

**Financing for results
to improve adolescent sexual and reproductive
health and wellbeing:
entry points for action**

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Abbreviations

ASRH	Adolescent sexual and reproductive health
ASRHR	Adolescent sexual and reproductive health and rights
CBO	Community-based organization
CCT	Conditional Cash Transfers
CHV	Community health volunteer
CHW	Community health worker
CSE	Comprehensive sexuality education
CSO	Civil society organization
DLI	Disbursement linked indicator
DPF	Development Policy Financing
FP	Family planning
GBV	Gender-based violence
GFF	Global Financing Facility
GRM	Grievance redress mechanism
HIV	Human immunodeficiency virus
HRITF	Health Results Innovation Trust Fund
IPF	Investment Project Financing
IPF-PBC	Investment Project Financing – Performance-based Condition
ISR	Implementation Status Report
LMIC	Low- and lower-middle income country
MAYE	Meaningful Adolescent and Youth Engagement
M&E	Monitoring and evaluation
MSK	Marie Stopes Kenya
NGO	Non-Government Organization
PforR	Program for Results
PBF	Performance-based financing
PDO	Project Development Objective
PPP	Public-Private Partnerships
RBF	Results-based financing
RMNCAHN	Reproductive, maternal, newborn, child and adolescent health and nutrition
SBCC	Social and behavior change communication
SDG	Sustainable Development Goal
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
SRHR	Sexual and reproductive health and rights
TOC	Theory of change
UCT	Unconditional cash transfer
UHC	Universal health coverage
UN	United Nations
WB	World Bank

About this Paper

This Paper provides practical advice for the design and strengthening of programs which use financing that is linked to results with the aim of achieving better outcomes for adolescent health and wellbeing. These approaches - called 'financing levers' in this document - are used at all levels, from the national down to the household and individual level. The Paper identifies entry points for using these financing levers to focus more resources on the high-impact practices which fulfil the rights of all adolescents to good sexual and reproductive health (SRH). In line with the World Health Organization (WHO), adolescence is defined as the period between the ages of 10 and 19 years.ⁱ

What do we mean by "financing levers"? This term is used throughout the Note to refer to a broad range of instruments that governments, donors, or development finance institutions might deploy that condition financing on an action or a pre-determined result. Examples include case-based and quality payments common in results-based financing (RBF) schemes but would also include performance-based block grants, prior-actions on budget support contributions, or conditional payments to individuals to support a health improving action.

While financing levers are the focus of this Paper, results-based approaches are considered to be part of a broader intervention package comprising both input and output-based financing, and as a component of health and education systems reforms. In particular, inputs are often needed to boost capacity to deliver the results that are financed through these levers, such as investment in infrastructure, supplies and equipment or training and mentorship.

The Paper looks at the application of financing levers in the health and education sectors and focuses on using these to enable adolescents to access:

- ❖ Adolescent-responsive sexual and reproductive health services and information
- ❖ Comprehensive sexuality education (CSE) in schools, communities and other sites

The Paper is primarily intended for World Bank (WB) and Global Financing Facility (GFF) teams and partners and their clients, wherefore the main references to financing instruments are related to the WB. Nonetheless, it may also be useful to a broader range of stakeholders utilizing financing levers to strengthen progress towards better adolescent health outcomes.

Why is it needed?

Decades of adolescent health programming have not led to the expected improvements in adolescent health outcomes. Global improvements in some adolescent health indicators mask highly uneven progress both across and within low- and lower-middle income countries (LMIC) where some 90 percent of adolescents live. Persistent high rates of child marriage, adolescent childbearing, HIV transmission and low coverage of modern contraceptives all impact on the lives of these young people.^{ii,iii} Girls in particular remain highly vulnerable to poor SRH outcomes.^{iv}

Adolescent girls in sub-Saharan Africa bear a disproportionate burden of poor SRH outcomes, with pregnancy and childbirth being among the leading causes of death.^{v,vi} Although fertility among young people has slowly and steadily declined, girls living in sub-Saharan Africa have the highest fertility in the world,^{vii} with one quarter giving birth before the age of 18.^{viii} This not only has a detrimental affect on their health, it also affects human capital formation and limits the ability of girls to contribute to broader societal goals.

High unmet need for contraceptives remains particularly acute among adolescents, leading to large numbers of unwanted pregnancies. It is estimated that, of at least 10 million

unintended pregnancies among adolescents each year, 5.6 million end in abortion, with the vast majority - 3.9 million - being unsafe abortions.^{ix} Meeting the reproductive health needs of young people avoids millions of unwanted pregnancies each year, avoids the higher costs of treating the complications of abortions and saves lives. Importantly, it also supports efforts of resource-constrained countries to realize their demographic dividend.^x

To make this possible, an explicit focus is needed across programs that seek to improve adolescent health and wellbeing on the rights of adolescents to good sexual and reproductive health (ASRH).^{xi} These efforts must take into account the diverse needs of different groups of adolescents, based on their specific attributes, circumstances, and experiences.^{xii} A rights-based approach supports countries in their work towards achieving the Sustainable Development Goals (SDG) and in particular, SDG 3, to ensure healthy lives and promote well-being for all at all ages. Sexual and reproductive health and rights (SRHR) are at the heart of the Global Strategy for Women's, Children's and Adolescents' Health (2016-2030) and are a focus of the [Global Financing Facility \(GFF\) Strategy \(2021 – 2025\)](#).

What is a rights-based approach to ASRH?

A rights-based approach to ASRH uses a set of human rights standards and principles to guide program assessment and design, planning, implementation, monitoring and evaluation, that enable individuals and couples to decide freely if, when, where and how to receive the information and services they need, and to be treated equitably and without discrimination. We therefore talk about ASRH'R' – including the R for rights (see also Annex 1).

Over the last two decades, different approaches have been implemented which use financing levers to incentivize improvements in the performance of health and education systems.¹ For example, schemes such as performance-based financing (PBF) or RBF have been used extensively in these sectors to strengthen service delivery, and payments are made to individuals and households that reward specific actions, such as utilizing a service. In addition, the WB has a range of financing instruments at their disposal which link disbursement of funds to achievement of results. These include: Development Policy Financing (DPF), which uses 'Prior Actions' as conditions for the release of funds; Disbursement Linked Indicators (DLIs) used in both Investment Policy Financing (IPF) and Program for Results (PforR), and Performance-based Conditions used in IPF (IPF-PBC). Using financing for results to improve adolescent health and wellbeing is aligned with the GFF Strategy to sustain a strong focus on results in its support to financing countries.

By leveraging these financing instruments, there is the potential to generate a stronger focus on the actions necessary to improve adolescent health outcomes. These instruments can also foster locally-tailored solutions to complex challenges by creating more decision-making autonomy and programmatic flexibility at different levels in the system. When making use of national public-financial management (PFM) and service delivery systems, they can also contribute to stronger systems and reduce fragmentation.^{xiii} Finally, the visibility and transparency they can introduce regarding the flow of funds and performance can support the work of civil society to hold policy-makers to account for the use of public resources. However, for adolescent health, these opportunities are still largely theoretical. To date, few interventions linking financing and results have focused on adolescents, and very few explicitly incentivize actions to improve

¹ See Annex 2 for brief descriptions of the principal financing approaches that are the subject of this Paper, and Annex 4 for a list of performance indicators used by the WB that focus on ASRHR.

ASRHR. Furthermore, where financing has been deployed with a results focus on adolescent health outcomes, little rigorous evaluation has been conducted.

How to use this Paper

This Paper presents suggestions for designing and adapting programs that aim to improve ASRHR outcomes using approaches that link financing to results or performance. It is structured around the outcomes and outputs of a Theory of Change (Figure 2), representing the key drivers for improving ASRHR outcomes (Table 1). Six outputs in the Theory of Change contribute to four outcomes, which support achievement of the impact: “Adolescents’ rights to good sexual and reproductive health are fulfilled in GFF-supported countries”. The final chapter provides suggestions for indicators and measurement of financing levers for ASRHR.

The six outputs can be seen as ‘modules’, allowing the reader to focus on those aspects of the Paper which are most relevant to their programs and context in which they are working. Table 1 provides hyperlinked shortcuts to the relevant sections, enabling the reader to move directly to the part of the Paper they wish to read.

Table 1 Overview of key drivers to improve adolescent SRH outcomes

Outcomes	Outputs
Outcome 1: An enabling environment supports adolescents to fulfil their rights to good SRH	Output 1: Key drivers for an adolescent responsive legal & policy environment
	Output 2: Key drivers for strengthening knowledge, attitudes and norms around ASRHR
Outcome 2: SRH information and services are adolescent responsive and utilized by adolescents in health and education settings	Output 3: Key drivers for strengthening the supply of adolescent-responsive services and CSE
Outcome 3: Adolescents are enabled and empowered to meet their SRH needs	Output 4: Key drivers for strengthening meaningful adolescent engagement in functioning accountability mechanisms
	Output 5: Key drivers for enabling and empowering adolescents to seek the SRHR services they need
Outcome 4: Evidence and learning are available to demonstrate what works to improve adolescent sexual and reproductive health	Output 6: Key drivers for strengthening the quality and availability of ASRHR data

Key recommendations

- ❖ **Ensure that financing incentives explicitly target adolescent-responsive actions**
 - When adolescents are included under broader population groups, such as women of reproductive age or children, their needs are often overlooked. Consider introducing explicit financing incentives for adolescents, such as finance-linked indicators for improving the quality and responsiveness of sexual and reproductive health care for adolescents, or which create conditions for meaningful engagement of adolescents in program activities.
- ❖ **Incorporate the voice of adolescents in program design** – Efforts to deploy financing levers to improve adolescent health outcomes at any level should seek to incorporate the views of young people, in order to better understand and address gaps in existing systems, structures and interventions for enabling access to adolescent-responsive sexual and reproductive health care.
- ❖ **Combine financing approaches that provide mutually reinforcing incentives** - Providing mutually reinforcing incentives at different levels of the system and across public and private sectors can lead to a more coherent and comprehensive approach that is better able to address the barriers to sexual and reproductive health services and information for different groups of adolescents.
- ❖ **Align financing incentives with national systems and processes** – To the extent possible, financing approaches for adolescent sexual and reproductive health and rights should be aligned with national health financing systems and avoid contributing to fragmentation of health financing and service delivery functions. When designing pilot adolescent health interventions using financing levers, plan for future integration into government systems (e.g. integration into public financial management systems, national budget processes, or other integrated approaches to strategic purchasing). Financing approaches that are aligned with national systems could also create greater harmonization of investments between development partners and governments.
- ❖ **Incorporate financial incentives for achieving better adolescent sexual and reproductive health outputs and outcomes into broader investment strategies** - Financing levers should be part of a broader portfolio of financing instruments and approaches, including those that pay for inputs. In particular, upfront investments may be needed to boost capacity to deliver the results that are paid for through financing levers (i.e. investments in infrastructure, supplies and equipment, technical assistance and training).
- ❖ **Use financing levers to provide support for a multisectoral approach to adolescent sexual and reproductive health and rights** – Approaches that aim to address barriers to sexual and reproductive healthcare for adolescents require coordination and collaboration across different agencies, such as those responsible for health, education, youth, labor, women and gender and social protection, as well as across government, civil society and the private sector. Financing approaches, including national level policy levers, can be used to incentivize multisectoral planning and action at different levels.

