notwithstanding the challenges for adolescents in our region for STI prevention, approaches to reduce gender-based violence, and clinical services to manage HIV or TB, investment in generic population approaches often failed to shift the adolescent health burden. Consequently, educational and health gains that are achieved through investing in earlier childhood are at risk of being attenuated as children mature through adolescence and into adulthood.[1,10]

Over 60 years ago, adolescence was defined by WHO as 10-19 years, but is now commonly defined as 10-24 years.[4] This upward extension in age is based on understanding the changing developmental and social context of adolescence. Adolescence is characterised by a rapid phase of growth and development which starts with puberty and ends with more adult cognitive functioning in the mid-20s. It is a phase characterised by social role transitions around education and employment, partnering and parenting. It is also characterised by the emergence of a new set of health risks and by rapidly changing health profiles.[3]

These health risks, including tobacco and other substance use, unhealthy diet, poor physical inactivity and overweight have little health impact during adolescence.[11] Rather, these risks play out across the lifespan to result in a heavy burden of adult noncommunicable diseases (NCDs; cardio-metabolic disease in the form of type 2 diabetes, stroke and heart disease, as well as cancer). NCD risks are escalating extremely quickly in the Indo-Pacific region.[12] For example, the rate of overweight and obesity in adolescents has increased 10-fold over the past 40 years in HIC. In contrast, Indonesia has seen a 10-fold increase in the last decade and 19.8% of adolescents in Indonesia are now over their healthiest weight.[13] Likewise, around half of all Indonesian males take up smoking before 24 years of age,[11] and almost half (46.5%) of Indonesian 11-17 year-olds have three or more NCD risks factors,[14] much higher than adolescents in the South-east Asia region overall (30%).[15] From an international development perspective, the economic and social losses associated with this growing burden will be immense, as will be the costs to the health care system as NCDs already constitute Indonesia's greatest disease burden.[13]

Despite this, investments to address poor nutrition in Indonesia remain narrowly focussed on reducing stunting in 0-5-year-olds, as there has yet to be the necessary policy pivot that embraces an upward extension of age (to be inclusive of adolescents) and a broadening of focus from underweight and stunting to include overweight and obesity. Likewise, the Indonesian Ministry of Health's current action plan for the directorate for prevention and disease control (2020-2024) has very limited targets for NCD control, which do not take into account the importance of children and adolescents in terms of their significance of onset for NCD risks. In the same way, most countries in our region are yet to prioritise investments in mental health, including by reducing stigma, building community mental health literacy, and providing access to mental health services. In both these cases, with the right partnerships in place, Australia could provide leadership in health policy.

Investments in adolescent health bring a triple dividend of benefit: to the young person now, as they age into healthier adults, and to the next generation as they become parents.[5] Stopping adolescents from starting to smoke is far cheaper than treating their acute myocardial infarctions or lung cancers 20 years later. Yet, health policy continues to be disproportionately focussed on problems rather than risks and therefore misses important opportunities for prevention.

Having said this, adolescents also have significant needs for health services as 1 in 10 adolescents has some form of chronic health condition. Yet in most countries, including in the Indo-Pacific, adolescents have least access to health care of any age group, and experience unique barriers due to their life stage (e.g., concerns that their parents will find out, or unsure where to go for medical help). This results in high unmet needs for health services.[16] Most medical colleges and universities have neglected any teaching and training on adolescent health, which contribute to the lack of a critical mass of technical expertise in adolescent health in every country in the Indo-Pacific. With support, Australian centres of excellence have an important opportunity to partner with educational institutions and professional associations to help build this expertise locally, country by country.

What development capabilities will Australia need to respond to these challenges?

Multisectoral approaches to health and education: Health Promoting Schools

An important development capability that is required to respond to these challenges is the ability to engage in multisectoral approaches to building human capabilities. One of the most important for children and adolescents is working at the interface of health and education. The educational orientation of the MDG era was primary schools, but within the SDG era, the focus is on promoting universal secondary education, especially for girls. When appropriately supported, schools can be an important setting to promote student health and wellbeing, including promotion of healthy gender norms, in ways which are highly complementary to academic endeavours. Rather than schools being seen as simply a platform for the delivery of health focussed programs, WHO's Health Promoting

Schools is a framework for countries to consider how to invest in sustainable and scalable option to address multiple challenges across both primary and secondary school populations.[17] Schools are an important point of confluence for a multisectoral approach to address many health and development challenges facing our region, including nutrition, WASH, NCDs and mental disorder, injury, sexual and reproductive health, gender norms and gender-based violence.