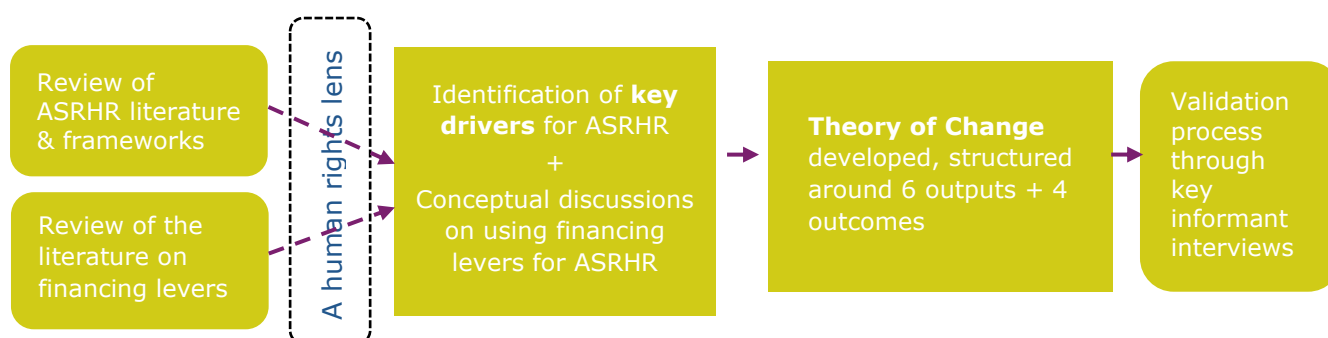
Theory of Change

The Theory of Change (Figure 2) was developed based on the current state of the scientific literature and implementation experience. It was developed using a human rights lens,² and illustrates the potential ways in which financing levers – that is, approaches which link financing to results or performance – can be used to achieve six outputs and four outcomes that are critical for improving ASRHR. The outputs represent the ‘key drivers’ or essential actions needed to fulfil the rights of adolescents to good SRH.

A review of the literature on results and output-based financing highlighted the very small number of programs with a specific focus on adolescents. An absence of age-disaggregated data in national information systems, together with the inclusion of adolescents within broader population sub-groups, such as children or women of reproductive age, means that these programs rarely incentivize results or performance that is specific to ASRHR. This document therefore represents a first step in identifying entry points for utilizing financial levers to improve ASRHR outcomes.

The Theory of Change and guidance were reviewed by key specialists in ASRHR, financing for results and health financing more broadly.³ The process of developing the Theory of Change is set out in Figure 1.

Figure 1: Developing the Theory of Change



The Theory of Change illustrates how different financing levers can be used to:

- ❖ Contribute to the creation of an enabling environment which supports adolescents to fulfil their rights to good SRH (**outcome 1**) by:
 - Ensuring adolescent responsive laws and policies are available and accepted, youth-informed and operationalized at all levels (**output 1**),
 - Creating ‘norms-shifting’ programming that generates knowledge and positive social norms and attitudes to ASRHR among communities and key gatekeepers for ASRHR (**output 2**),⁴
- ❖ Make available SRHR information and services which are adolescent-responsive and are utilized by adolescents in health and education settings (**outcome 2**) by:

² That is, information was extracted and organized according to the rights-based principles, set out in Annex 1, Figure 4.

³ Please see Annex 6 for a full list of key informants.

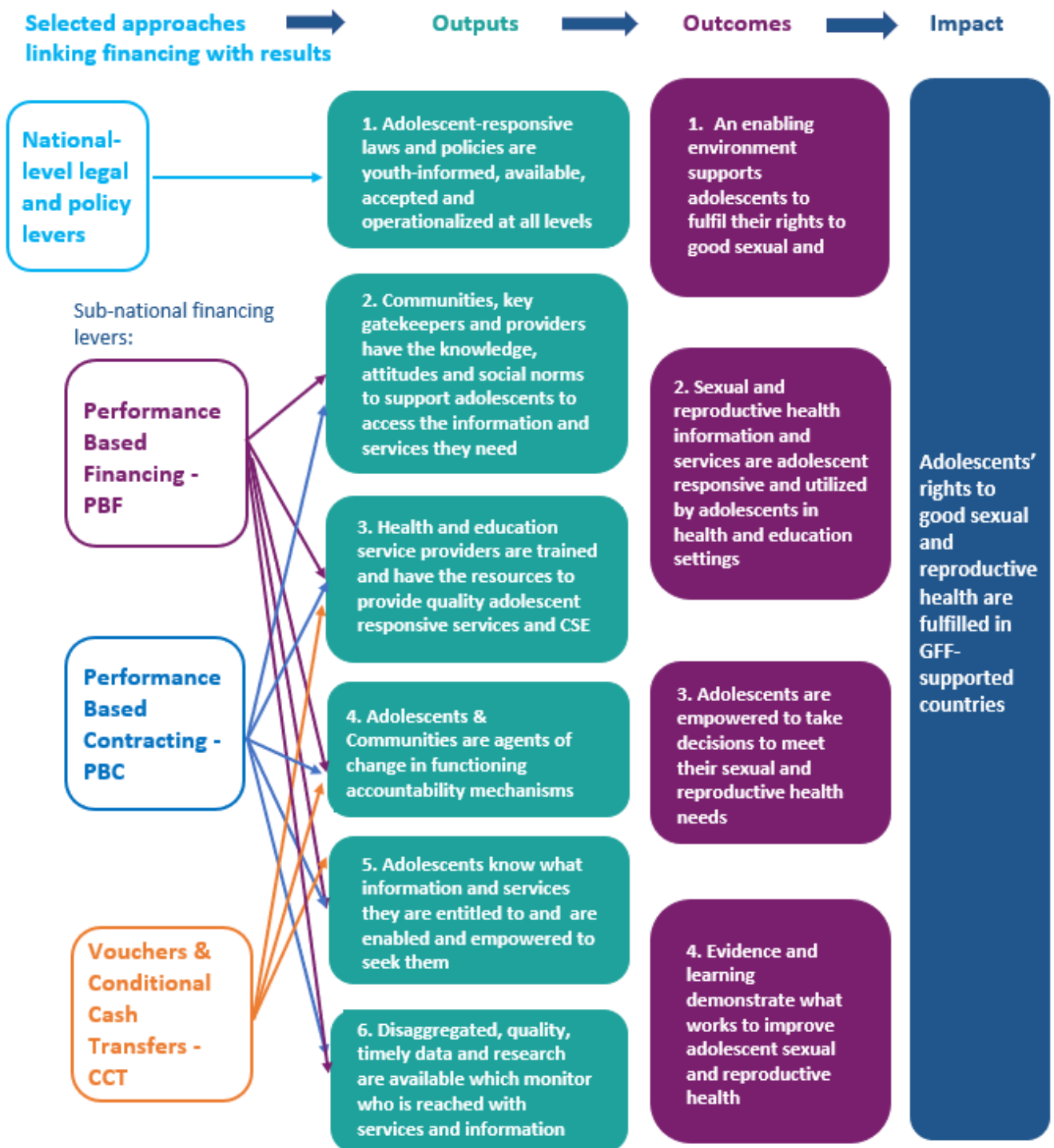
⁴ The term ‘gatekeepers’ is used to indicate the people that exert control over access by adolescents to information and services (i.e. parents, health providers, teachers, community elders etc.). They may also oversee how work is being done and whether it meets certain standards.

- Training, equipping and supporting service providers (health service providers, teachers and administrators) so they have the knowledge, skills and resources to provide adolescent-responsive SRHR care and CSE (**output 3**),
- ❖ Empower adolescents to take decisions related to their SRH needs (**outcome 3**) by enabling them to:
 - Be agents of change in functioning accountability mechanisms, creating opportunities for meaningful adolescent engagement to inform SRHR policies, programs, and results (**output 4**),
 - Know what information and services they are entitled to and be empowered to take informed decisions about their SRHR (**output 5**),
- ❖ Demonstrate what works to improve ASRHR (**outcome 4**) by:
 - Ensuring disaggregated, quality, timely data and research are available to monitor who is reached with services and information and to grow the evidence-base for what works to improve ASRHR outcomes (**output 6**).

A number of cross-cutting elements are important for the achievement of the Theory of Change:

- ❖ **Applying an intersectional lens** to the design and implementation of interventions that link financing with results to improve ASRHR. This means ensuring that approaches cater to needs of different groups of adolescents;
- ❖ **Situating financing levers within a broader portfolio of approaches** that includes paying for inputs, and aligning these with national systems and processes;
- ❖ **Using a multipronged and adaptive systems approach**, while recognizing the reality of the country context and focusing on what is feasible and practical. The evidence is growing that using a combination of financing mechanisms and approaches that target different levels of the system, and which work on both the supply-side and demand-side, brings the best results.^{xiv}

Figure 2 Theory of Change for improving the health and wellbeing of adolescents using approaches which link financing with results: 'financing levers'



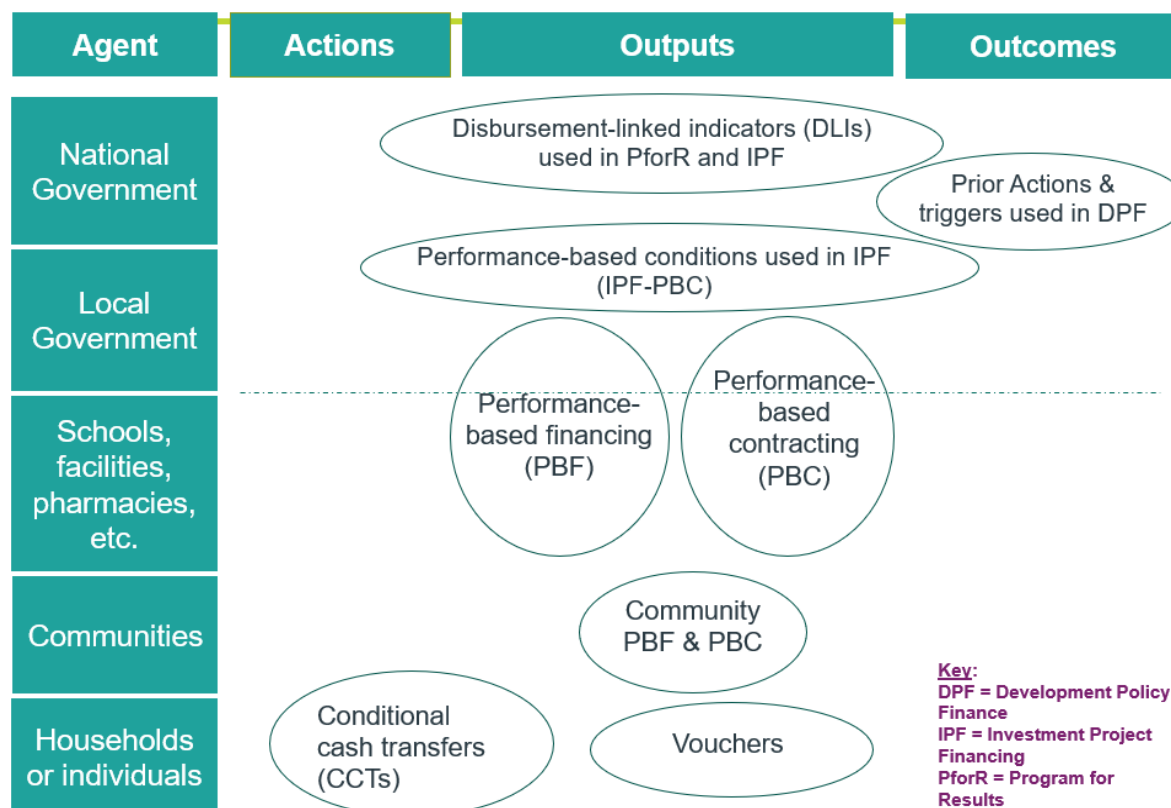
Utilizing financing levers to advance ASRHR

Programs that link financing to results or conditions vary in terms of their objectives and also with respect to the level at which they operate.⁵ Furthermore, a wide range of terms are used to describe the different approaches and instruments, some of which are used interchangeably.⁶ In all of them, however, a 'principal' delegates tasks to a 'agent' and provides financial and/or other material incentives that are linked to the agent's performance. Thus, these financing approaches operate on what economists call a principal-agent model and may involve relationships between many different types of principals and agents, including: multilateral organizations and recipient governments; federal and sub national governments; governments and public or private health facilities; district authorities and health workers; or public programs and families or individuals.^{xv}

Performance has to be defined and measured. Given that performance measures (indicators) must be agreed by both parties, these approaches aim to align objectives and understanding between them (e.g. improving SRH care for adolescents and what this means in practice). The identification of 'good enough' measures of performance which are not too costly to measure and verify is central to the success of financing for results.

Figure 3 provides a snapshot of the principal financing approaches that are referred to in this Paper, including WB financing instruments that illustrate how conditions can link financing with results or performance. The Figure places each financing approach and instrument at the level of the system where it typically operates (i.e. the national, sub-national, community or household level), and along a continuum of the actions, outputs and outcomes which they are expected to achieve.

Figure 3: Selected approaches linking financing with results



⁵ Table 3, Annex 2 provides short definitions of selected relevant financing approaches.

⁶ For more information on these terms, see Box 1, p. 4 in [Savedoff W. \(2010\)](#).

Financial incentives for strengthening ASRHR

There is continued debate about the success, value for money and sustainability of results-based and performance-based financing schemes used to strengthen service delivery and access, although evidence continues to grow on what works.^{xvi} Concerns typically focus on the added complexity (and therefore the costs) which such approaches can introduce and the lack of alignment with national systems and processes. For example, performance-based financing - which is used in many African countries to introduce and roll out strategic purchasing of health services - requires levels of provider autonomy, spending flexibility and measurement capacities that may not be part of existing structures and systems (i.e. public financial management and information systems). Introducing financing levers into contexts where other health financing schemes are present can contribute to fragmentation and inefficiencies in health financing where the schemes are not sufficiently aligned and harmonized.^{xvii}

That being said, financial barriers are a significant deterrent to accessing healthcare for adolescents due to their limited access to financial resources. Adolescents require access to SRHR services that are free and/or affordable at the point of delivery, and available across a range of different sites, including public and private health facilities, workplaces, schools and communities, and with adequate opening times. In many countries, however, this objective remains a distant goal.

In the meantime, financial incentives for ASRHR service purchasing can be used to compensate providers for the costs of service delivery, alongside input-based subsidies, such as those provided through costed plans and budgets. Incentives can also be used to support adolescents with the indirect costs of accessing services, such as transport to a health facility or purchasing items required for delivering at a facility (i.e. through voucher schemes or conditional cash transfers). Given the lack of progress to date in increasing access to SRHR care for adolescents, it is important to select approaches which provide incentives on both the supply- and the demand-side and, where possible, reduce fragmentation (e.g. via pooling funds) and counteract incentives to ration care for adolescents. And finally, ministries of finance can use financing levers to incentivize line ministries to remove user fees for adolescents within sectoral strategies and plans, such as through results-based grants.

Entry points for using financing levers to strengthen ASRHR

This section follows the Theory of Change, and takes each of the six outputs and the outcomes they contribute to, identifying:

- a) 'Key drivers' which are the minimum package of activities needed to effect sustainable change at the level of the output; and
- b) Financing levers that can potentially be used to incentivize progress for each key driver.

Although broad intervention areas to improve ASRHR outcomes are similar across most settings and are captured in outputs 1 – 6 below, the specific actions needed in each context will differ.⁷

In order to make real progress in achieving ASRHR outcomes in a sustainable way, actions are needed across all six outputs. However, limited available resources (internal and external funding and human resources) together with limited fiscal space in resource-constrained countries, mean that it is usually not feasible for governments to tackle them all at once. This requires the prioritization of certain activities over others and decisions on priorities and entry points for action should be made at the country level, based on the wide-ranging assessments and consultations.

The following sections of this Paper provide suggestions for using financing levers at different system levels to achieve the outputs and outcomes of choice. Short case studies, drawn mostly from the WB and GFF health and education portfolios, are used throughout to provide real-life examples and to demonstrate feasibility. This Paper refers to ASRHR services. While decisions on the content of ASRHR service packages will be highly country and context-dependent, Box 1 illustrates a minimum package of adolescent-responsive SRH services, as set out by the WHO and other adolescent health stakeholders.

Box 1: Defining a package of ASRHR services

A package of essential ASRHR interventions consists of the following:

- Comprehensive Sexuality Education (in and out of school)
- Counseling and service provision for a range of modern contraceptives, with a defined minimum number and types of methods
- Antenatal, childbirth, and postnatal care, including emergency obstetric and newborn care
- Safe abortion services and treatment of complications of unsafe abortion
- Prevention and treatment of HIV and other sexually transmitted infections
- Prevention, detection, immediate services, and referrals for cases of sexual and gender-based violence (GBV)
- Prevention, detection, and management of reproductive cancers, especially cervical cancer
- Information, counseling, and services for subfertility and infertility
- Information, counseling, and services for sexual health and wellbeing

Source: [Engel et al. 2019:S44](#)

⁷ Guidance on developing context specific intervention models to improve ASRH can be found in the guidance documents of WHO ([Global Accelerated Action for the Health of Adolescents \(AA-HA!\) Guidance to support country implementation](#)), and the Global Strategy for Women's Children's and Adolescents' Health ([Technical Guidance for Prioritizing Adolescent Health](#)). See Annex 6 for further resources. Please also see [Miedema, Le Mat & Hague 2020](#) for a definition of CSE.

Outcome 1: An enabling environment supports adolescents to fulfil their rights to good SRH

Strengthening the enabling environment for better ASRHR outcomes embraces actions across two main implementation areas: laws and policies that provide access to adolescent-responsive SRH information and services; and, positive social norms and attitudes towards adolescent sexuality and SRHR.

Output 1: Adolescent responsive laws and policies are youth-informed, available, accepted, and operationalized at all levels

Output 1: Key drivers for an adolescent responsive legal & policy environment⁸

Output components	Key drivers for adolescent-responsive laws and policies	Financing levers
Adolescent-responsive laws and policies are available	Establish/strengthen a multisectoral task force (including civil society) at national and sub-national levels to oversee efforts to strengthen adolescent health and wellbeing	Prior Actions, DLI, IPF-PBC
	Multisectoral task force reviews relevant laws, policies & strategies and identifies critical changes needed to enable all adolescents to access ASRHR services and to receive CSE in and out of school	Prior Actions, DLI, IPF-PBC
	Develop policy for free public ASRHR services, and make contraceptives affordable, including in the private sector	Prior Actions, DLI, IPF-PBC
	Ensure ASRHR is mainstreamed in relevant sector strategies, such as health (including community health) and education. Where needed, develop specific adolescent strategies, which include ASRHR and CSE. Ensure meaningful adolescent engagement in the strategy development process.	DLI, IPF-PBC
	Cost new strategies and plans and put in place measures for monitoring and evaluation. Introduce accountability measures to track progress of policy implementation	DLI, IPF-PBC
	Develop roadmap for disseminating relevant legal and policy changes as they relate to adolescents at all levels of the system	DLI, IPF-PBC
Adolescent-responsive laws and policies are accepted and operationalized at all levels	Inform and train health staff (public, private) in adolescent-responsive laws and ASRHR policies, including health community workers	PBC, (incl. at community level)
	Inform and train education staff (public, private) in adolescent-responsive laws and CSE policies. Disseminate laws and policies to adolescent safe spaces	PBC
	Inform and train other gatekeepers on legislative changes, such as the media, local administrators and officials, ministry of justice and police, and community groups and youth-led organizations, among others	DLI, IPF-PBC PBC

⁸ For output tables 1 – 6, DLI = disbursement linked indicator; IPF-PBC = Investment Project Financing – Performance-based condition; PBC = performance-based contract; PBF = performance-based financing.

Aid instruments which use financing levers can play an important role in catalyzing policy and legal reforms and in supporting a multisectoral approach to adolescent health. Such an approach should include representation and meaningful engagement by civil society (including youth-led organizations) to ensure the rights of adolescents are taken into account and relevant reforms are discussed.

Using financing levers to accelerate progress towards ASHR legal and policy reforms

Legal and policy reforms are often needed to remove constraints to accessing SRH services and information, and to provide CSE to adolescents. In the health sector, these policies may relate to abolishing restrictions to accessing contraceptives based on age, marital status or parity, such as requirements for adolescents to be accompanied by husbands or parents when attending a facility⁹. Policy reforms should also prioritize the removal of user fees for adolescents at public health facilities.

Policy and legal reforms are also often needed to strengthen the enabling environment for public-private partnerships (PPPs) so that non-state actors can be contracted to provide SRH services in order to widen the number of accessible service delivery points where young people can access free or subsidized SRHR services and information, such as through service delivery agreements or voucher schemes. In the education sector, a change in policy may be required so that pregnant girls can remain in school to continue their education, or to remove policies that promote abstinence-only education or which discourage sexuality education.