"The concept of health-promoting schools (HPS) is a whole-school approach to promoting health and educational attainment in school communities by capitalizing on the organizational potential of schools to foster the physical, social–emotional and psychological conditions for health as well as for positive education outcomes."[18p.1]

WHO first promulgated health-promoting schools over 25 years ago. Across our region, many countries have implemented some health promoting components, some of which are underpinned by national policy, others not. However few countries provide more integrated approaches.[19] WHO and UNESCO recently published the first global standards on Health Promoting Schools[20] which provides a framework for national governments to develop, plan, fund, implement and monitor whole-school approaches in our region. Different investments are required for this, that support:

- Collaboration and advocacy for strong governance such as clear policy guidance across all relevant levels of government and schools.
- A whole-of-government approach and active collaboration between government ministries (especially health and education), civil society, schools and their communities.
- Investment in staff training in schools.
- Incorporating an evidence-based and data driven approach to implementation, with appropriate monitoring embedded in practice.
- Meaningful youth and community engagement.

The Centre for Adolescent Health led the development of the new Global Standards for Health-promoting Schools.[18-20] There is growing appreciation of the importance of schools not simply as platforms for delivering specific topic interventions but rather, as settings out of which healthy development emerges. In Australia the experiences of the pandemic have brought particular attention to the role of schools in relation to mental health and wellbeing, but the Global Standards for HPS are applicable for any topic. In Australia's Indigenous communities for example, there is much interest in this framework in the context of water and sanitation and eye health. One of the largest trials of a whole-school health promoting intervention in secondary schools was the SEHER trial in India.[21] This RCT was shown to be highly effective in relation to education engagement as well as mental health outcomes. The following quotes from a recent evaluation are testimony to the benefits for both health and education outcomes:[22]

"Students in the rural area are naturally shy. This program encouraged them to be vocal about their needs... either through raising them in group meetings or the classroom or through a written chit dropped in the speak-out box… students became vocal. They would ask questions during the classroom sessions. They would discuss topics like child marriage, the dowry system, the education of girls, depression, and so on, in debates. There were activities on mental health… how to handle stress, how to manage anger, and relationships. This all helped the students."

Another teacher emphasised benefits to student-teacher relationships from the SEHER intervention;

"This program brought some sort of schedule and discipline among the students. We have seen improvement in the student-teacher relationship... Students started sharing a bond with the school and

the teachers… the girls could approach me and other teachers with their problems. This is important to improve their health and overall life."

Others mentioned improvements in school attendance and student engagement in learning. One noted;

"We did observe an increase in students' attendance during the SEHER program" while another said, *"It helps in improving students' engagement."*

Data for Decision Making

Lack of investment in adolescent health by countries in our region can reflect lack of visibility of adolescent health issues due to the absence of data collection and/or lack of age disaggregation. Ensuring that population data are disaggregated by age brings visibility to children and adolescents. Thus, rather than age splits at 14 or 18 (eg 0-14 years, 15-65 years), disaggregating data in 5-year age bands across childhood and adolescence is encouraged (0-4, 5-9, 10-14, 15-19, 20-24).

Data systems have similarly focused on indicators on maternal and early child health. In many countries in our region, data systems do not focus on populating indicators of relevance for 0–24 years. The 2016 Lancet Commission on Adolescent Health identified 12 key indicators for tracking adolescent health and wellbeing, and later reported on these indicators globally, at a country level.[1,11] These indicators include *health outcomes* (health outcomes (disability-adjusted life-years [DALYs] due to communicable, maternal, and nutritional diseases; injuries; and non-communicable diseases); *health risks* (tobacco smoking, binge drinking, overweight, and anaemia); and *social determinants of health* (adolescent fertility; completion of secondary education; not in education, employment, or training [NEET]; child marriage; and demand for contraception satisfied with modern methods). These indicators highlight that promoting the capabilities of and opportunities within adolescence will require multisectoral collaboration within government, most notably health and education.[1,11]

We suggest that from its outset the new International Development Policy and Australian Centre for Disease Control (CDC) adopt a holistic approach to building data systems and the capacity to analyse them. This will require collaboration with those having expertise in adolescent health. It will also benefit from data monitoring systems that build capabilities in multi-sectoral data linkage. While mortality data is a key aspect of health monitoring in adolescence, the non-fatal burden is particularly critical to assess as are health risks, and access and utilisation of health services.