- ❖ **DPF and policy/legal reforms:** There is recent experience of using DPFs to encourage human capital development-related policy action, including the introduction and implementation of legal and policy reforms in the health and education sectors. For example, the World Bank 'Niger First Laying the Foundation for Inclusive Development Policy Financing' uses a set of complementary policy levers (Prior Actions) to establish an enabling environment for better adolescent health and wellbeing in the health and education sectors (case study 1).

Case study 1: Accelerating legal and policy reforms for adolescent SRH in Niger

The WB started providing financial support to the Government of Niger and relevant implementing authorities to implement the PDES II Economic Development Plan (2017 – 21) in 2019 using a DPF (the first in a series of two). The objective was to lay the foundation for inclusive development. Prior Actions included presidential orders and ministerial decrees for: the establishment of Child Protection Committees at national, regional, departmental, commune, and village level to promote the abandonment of child marriage; enabling access to Family Planning (FP) counselling and services for married adolescent girls without their parents or husbands' mandatory accompaniment, in order to improve access to health services; and, allowing adolescent girls to remain enrolled in school in the event of pregnancy or marriage, to improve educational attainment (itself linked to delayed fertility). [P169830](#)

- ❖ **DPF and PFM reform:** DPF can also be used to support PFM reforms in order to, for example, increase financial flows directly to health facilities or schools and enable greater budgetary autonomy at lower system levels. Such reforms can be useful in facilitating the scale-up of PBF. In Madagascar, for example, the Investing in Human Capital Development Policy Financing program ([P168697](#)) includes a Prior Action whereby the head of government must establish rules relating to the management of

⁹ See also the following guidance on actions to address policy barriers related to the age of consent, WHO (2021), in print *Assessing and supporting adolescents' capacity for autonomous decision-making in health-care settings. A tool for health-care providers*.

budget allocations by the ministry of public health to primary health centers and for the elaboration of a procedures manual for allocations to these centers.¹⁰

- ❖ **DPF and multisectoral collaboration:** DPF operations can be used to support and encourage a coordinated, multisectoral approach, which is essential for enabling improvements in adolescent health and wellbeing. In Burkina Faso ([P170934](#)), improvement in the efficiency of health and social services is incentivized through a Prior Action which links funding to inter-ministerial coordination: a decree stipulating that ministries come together to agree on the criteria and mechanisms for a national poverty identification scheme.
- ❖ **DLIs and IPF-PBC** can be used to incentivize the same types of legal and policy development and financing reforms described above. Their use depends on the type of financing instrument of which they are part (e.g. PforR or IPF). For example, in PforR, the cost of the action is not linked to DLI allocation, which means that the financial incentive can be set at a higher level to reflect the importance of the desired reform or action. These lessons were incorporated into the 'Mozambique Primary Health Care Strengthening Program' (2018-2022) ([P163541](#)), where higher weight was given to process indicators at the start of the program to jumpstart the system and help overcome inertia, with subsequent shifts in emphasis to output and outcome indicators later in the program.

Using financing levers to support the roll out of ASRHR policy and legal reforms

Of course, it is not sufficient to enact laws and policies, they also have to be costed and disseminated. Efforts must be made to ensure they are both understood and accepted by key gatekeepers for ASRHR. Complementary, linked financing instruments can help to ensure a more coherent and coordinated approach. For example, in the 'Niger First Laying the Foundation for Inclusive Development Policy Financing' (Case study 1), financing for the operation of the newly established child protection committees is being channeled through an IPF.

- ❖ **DPF:** As the term suggests, Prior Actions used in DPF operations should ideally be stated as actions (i.e. actual changes) rather than intentions or commitments to act.^{xviii} This makes them less appropriate for financing the development and dissemination of costed strategies and plans, unless accompanied by concrete budget allocation and disbursement, since strategies and plans can and frequently do remain on the shelf for many years. While a series of DPF operations can be used for a series of actions that follow on from legal and policy reforms, they are a more blunt instrument in this regard.
- ❖ **DLIs:** DLIs can be used to incentivize the roll-out and integration of legal and policy reforms into health and education sector systems and structures, disbursing funds in proportion to the achievement of the incentivized actions. For example, the above-mentioned Mozambique Primary Health Care Strengthening Program has a DLI which pays out according to the percentage of secondary schools offering SRH services and in Ethiopia, DLIs are financing the development of an Adolescent and Youth Health Strategy and the roll-out of adolescent-responsive services in primary health centers, among other activities (Case study 2).

Depending on the context in each country, incentivized activities might include communications campaigns to inform different constituencies about the ASRHR reforms, translation of laws and decrees into plain and local languages, orientation for different types of adolescent gatekeeper (including community and faith leaders, health

¹⁰ Other relevant examples of DPF Prior Actions can be found in the World Bank [DPF Prior Actions Database](#).

providers and teachers), and making copies of the relevant laws and policies available at all levels - particularly at sites where adolescents come for information and services.

Case study 2: Ensuring DLIs facilitate the enactment of reforms in Ethiopia

The Ethiopia Health Sustainable Development Goals Program for Results (2013 – 2022) illustrates how DLIs can be used to focus attention on key actions at different levels of the system and at different stages in the program lifecycle. Four years into the program in 2017, the project introduced new DLIs with the aim of improving the quality of adolescent health services, including:

- The development and endorsement of an Adolescent and Youth Health Strategy
- The development of a package of health services to be delivered in schools
- The development of a training manual for health care providers to build competencies in providing the minimum health services package to adolescents
- Increased primary health care centers providing minimum package of adolescent health services

In August 2019, the Implementation Status Report (ISR) showed improved quality of adolescent services after previous reports showed little progress. [P123531](#)

Using financing levers to institutionalize mechanisms for adolescent participation

It is important that policies and strategies relevant to ASRHR (e.g. strategies for adolescent health, community health, primary and secondary education) lay the foundations for strengthening and institutionalizing meaningful adolescent engagement at all levels. The appropriate platforms and mechanisms for accountability and oversight will be different in each country and context and will depend on what the strategy is trying to achieve. Examples include national level structures (e.g. technical working groups responsible for inputting to legal reforms and strategy development, youth parliaments and councils), hospital and health facility advisory committees, school boards and parent teacher associations, and village health and area committees. Civil society organizations (CSO), including youth organizations and grassroots movements, can also play an important role in the design and operationalization of accountability mechanisms.

Output 2: Communities, key gatekeepers and providers have the knowledge, attitudes and social norms to support adolescents

Output 2: Key drivers for strengthening knowledge, attitudes and norms around ASRHR

Output components	Key drivers for norms-shifting programming	Financing levers
Communities, key gatekeepers and providers have the knowledge and attitudes to support adolescents....	Map/identify relevant CSOs (i.e. community, youth-led, faith-based, professional, research)	PBC DLI, IPF-PBC
	Map/identify adolescents and work out where and how they can be best reached in order to develop effective strategies for different groups	PBC DLI, IPF-PBC
	Incentivize community and intergenerational dialogue to discuss social norms and improve community understanding of the benefits of ASRHR information and services and CSE	PBC PBF Vouchers CCT

Output components	Key drivers for norms-shifting programming	Financing levers
	Engage men and boys in activities to reenforce positive social norms and behaviors and facilitate couple counselling	PBF & PBC
	Ensure service providers, teachers, and community and faith leaders have the knowledge and attitudes to support adolescents	See Output 3
...to access the information and services they need.	Use diverse platforms and activities to engage multiple groups with the aim of reaching all adolescents (i.e. regardless of age, marital status, parity, gender, physical ability, residence, workplace and/or school), including digital and social media and through existing mass media campaigns	PBF & PBC Vouchers
	Equip community health workers and other agents (i.e. call center staff) with the knowledge, capacity and skills to empower adolescents (i.e. through counselling, provision of practical information)	

Using financing levers to strengthen knowledge, attitudes and social norms

Adolescents often avoid engaging with SRH information and services due to the perceived and real discrimination and disapproval they face among community members, family and friends.^{xix} It is important to engage with different groups whose attitudes and beliefs impact strongly on the ability of adolescents – particularly girls – to acquire ASRHR knowledge and to access services. These include men and boys of all ages, traditional and religious leaders and village elders. Community and intergenerational dialogue is a constructive approach to tackling restrictive social norms and attitudes to ASRHR,¹¹ and can lead to better engagement of community members and parents in the delivery of ASRHR information in schools, helping to make CSE in schools, communities, and other sites a more effective and accepted approach.

It is important to consider the rights of adolescents at all times - particularly their right to confidentiality and privacy – and to consider who is not being reached. Adolescents should ideally be active participants in the design, implementation, and evaluation of any activities that focus on their health and wellbeing. In addition to ensuring partnership and leadership opportunities for young people, mechanisms for meaningful engagement by adolescents in the community (i.e. for receiving and acting on feedback from adolescents) can help to nudge restrictive social norms in the right direction by equipping community gatekeepers with the knowledge to support adolescents in accessing the information and services they need.

Changing social norms can be a slow and gradual process, requiring not only time but funding for complementary interventions at different levels. Financing levers can be used to finance engagement with different key groups with the aim of changing mindsets and creating a positive enabling environment. For example:

¹¹ Community dialogues are an interactive participatory communication process that brings together different generations – typically the older generations and millennials – with the aim of addressing some of the barriers that youth face related to their access to ASRHR information and services.

- ❖ **PBC:** A performance contract with a non-government organization (NGO) or other organization (e.g. research or training institutes) can be used to map and assess the capacity of different CSOs to implement ASRHR activities (i.e. their size, funding, activities, capacities). The same approach can be used to contract CSOs (in this case, community, faith-based, youth-led or other local organizations) to map adolescents in a given area (i.e. where adolescents can best be reached), and to develop effective strategies for engaging with them on ASRHR topics. This might be in or around schools, in the community, at workplaces (e.g. markets), youth clubs and so on. Performance contracts with community organizations can also be used to finance a range of community-based activities, including engagement with different specific groups (case study 3). Performance contracting can be undertaken by the relevant ministry or it can be assigned to a non-state or para-state organizations which will require (or will need

Case study 3: Using PBC to work with religious leaders and engage in social behavior change in Nigeria

The Nigeria Accelerating Nutrition Results project (2018 – 2023), financed through an IPF, aims to increase utilization of quality, cost-effective nutrition services for pregnant and lactating women, adolescent girls and children under five. The project design includes a range of PBCs with non-state actors to scale up health and nutrition services, including a performance contract with a specialized non-state actor to engage with religious leaders at all levels for behavior change communication around key nutrition and adolescent health services. PBCs are also being used to provide counselling to adolescent girls on health and nutrition, and to provide alternative delivery channels for SRH services to married adolescents to promote birth spacing.

Supporting and enhancing these activities, the federal ministry of health will use performance-based contracting to air a national mass media campaign that focuses on key messages related to health and nutrition behaviors, including those related to adolescents. The project also intends to support the government to test - at large scale - the contracting of non-state actors to deliver these services. Highly relevant learning should therefore emerge over time. [P162069](#)

to develop) contracting and performance management capacities in order to manage the contracts effectively and efficiently.

As case study 3 shows, **DLIs can also be used to strengthen contracting approaches** by financing complementary activities, such as media campaigns. DLIs can also be used to strengthen management and administration of the contracting process by channeling funds to government or non-government contracting agencies at the regional, district, community level for institutional strengthening (e.g. for the design of performance management processes and systems and tools, and training).

- ❖ **Conditional Cash Transfers (CCTs) and vouchers:** Demand-side financing approaches, such as CCTs and vouchers, can strengthen the ways in which PBF and PBC (as well as other strategic purchasing approaches) engage with communities, channeling funds to community organizations in exchange for certain activities (i.e. organization of community and intergenerational dialogues, or SRH service points in the community) (case study 4).¹² Voucher schemes have been shown to help overcome the fear and stigma that are often associated with receiving ASRHR information and services by incentivizing community health workers to assist adolescents to access the services.^{xx} Adolescents feel empowered when agents from their own communities support them and this further helps to change community norms especially when combined with activities to address social norms in the community (**Error! Reference source not found.**).

¹² See also Annex 3 which provides a brief explanation of how PBF and vouchers can work in combination.

Case study 4: Using PBCs and CCTs to strengthen community engagement in the Gambia

The Maternal and Child Nutrition and Health Results project (2014-2019) in the Gambia financed by the Health Results Innovation Trust Fund (HRITF) aimed to increase the utilization of community nutrition and primary maternal and child health services in selected regions. PBCs were introduced to contract village support groups to provide social behavior change and communication activities (SBCC). The regional health directorates of the Ministry of Health contracted Village Development Committees (bodies which serve as the lowest local governance level) which in turn contracted village support groups to undertake activities designed to increase demand and utilization of health and nutrition services. This was done through linking cash payments to the provision of counseling on hygiene, sanitation, and other RMNCH services, as well as providing referrals to health facilities for delivery. Verification of the results and payments were implemented by the National Nutrition Agency. A sub-national PBF contracted public and private health facilities to provide a package of MCH and nutrition services and included CCTs to women provided for timely antenatal care visits with a skilled provider. While this project did not explicitly include indicators or incentives focused on adolescent health and nutrition, there are interesting lessons from this approach: a combination of PBC, PBF and CCTs can be used to engage community groups and facilitate their work, as well as to support health providers to organize multiple service delivery channels that are important for ASRHR service delivery. [P143650](#)

Outcome 2: SRH information and services are adolescent responsive and utilized by adolescents in health and education settings

This outcome is about strengthening the supply of good quality services to adolescents, including information about their SRHR provided in communities, schools and workplaces, good quality services that are available through a range of delivery channels (including in schools), and CSE in schools, communities, workplaces and other sites.

Output 3: Health and education service providers are trained and have the resources to provide quality adolescent responsive services and CSE

Output 3: Key drivers for strengthening the supply of adolescent-responsive services and CSE

Output components	Key drivers to strengthen ASRHR services and information	Financing levers
Health service providers have been trained...	Develop/strengthen guidelines and standards for ASRHR services (including definition of an integrated service package for provision of a full range of essential ASRHR services)	PBF DLI, IPF-PBC
	Develop/revise curricula and other training materials and job-aids, including for supportive supervision, and ensure available budget	PBF DLI, IPF-PBC
	Train all members of health workforce (including support staff) using high-impact pre- and in-service training techniques (i.e. low-dose, high-frequency, interactive) and ensure follow-up with refresher training, mentorship, and supportive supervision	PBF & PBC DLI, IPF-PBC
	Strengthen infrastructure required for ASRHR (privacy, comfortable waiting and counselling spaces)	PBF & PBC

Output components	Key drivers to strengthen ASRHR services and information	Financing levers
...and have the resources available...	Ensure available equipment, supplies, tests, contraceptives, medicines, transport facilities, etc. required for ASRHR	PBF & PBC DLI, IPF-PBC
...to provide quality adolescent responsive services.	Incorporate ASRHR indicators in Quality Assurance and Quality Improvement frameworks, including for PBF, and incorporate adolescent feed-back	PBF & PBC Vouchers
	Integrate ASRHR services into other services to provide additional opportunities to reach adolescents	PBF & PBC
	Ensure effective follow-up care after first uptake of ASRHR services, and strengthen referral linkages to specialist adolescent health services (e.g. mental health services)	PBF & PBC, Vouchers
	Ensure multiple service outlets with appropriate opening times, including in the private sector, in collaboration with schools and communities. ¹³ Ensure service points are discrete, confidential and provide 'rapid' care (i.e. without long waiting times)	PBF & PBC Vouchers
Teachers have been trained and have the resources available to provide quality CSE.	Develop/revise curriculum, technical guidelines, job-aids and standards for CSE in and out-of-school and ensure budget available for CSE materials, and pre- and in-service training of teachers in public and private schools. Strengthen teacher supervision and adapt exams to include CSE	DLI, IPF-PBC PBF
	Train teachers in public and private schools. Make training (including materials) available and accessible to relevant CSOs to enable them to implement out-of-school CSE	PBF & PBC
	Provide good quality CSE in schools, communities, workplaces and other sites and monitor its effect	PBF & PBC

Many of the actions required to strengthen the supply of ASRHR services are the same as those needed to improve broader health services for all clients. These actions include the development of ASRHR curricula, provision of improved training (pre-service, on-site and refresher training), supportive supervision, a continuous supply of commodities and medicines, functioning equipment, and so on. However, certain key drivers of quality care are particularly important for adolescents, including a welcoming and safe space, privacy and confidentiality, and non-judgmental attitudes of staff.

Moreover, it is important to deliver services and information to adolescents where they are, which means providing CSE both in and out of school, and appropriate school health services that are provided by health workers to students enrolled in primary and secondary education either within or outside the school premises.¹⁴

¹³ Private sector here denotes private schools, private-for-profit and not-for-profit health facilities, pharmacies and drug stores and other providers of services at different levels of the health system.

¹⁴ See in particular the [2021 WHO Guideline on School Health Services](#), and the revised [UN International technical guidance on sexuality education \(revised edition\)](#) (2018).

Using financial incentives to strengthen professional development of staff

ASRHR needs to be integrated into the relevant professional development activities for staff at health facilities and schools, including orientation and training, values clarification (see Box 2), refresher training, mentorship, supportive supervision, and client feed-back. Training curricula for ASRHR need to be developed and improved, based on the global guidelines as well as the knowledge of what works to improve ASRHR in a particular context and setting.¹⁵ Technical guidelines based on national protocols and standards should integrate adolescent specific guidance and should be available at all service delivery points.

Box 2: What is 'values clarification'?

'Values clarification' for ASRHR is an important part of a broader package of activities aimed at changing attitudes and social norms. In this approach, people examine their own attitudes towards adolescent sexuality and SRH, learn about adolescents' needs and rights, and discuss the rationales for providing good quality SRH services and information. These activities are reinforced through broader efforts to strengthen societal norms and attitudes to ASRHR, such as legal/policy reforms, and mass and social media campaigns.

- ❖ **DLIs or IPF-PBC** can be used to incentivize (and finance) the development and roll-out of a wide range of activities which support professional development. These include training curricula, standards for supervision or other mechanisms to ensure trainees apply acquired knowledge and skills, and technical guidelines and resources needed to improve the quality of ASRHR services and CSE. DLIs can be structured so as to consolidate and build on results as they are achieved, and can be used to prioritize certain ASRHR-related activities (e.g. the incorporation of ASRHR topics into standards for supportive supervision). These aspects are illustrated by the example of the World Bank's secondary education program in Bangladesh, which uses DLIs to incentivize a comprehensive package of activities (key drivers) for improving delivery of and access to adolescent SRH services and information (case study 5).¹⁶

Case study 5: Using DLIs in Bangladesh to incentivize teachers' professional development as part of a school-based program for ASRHR

Recognizing the strong links between education outcomes and the health and wellbeing of young people, particularly girls, the Transforming Secondary Education for Results project in Bangladesh (2017 – 2022) uses DLIs to finance the development and implementation of an Adolescent Girls Program, including key actions to strengthen teachers' professional development:

- ❖ Inclusion of adolescent health topics in the curriculum
- ❖ Awareness raising around adolescent health for students, teachers and communities
- ❖ Promotion of links between health services and schools
- ❖ Inclusion of adolescent health in teachers' continuous professional development
- ❖ Formation of school-based committees

These activities are complemented by incentives to female students to stay in school, and the introduction of school-based counselling and promotion of positive relationships for students. Importantly, collaboration between the Ministry of Education and Ministry of Health and Family Welfare on the design of the program is also a DLI, and the program also delivers performance-based grants to participating schools for improved governance and management and to strengthen accountability mechanisms (see also [Error! Reference source not found.](#)). [P160943](#)

¹⁵ See footnote 7 for international standards and guidance.

¹⁶ This program is financed by the World Bank through a PforR with an IPF component.

Using supply- and demand-side incentives to strengthen service coverage and quality

It is important to broaden service delivery channels that can reach different groups of adolescents. This can be achieved by purchasing ASRHR services from a range of approved providers in public and private sectors, integrating ASRHR services within wider health services, introducing or strengthening ASRHR service provision in schools, and establishing functioning linkages between schools and health services. It is important to ensure a coordinated approach from the community up to the national level. This means strengthening referral systems, including directing adolescents from different departments within a broader facility (e.g. outpatient services or emergency care) to contraceptive and SRH services, and from SRH services to higher-level facilities and to other specialist services, such as mental health services, when required. These are all key drivers for improving the quality of care for adolescents.

The incentive structures of different results-based approaches can be used to place particular emphasis on meeting the needs of specific population groups (i.e. adolescents), and to channel funds to underutilized, high-value services, such as post-partum family planning for young adolescent mothers or nutritional supplements for adolescent girls. Synergies can be achieved by combining financing levers (say, PBF, PBC and/or vouchers) to reach different groups of adolescents through different channels in a more coordinated approach both within sectors (e.g. between public and private health providers) and across sectors (i.e. linking health, education and other sectors).

- ❖ **PBF, PBC and vouchers** can be used to introduce or extend strategic purchasing of adolescent health and education services, routing funds directly to lower levels of health and education systems, and increasing the supply of services through alternative channels (including at the community level). In PBF, quality improvements are incentivized by adjusting the fee for service by a quality score, while in vouchers and PBC, quality is typically controlled through entry level requirements to the scheme and subsequent period quality assessments. Results-based payments can then be used at the local level to address quality bottlenecks by, for example, purchasing out-of-stock drugs or hygiene products, or hiring contract staff.