Moreover, in alignment with the principle of inclusion health,[23] multi-sectoral data linkage ensures that data from socially excluded groups, who are typically hard to reach, are also considered in public health-decision making. Linking health and administrative data with databases related to contact with the justice system and the use of homelessness support services, for example, makes it possible to identify pockets of disadvantaged people who might be in need of more tailored solutions. These and other indicators of social determinants of health are critical to better understand health risk gradients while accounting for group and region-specific differences.[24]

Previous DFAT development initiatives, for example the Tupaia an Tamamu health records systems in Samoa or the co-funding of Cambodia's IDPoor system provide demonstrations of the kinds of systems that can be built upon to enable multi-sectoral data linkage that would incorporate health data and data on the social determinants of health.[25]

How should the new policy reflect the Government's commitments to build stronger and more meaningful partnerships in our region, founded on mutual trust and respect and shared values of fairness and equality?

Consistent with the adage from the disability sector of "nothing about us without us", an important partner for community development is young people themselves, including young women. There are different models for engaging young people as active participants in a wide range of development priorities, including policy development, program development and research[1]. Ensuring that young

people are respectfully and genuinely engaged matters. Young people's powerful contribution to national and global climate policy and practices exemplifies the importance of listening to young people and supporting their ability to be agents of change within their communities.

A well recognised challenge faced by researchers and practitioners interested in international development is that partnerships take time to develop. Time requires systems that support the relationships - and funding. The current highly competitive orientation of research funding does little to support the time required to build and sustain collaborative, meaningful relationships that are founded on trust, respect and a shared set of values. For example, the focus on research outputs that supports career funding for early career researchers means that collaborations with high income country researchers such as in North America or Europe are more likely to result in high impact publications. Certainly, research project funding, with its uncertainty from year to year, is not a strategy to fund lasting partnerships.

One model to consider is the Australian Network of World Health Organization Collaborating Centres. Recently convened by the Australian Global Health Alliance, these collaborating centres have a depth and breadth of international development expertise and regional connections. The CCs are typically smaller, more nimble units than universities or research institutes (e.g. Centre for Adolescent Health). Each has critical mass around a particular population (e.g. adolescents), discipline (e.g. midwifery), disease (e.g. HIV), or practice (e.g. health promotion). A recent capacity mapping exercise highlights the scope of expertise. It also quietly highlighted the vulnerability of each centre, as few have any core funding (none is provided by WHO). Providing some core funding to collaborating centres would go a long way to enhancing their work.

One mechanism for building longlasting relationships that advance quality health care systems is the opportunity for Australian health services to train clinicians. The RCH, Melbourne has a long history of training future leaders from our region, who typically spend 1-2 years working in a clinical speciality area to learn advanced clinical or research skills (often both). Typically funded by national governments, beyond valuable technical skills, these individuals also gain a wider set of attitudes and skills that underpin quality healthcare systems through exposure to the public health ethos (equity), and ethical care. Many training relationships have proven remarkably successful including for two-way training experiences. Sadly, increasing financial demands on hospitals have changed the previously somewhat laissez-faire approach to accepting international trainees; the many hurdles faced means that many hospital departments are far less accepting of international trainees. Notwithstanding the state-based funding of hosptials, developing a funded system in Australia that requires hospitals to bid for the opportunity to provide extended training opportunities, including mentorship and leadership training, would bring a different ethos and priority around this.

Finally, and as noted a number of times throughout this submission, there is a major lack of technical capacity as well as a lack of clinical capacity in adolescent health in the countries in our region. Investing in building a workforce that has a stronger understanding of the importance of adolescence within the lifecourse is a priority for many countries. We run a free online 6-week course that provides an orientation to global adolescent health (https://www.coursera.org/learn/youth-health). Each year, we have requests for scholarships from people in our region to proceed from that orientation course to one or other of our postgraduate courses that are run through the University of Melbourne (https://www.rch.org.au/cah/education_training/Postgraduate/). The provision of annual scholarships for a small number of people from the region would be an ideal way to provide accredited training in adolescent health that would in time be repaid as these future leaders develop their own local courses.

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