Decision-making for investing these funds usually rests with the staff of participating organizations, guided by 'business plans'.¹⁷ Where services for adolescents are explicitly incentivized, recipients will be motivated to use the funds received to tailor services to the needs of this group, because this will help to engage more adolescents in the services offered and hence earn more income. They may, for example, invest PBF payments in creating more private and welcoming areas for adolescents (for registration, waiting and consultations), or in establishing systems for involving adolescents in the design and delivery of services and CSE.

- ❖ **PBF** can be used to incentivize other quality-improving processes, such as attaining minimum adolescent-responsive standards of care at facilities or CSE standards in schools. In the vast majority of PBF interventions to date, it is assumed that adolescents will benefit either as part of a wider target group of 'women of reproductive age' or as children. This makes it hard to understand which adolescents are being reached, and risks missing those who are hardest to reach, such as young married adolescents and sexually active unmarried adolescents. Only very rarely do PBF indicators explicitly incentivize adolescent SRH services, although one project in Uganda is doing just this (case study 6).

¹⁷ In PBF, district and/or regional health and education teams or other relevant local agencies will usually input to business plans and investment decisions.

Using financing levers to leverage private sector capacity

Efforts to strengthen the supply of good quality services and information must reflect the persistent inequalities in access to services among different groups of adolescents and address the gaps in service utilization. Using multiple channels to deliver information and

Case study 6: Using PBF to improve availability and quality of health services from the bottom up in Uganda

The Uganda Reproductive Maternal and Child Health Services Improvement Project (2016-2021), financed through an IPF operation, includes a sub-national PBF which rewards participating facilities and selected other parties based on the quantity and quality of services delivered from the essential health services package (EHSP). The PBF package of services includes adolescent responsive services at participating facilities, schools and in the community (i.e. through village health teams) and referrals from the community and primary health center level (Health Center - HC II) for adolescent care, sexuality and life skills education. At higher health system levels (HC II up to hospitals), facilities are incentivized to provide an adolescent friendly package of health services (including BCC and Information Education and Communication (IEC) materials) together with direct provision of post-abortion care. [P155186](#)

services to adolescents is a key driver for reaching different groups. Adolescents often choose to access SRH services from the private sector (particularly unmarried adolescents and out of school youth), and financing approaches can be used to support governments to leverage the capacity of private sector providers, which is also a Strategic Direction of the [GFF Strategy \(2021 – 2025\) \(case study 7\)](#). In addition, CSOs can be contracted to implement CSE out-of-school.

- ❖ **PBF, PBC and vouchers** are all approaches which enable contracting of private sector organizations, including private for-profit and not-for-profit healthcare providers and faith-based providers, private schools, private training institutions, professional organizations, and non-state community-based/youth organizations and NGOs. In the absence of PPP legal and policy frameworks, these approaches can introduce lessons and skills for contracting out (including negotiating contracts, monitoring, oversight and compliance), claims processing (vouchers), accreditation and quality assurance, verification and fraud control. See also **Error! Reference source not found.** for an example of using vouchers to contract private health facilities for adolescent family planning services.

Ensuring coordination across different financing levers

When different types of financing levers are combined, it is important to exploit potential synergies and to ensure coordination of incentives across the different approaches and instruments.

- ❖ **Combining PBF and vouchers:** There is strong evidence that vouchers can increase the use of targeted services and enhance equity of access.^{xxi} Where vouchers and PBF are combined in a single scheme, this has the potential to strengthen knowledge of and demand for SRH services among adolescents and to accelerate utilisation of those services at the PBF facilities. A combined scheme is preferable because when these schemes exist in parallel, there is the potential to 'double pay' facilities that participate in both schemes for the delivery of the same services. Annex 3 describes how to adapt a voucher scheme so that it can be combined with a PBF.

- ❖ **Combining PBF and PBC:** Combining PBF and PBC can extend service coverage by engaging a range of service provider types that cater to different groups of adolescents and their preferences. The Multisectoral Nutrition and Health project in the DRC (2019-2025) illustrates how PBF and PBC are being used in a coordinated way to address a range of challenges related to poor reproductive health and early motherhood among adolescent girls (case study 7).

Case study 7: Using PBF and PBC for a multisectoral and coordinated approach to service delivery in DRC

The Multisectoral Health and Nutrition Project in DRC (2019-2025) uses a three-pronged approach to strengthen service delivery from the bottom upwards: improving service supply and strategic purchasing; improving the delivery of community interventions and social and behavioral change; and, demonstrating the added value of multisectoral convergence to improve nutrition outcomes.

PBC is used to purchase family planning services for adolescents from non-state providers (based on evidence that young people prefer to access contraceptives through the private sector), as well as to contract NGOs to identify and manage community-based volunteers called *Relais Communautaires*. These volunteers provide a basic package of community nutrition and health services, including counseling and behavior change communication related to reproductive health and gender issues, nutritional supplementation, contraceptives and referrals to health facilities. A PBF scheme also includes incentives for nutrition sensitive services to adolescent girls. Unconditional cash transfers are designed to improve access to nutritious food for pregnant women and mothers of young children, and other inputs will strengthen the supply of services.

This coordinated approach was designed to tackle: i) the absence of a coordinated response at the community health level; ii) low availability and quality of health, FP, and other nutrition-sensitive services; and, iii) weak governance and management capacity of state actors at the local, provincial, and central levels.

[P168756](#)

There is some concern that numerical goals for uptake of contraceptives may violate rights-based principles for adolescents, and it is important that measures for monitoring and measuring results-based financial incentives (i.e. verification processes) respect voluntarism and choice of ASRHR services, particularly with regard to contraceptives.^{xxii} Guidance has been developed which supports the operationalization of rights-based principles for contraceptive services in results- and output-based programs.¹⁸

¹⁸ A Health, Nutrition, and Population (HNP) Discussion Paper (8663) of the World Bank presents a conceptual framework that can be of use to task teams in the decision-making process for FP in results-based financing programs ([Chowdhury et al. 2013](#)). See also the chapter on Indicators and Measurement for information about verification of ASRHR services.

Outcome 3: Adolescents are empowered to take decisions to meet their SRH needs

Empowering adolescents to initiate action and take decisions related to their bodies and sexual and reproductive health is essential for enabling them to fulfil their potential in life. It is one of the five 'game changers' of the World Bank's [Africa Human Capital Plan](#), which aims to empower women by reducing adolescent fertility rates to support Africa's demographic transition. However, empowering adolescents (particularly adolescent girls) and enabling them to use SRH services, remains one of the most persistent bottlenecks in SRH programming. Effective participation by adolescents in ASRHR design, implementation and evaluation is critical, including introducing opportunities for partnership with adults (see Box 3). Meaningful engagement and even leadership can also support functioning accountability mechanisms (enabling adolescents to hold duty bearers to account), providing adolescents with the information they need via multiple channels, and building their confidence and trust in using the available services are important parts of the solution.

Box 3: What does empowering adolescents mean in practice

Empowerment is an inherently complex concept and empowerment of adolescents is also a multisectoral issue (i.e. not specific to one sector). The use of the word empowerment with relation to ASRHR in this Paper refers to the creation of an environment and culture that allows for the autonomy of adolescents, and in which they are respected, valued and trusted. It does not deny young people their intrinsic power but rather enables them to express this power in a safe environment by providing them with the tools and information they need to realize their SRH rights.

Output 4: Adolescents and communities are agents of change in functioning accountability mechanisms

Output 4: Key drivers for strengthening meaningful adolescent engagement in functioning accountability mechanisms

Output components	Key drivers for meaningful adolescent engagement	Financing levers
Adolescents and communities are agents of change in functioning accountability mechanisms (with service providers and decision makers)	Institutionalize the participation of adolescents in relevant governance and accountability structures (i.e. health facility committees and school committees and boards) at all levels through integration into policies, strategies and plans	DLI, IPF-PBC
	Enable the effective participation of adolescents in governance and accountability structures and approaches to enable their meaningful involvement (i.e. safe spaces, treat as equal partners), and supporting positive youth development (PYD) approaches	Community PBF & PBC CCTs & Vouchers DLI, IPF-PBC
	Institutionalize national accountability mechanisms to track if and to what extent marginalized adolescents are reached	DLI, IPF-PBC
	Train government officials to use approaches for adolescent participation (i.e. advisory platforms)	
	Share progress with and collect feed-back from adolescents and communities, including complaints mechanisms	

Using financing levers to strengthen adolescent participation in accountability mechanisms

Engaging CSOs, including youth-led organizations, and youth at all levels is central to the GFF multi-stakeholder approach, and to the achievement of country goals prioritized in the country Investment Cases, and is set out in the [CSO and Youth Engagement Framework \(2021–2025\)](#). Active participation and engagement of youth-led organizations is particularly important in accountability structures, since these structures often play a role in the design and oversight of activities designed to support adolescents (see Box 4).

Box 4 What is meaningful adolescent engagement?

While interpretations of, and expectations for meaningful adolescent engagement need to be agreed locally between stakeholders, the [Global Consensus Statement on Meaningful Youth and Adolescent Engagement](#) (known as MAYE) provides a useful definition that can be tailored to local contexts: “Meaningful adolescent and youth engagement is an inclusive, intentional, mutually-respectful partnership between adolescents, youth, and adults whereby power is shared, respective contributions are valued, and young people’s ideas, perspectives, skills, and strengths are integrated into the design and delivery of programs, strategies, policies, funding mechanisms, and organizations that affect their lives and their communities, countries, and world”.

Mainstreaming community and youth engagement is also essential for fulfilling the ‘added focus’ rights-based principles of Transparency and accountability; Agency, empowerment and autonomy; and Voice and participation (see Annex 1, Figure 4).

While national health and education policies and strategies can support the institutionalization of accountability structures, including by stipulating participation of youth-led organizations, explicit efforts are needed on the ground to enable active and meaningful participation, rather than ‘box-ticking’. Activities are needed that help ensure the views of different groups of adolescents are heard and considered, and their costs covered.

Different financing approaches may be more appropriate for providing incentives to strengthen accountability structures at different levels. For example, PBC and PBF can be used to revitalize and strengthen health facility advisory committees and school boards, as well as to finance participation by youth and community organizations. These activities can be reinforced through the selection of DLIs in IPF and PforR operations to strengthen the policy environment for adolescent participation (i.e. through the explicit incorporation of adolescents in relevant policies and strategies as participants in accountability mechanisms).

In fact, accountability is inherent in many results-focused financing approaches, because results need to be monitored and verified (see also Indicators and measurement). PBF in particular often includes the contracting of CBOs and CSOs to trace clients and verify that the recorded services were actually used, and to undertake user satisfaction surveys to capture patient feedback. However, enabling effective participation and capturing the real voices of adolescents in PBF programs remains challenging and requires specific efforts.^{xxiii} One approach for capturing feedback from adolescents that has been successfully trialed is the use of mystery clients.^{xxiv}

- ❖ **PBF & PBC** can channel funds to strengthen the functioning of accountability mechanisms by linking disbursements to the number and quality of engagements. There are few examples of financing levers being used explicitly to incentivize adolescent participation in accountability platforms at any level in the health and education sectors. However, performance grants through PBF and PBC are being provided to institutions (i.e. health facilities, schools) which meet minimum accountability requirements (**Error! Reference source not found.**) and these requirements could be extended to include the participation of adolescents.

Case study 8: Using performance grants to strengthen accountability in Bangladesh

In the Bangladesh Transforming Secondary Education project (2017–2022), performance grants are provided to schools which meet the minimum accountability requirements. These requirements include a functional Parent Teacher Association (PTA), school management committee, achievement of performance targets, teacher attendance, and improved water and sanitation facilities. In addition to performance grants, a DLI incentivizes the number of institutions meeting these minimum requirements. It would be a short step to adjust the definition of 'functional PTA' and the make-up of school management committees to include adolescent representation (see **Error! Reference source not found.**) [P160943](#)

- ❖ **CCTs** can provide the resources necessary to cover the costs associated with the functioning of accountability mechanisms, conditional upon the effective participation of adolescents. CCTs and unconditional cash transfers (UCTs) can also channel funds to hard-to-reach, poorer or otherwise more vulnerable communities and individuals to support participation. Operational definitions will be needed that are tailored to the context in which implementation is taking place (see Box 4) and process indicators will be needed to monitor participation and conditionalities where relevant.¹⁹

Using financing levers to strengthen adolescent feedback mechanisms

It is important to consider which groups of adolescents are able to participate, who is left out and what extra efforts are needed to reach them, and whether participation is effective (i.e. adolescents have a voice and can influence decisions and actions). Adolescents should be involved in both defining and measuring the quality and effectiveness of their participation in different accountability mechanisms.

Ensuring adolescents have the opportunity to feed back their views and have the right of redress are essential components of effective participation. The Tanzania Secondary Education Quality Improvement project (2019–2026) ([P170480](#)) aims to strengthen grievance redress mechanisms (GRM) across all system levels through: the use of suggestion boxes; appointment of GRM focal persons on school boards and committees; identification of GRM focal persons at the local government, regional and national levels; and guidance and counselling for teachers at participating schools. While these activities are not incentivized through financing levers, it would be relatively straightforward to link progress in achieving these activities to financial incentives.

¹⁹ Both conditional and unconditional cash transfers (UCTs) are widely used to improve adolescent health outcomes. A World Bank evidence review Improving the Well-Being of Adolescent Girls in Developing Countries provides a useful summary of both CCTs and UCTs.

Output 5: Adolescents know what information and services they are entitled to and are enabled and empowered to seek them

Output 5: Key drivers for enabling and empowering adolescents to seek the SRHR services they need

Output components	Key drivers for enabling and empowering adolescents	Financing levers
Adolescents know what information and services they are entitled to and are enabled and empowered to seek them	Identify the most feasible strategies for ensuring girls receive information and can take decisions related to their SRHR through multiple channels, including a variety of agents, outlets and locations, such as community agents who visit adolescents, e-health (i.e. call centers, SMS, social media and other digital platforms/support); public and private health facilities and schools, pharmacies and drug stores	DLI, IPF-PBC
	Design, adapt and apply tools to empower adolescents to decide about their SRH (e.g. life-planning discussions, goal cards, financial counselling and planning, etc.)	Community PBF & PBC
	Provide age-appropriate CSE that responds to social and gender norms in schools (public, private), communities, work places or other relevant sites and caters to the development stage of different adolescents	PBF & PBC
	Empower adolescents to access ASRHR care, including through provision of face-to-face information, counselling, and referral and entitlement to ASRHR services (e.g. referral cards, vouchers)	Community PBF & PBC Vouchers
	Provide care that is free at the point of delivery (and affordable contraceptives) and ensure girls are confident about their entitlement to free ASRHR services (i.e. through (e-)vouchers, referral cards or other entitlement)	See Error! Reference source not found. and Output 2

Empowering young people and enabling them to use the SRH services they need is a complex endeavor, requiring an in-depth understanding of the context and environment in which young people live and work, as well as the barriers they face in accessing information and services. Approaches are needed which tackle social norms and to change behaviors related to ASRHR among different constituencies at different levels (see also output 2). These should draw on local knowledge to be developed using participatory methods (see Box 5).

Research on access to contraception among young people suggests that the effect of social norms on behavior is associated with 'ability' to act, as opposed to solely relying on young people's motivation, which has been a long-held assumption. Ability here is defined as both the mental and practical ability to access contraception. Health interventions that increase girls' and women's ability to access and use contraceptives, such as a SRH voucher scheme or a PBF intervention, may be able to overcome some of the negative effects of these social norms. This means tackling embarrassment and lack of confidence in being able to obtain and use a contraceptive method, as well as providing information on where to access the services they need.^{xxv}

Box 5 Important activities for empowering young people

Some important elements in any adolescent empowerment strategy include:

- ❖ Building relationships with adolescents over time
- ❖ Creating opportunities for face-to-face SRH counseling, whether by phone or digitally
- ❖ Provision of practical information about SRHR (the what, why, where) from a trusted, and where possible, confidential source
- ❖ Tokens or vouchers which convey an entitlement to free or highly subsidized ASRHR care
- ❖ Accompanying adolescents to the ASRHR service points, where necessary

Girls can be empowered through support from trusted agents in their own communities; e.g. through counselling and information provided by trusted community volunteers (such as an 'auntie' or other trusted adult), health workers or school staff. Some programs use peer-led approaches, however, there is some evidence to show that peers are not always the most appropriate source of SRHR information for young people. Developing the skills of adults in the community to respond to the needs of adolescents is consequently an important element of any strategy that aims to empower young people, be it through community dialogues, participation in values clarification workshops, or other activity.

Source: [Chandra-Mouli, Lane and Wong \(2015\)](#)

Using financing levers to empower adolescents to seek the information and services they need

The most appropriate strategies to empower girls can be different in each context and **DLIs** can be selected to finance and incentivize the development of these strategies, while also incentivizing multisectoral inputs to strategy development and participatory processes that include adolescents. **PBC** can be used to channel funding to local organizations and groups such as NGOs, accountability platforms and community organizations to undertake needs assessments and strategy development, which must reflect the political economy and social structures and norms in a particular context. Strategies should be periodically reviewed.

Community PBF, PBC, and vouchers can all be used to deliver practical information and guidance related to ASRHR, as well as to introduce fee waivers or subsidies at the community and health facility levels for identified vulnerable population groups.

- ❖ **Vouchers** are a particularly useful tool for generating demand for services and enabling adolescents to access SRH services (**Error! Reference source not found.**). While this area remains under-researched, there is now a wealth of program experience from voucher schemes that target adolescents with ASRHR services (i.e. in Kenya, Madagascar, Nicaragua, Uganda, and Zambia).²⁰

Vouchers provide a personal invitation to the adolescent to take a service, which is empowering because it not only confers the right to access the service, it also serves as a guarantee that the service will be free at the point of delivery. Voucher distribution provides critical opportunities to deliver interpersonal counselling and communication to adolescents by community agents, as well as practical information on the 'what, why and where' of SRH services. These agents often receive performance-based payments for each voucher distributed and/or used,²¹ which has shown to motivate agents to find adolescents where they are, to counsel and give them the necessary

²⁰ The World Bank has financed voucher programs in Uganda and Zimbabwe, working with development partners. See list of references for additional reading on vouchers.

²¹ It can be difficult to set performance payments at the right level and sometimes time is needed to get this right (i.e. when set too low they can be a cause for inaction and when too high this can provide perverse incentives). Monitoring is important to guard against potential gaming.

information and accompany them to the health services. These aspects of voucher schemes are an invaluable way to bring adolescents into ASRHR care.^{xxvi}

In addition, vouchers provide a useful tool to implement interpersonal counselling and communication on ASRHR at scale, which can be difficult to achieve. Vouchers (or referral cards) for ASRHR services provide a practical tool to streamline this process. This is because vouchers are handed out (either physically or digitally) to each intended beneficiary and this activity can be accompanied by information and counselling on the voucher services on offer. This is essential for engaging intended beneficiaries and linking them to the services. The collection of data on vouchers distributed facilitates monitoring of counselling activities and this in turn supports scaling based on what works.

- ❖ **CCTs:** CCTs (and indeed UCTs) are widely used to incentivize girls to remain in school and can also be used to facilitate access to nutrition services (e.g. nutritional supplementation) and safe delivery services (ante and post-natal care and facility-based delivery). There are, however, potential ethical considerations for using CCTs to build demand for family planning services, other than those which simply reimburse the indirect costs associated with accessing services, such as travel costs. The need to ensure safeguarding for all adolescents means that paying young people to access contraceptive services is not a viable strategy; unequal power dynamics between adolescents and adolescent gatekeepers gives rise to the potential for coercive behavior.²²

Case study 9: Vouchers for adolescents significantly increase SRH service up-take in Kenya

Marie Stopes Kenya (MSK) started providing free services to young people of 10 to 19 years in 2016, extending opening hours suitable for youth, and organizing special youth-only days. Providers were trained in youth responsive service provision and received sensitization on the Kenya Adolescent SRH policy. Intensive BCC activities were organized, including parent meet-ups, and the use of voluntary Teen Connectors based at the MSK clinics who mobilized young people and escorted them to centers, and who were paid a small performance payment for each successful client referral.

In 2017, MSK introduced a youth voucher through its AMUA Social Franchise clinics removing user fees for a comprehensive basket of SRH services for adolescents. Vouchers were distributed by trusted community workers (Community Health Volunteers - CHVs), paid monthly per voucher used at one of 124 AMUA participating youth-responsive centers. CHVs provided face-to-face counselling and information, involved community leaders in dialogue, and accompanied adolescents to facilities, if requested. As the program took off, providers overcame their fears of 'legal' issues and parental disapproval and gained skills to counsel adolescents. Motivated by voucher-income, CHVs and AMUA clinics created youth spaces, expanded opening-hours, and organized outreach, including at local schools.

The results included:

- ❖ A quadrupling in the proportion of clients aged 10-19 years in voucher clinics, with no displacement of older clients (no increase was seen at non voucher clinics)
- ❖ Over two thirds of girls chose long acting and reversible contraceptive methods
- ❖ A high proportion (84%) of voucher users had never previously used contraceptives and most were single (89%) and had no children (75%)

Source: [Omari et al. \(2018\)](#). How and why do vouchers increase uptake of Sexual Reproductive Health Services among adolescents in Kenya

²² There is good evidence that using UCTs can also lead to important results in this area (see [Bergstrom & Özler 2021](#)). Given UCTs do not tie cash to specific actions, they are free of some of the ethical issues raised here, while being easier to manage and monitor.

- ❖ **Community PBF or PBC** with youth and other relevant organizations can be used to design culturally appropriate tools that support youth engagement and empowerment around ASRHR issues. There is now a wealth of experience as well as a range of tools and guides that can be used and adapted. Examples include 'goal cards' which help a girl to plan her life or to have life-planning discussions with her partner; life-skills sessions that can be provided at ASRHR service points; and score cards where girls can score the quality of the ASRHR services and provide feedback to service providers. Some programs have been testing a financial planning approach which positions contraception as a tool to achieve self-defined life goals.²³ PBF and PBC can also be used to contract community and youth organizations to conduct community dialogue, and provide practical information and guidance, as illustrated in Output 2 above.

Using financing levers to provide free services to adolescents

The knowledge that they can access services which are either free or highly subsidized in both public and private sectors has an empowering effect for adolescents.^{xxvii} Where SRH services are not provided for free, options for reimbursing service providers for the costs of provision should be considered in order to provide adolescents with subsidized or free access. Different options include:

- ❖ **PBF:** a defined package of services is purchased on behalf of adolescents who receive free ASRHR care in participating public and/or private facilities which are reimbursed a pre-agreed fee for service that is modified according to a quality score, with greater incentives for better quality care;
- ❖ **Vouchers:** a defined package of services is purchased on behalf of adolescents in the form of a voucher booklet distributed directly to adolescents, which can be exchanged for services in designated facilities or other accredited outlets providing adolescent-responsive care (i.e. public or private health facilities, pharmacies, drug stores). These outlets are reimbursed the cost of service provision. Community agents who distribute the vouchers receive performance-based incentives for vouchers utilized;
- ❖ **Combination of PBF and vouchers:** vouchers can be integrated in a PBF, whereby vouchers serve as a proof of entitlement to adolescents that they will receive free ASRHR care, and the PBF scheme reimburses participating facilities for the voucher services utilized (see also Annex 3);
- ❖ **PBC:** a defined package of services is purchased on behalf of adolescents through the contracting of non-state providers (e.g. using service delivery agreements) which are reimbursed a pre-agreed amount for verified services utilized by adolescents, who in turn receive the services at subsidized rate or for free. As with vouchers, this approach can be utilized to contract providers of a minimum quality standard, and to broaden service delivery channels for adolescents by contracting with, for example, networks of pharmacies and drug sellers;
- ❖ **Other pre-payment mechanisms:** these include health equity funds which are third-party arrangements that reimburse public or private health facilities for the user fees for a defined service package provided to a defined group such as the eligible poor.^{xxviii}

These approaches draw on marketing know-how by capitalizing on what are sometimes referred to as the 4 Ps of product, price, promotion and place (with 'policy' added as a 5th P in some literature).^{xxix} Whichever approach is selected, it is important to consider the ways in which the services and information are:

²³ See for example, [Smart Start](#) in Ethiopia.

- ❖ Promoted – adolescents are made aware of the availability of free and/or subsidized services and are confident that services will be free (or low cost) at the point of delivery (i.e. through the provision of a physical or electronic voucher or referral card)
- ❖ Distributed - adolescents receive good quality face to face counselling and practical information within their own communities, which serves as an additional catalyst to visit ASRHR services. Providing referral agents (which may be community health workers or even a call center agent) with performance-based rewards based on successful referrals (i.e. the adolescent visits the service) provides an incentive to do the work well.

Outcome 4: Evidence and learning demonstrate what works to improve ASRHR

Adolescents rarely feature among the quantitative or qualitative results of programs which aim to improve SRHR outcomes. It was not until the advent of the SDGs in 2015 that an explicit adolescent health indicator was introduced to measure progress towards global health targets ([indicator 3.7.2 on adolescent fertility](#)). Even today, this indicator is not reported for many LMICs, including those in sub-Saharan Africa. And while adolescents are the focus of the up-dated Global Strategy for Women's, Children's and Adolescents' Health (2016-2030), results are most often presented for all women of reproductive age (including adolescents), which hides progress for this important group.^{xxx}

The lack of disaggregated data in national data systems lies at the heart of this challenge – data systems are often not designed to gather information on adolescents (see Box 6). Poor availability of disaggregated data results in poor understanding of health needs among different groups of adolescents and consequently insufficient focus on the approaches required to address these needs.

Output 6: Disaggregated, quality, timely data and research are available which monitor who is reached with services and information

Quality data are essential for informing planning and policy decisions by governments and to design and tailor approaches which meet the needs of adolescents at different stages of this fast-changing period in their lives. However, many information management systems in resource-poor countries (i.e. health management information systems and other relevant data systems) do not disaggregate by age groups that are sufficiently narrow to inform policy and programming. Furthermore, the indicators and other measures of ASRHR tend to be narrow, often only looking at teenage pregnancy rates, while broader measures of wellbeing are missing. It is therefore important to consider both data disaggregation and the need for metric innovation.

It is also important to remember that the needs of younger adolescents are harder to address and are therefore frequently overlooked. These needs require specific approaches to messaging, information and service delivery which in turn require data. Where necessary data are not available in information systems, they might be gathered through regular, ad-hoc or even site-specific surveys.

Output 6: Key drivers for strengthening the quality and availability of ASRHR data

Output components	Key drivers for good ASRHR data	Financing Levers
Disaggregated, quality, timely data and research are available which monitor who is reached with services and information	Strengthen and use existing Health Management Information Systems (HMIS) by supporting disaggregation for gender and age (10 – 19 years at a minimum – Box 6)	PBF Prior Actions DLI
	Include ASRHR indicators in HMIS, including school health, ²⁴ and other indicators relevant to track the extent to which different groups of adolescents are reached	DLI
	Include CSE in Educational Management and Information Systems (EMIS). For CSE implemented by CSOs ensure data are collected and used	PBF & PBC Prior Actions DLI
	Include Meaningful Adolescent and Youth Engagement (MAYE) indicators in existing HMIS and EMIS, and monitoring of community work implemented by CSOs	DLI
	Strengthen monitoring by using quantitative and qualitative data to determine needs of different groups; ensure structures are place for data analysis and incentivize corrective actions	DLI PBF
	Disaggregate data to improve health service quality - include adolescent indicators in quality assessment and quality improvement frameworks	PBF & PBC
	Collect feed-back from a variety of sources involved in CSE implementation, including teachers and adolescents to further improve guidance/standards and training materials	Community PBF & PBC
	Identify research groups and academic institutes, develop TOR for operational and implementation research and commission research	PBC DLI

Using financing levers to strengthen the quality and availability of ASRHR data

The collection and use of timely, accurate data are a central part of most output-based financing approaches (particularly PBF and vouchers). If done well, financial incentives can contribute to the availability and use of better-quality data for decision making at all levels— from the smallest health center to the health ministry.^{xxxii}

²⁴ School health here refers to school-based interventions to promote health services

Prior Actions used in DPF and DLIs/IPF-PBC used in IPF and PforR can be used to link financing with data systems reforms, including the introduction and/or strengthening of digital information systems. Prior Actions in DPFs can be used as financial levers to incentivize the introduction of legal, policy and systems reforms (see also Output 1), while DLIs or IPF-PBC can also be used to accelerate the operationalization and introduction of these reforms at different system levels, including the roll-out of training and technical support. DLIs or IPF-PBC can also be used to incentivize changes in the rules that govern information systems and their configuration, including the level of data disaggregation. The minimum level of disaggregation should include: gender, service type and age groups (see Box 6);

Box 6: Age disaggregated data in HMIS

Even in programs and plans which are explicitly designed to improve adolescent health outcomes, such as the GFF Investment Cases, results are more often reported on other supported groups such as women and children, because the data on ASRHR are not available in national systems.

At a minimum, health management information systems should collect and analyze data for the 10 – 19 age group. Ideally, systems should disaggregate further by collecting data on younger (10 – 14 years) and older (15 – 19 years) adolescents to ensure the needs of the younger age group are addressed as well.

- ❖ **PBF & PBC** interventions can be used to incentivize the availability of qualified monitoring and evaluation (M&E) staff and the reporting of accurate, complete and timely data to the HMIS from the community level (e.g. through community PBF), health facilities or schools, to the district level where data are aggregated, and onwards up through the system. Technical assistance to managers and implementers of programs which link financing to results to improve and strengthen reporting systems (e.g. skills and knowledge, tools development) can also be useful.
- ❖ **PBC** can also strengthen data reporting by non-state providers. Accurate reporting of data by non-state healthcare providers into national HMIS is nearly always challenging. PBCs can use the conditions of contracts to stipulate how data should be reported. The contracting agency (the principal) must monitor these conditions, with penalties for non-compliance. Both PBF and PBC may require changes to facility registers and forms which can increase the program's costs (human and financial resources, as well as time). Where possible, M&E systems should be aligned with and strengthen existing national reporting systems.

Indicators and measurement

There is, as yet, little experience of using financing levers to incentivize ASRHR outputs and outcomes, and consequently little knowledge of what works in terms of indicator selection. The USAID-funded Measure Evaluation Project has put together a [compendium of RBF indicators](#), divided into four indicator categories: structural quality, service quality, service use and intervention coverage, and health outcomes and impact. The guidance contained in this chapter draws on this compendium, as well as other key sources.²⁵

The adolescent health literature points to the need for standardization and prioritization of indicators for the evaluation of youth responsive health services.^{xxxii} Standardization is helpful for comparing progress across countries. However, a number of factors also need to be taken into account when selecting indicators, including the additional costs of data collection and analysis (financial and human resources and time), particularly for composite indicators, and the complexity which indicators can add to the calculation of rewards and overall program management. It is also important to consider the intended effects as well as potential unintended effects of the financial incentives created by linking fund disbursement to financing-linked indicators. These factors should be reviewed regularly (say, annually) and adjustments made as needed.

Alignment between results chain and indicators of focus

In WB and GFF-supported projects, there is a missed opportunity to align financing incentives with the results framework indicators on adolescents. The need for a specific focus on adolescents across program design, implementation and monitoring is now clear and, in response, WB projects and GFF Investment Cases are adopting Project Development Objectives (PDOs) and intermediate outcome indicators which focus on adolescent health. Where feasible, results framework indicators for monitoring WB projects (e.g. PDO indicators), finance-linked indicators or conditions (e.g. Prior Actions, DLIs and IPF-PBC), and other types of financial incentive such as those used in PBF schemes should be aligned within programs that use financing for results, as in the case of Liberia (Case study 10). This strengthens the overall incentive effect and is in line with the [GFF Strategy](#) which intends to 'sharpen links in the expected causal chain between the activities financed, outputs, intermediate and long-term outcomes'.

²⁵ These include USAID's [Data for Impact](#), and PRB's [Youth Family Planning Policy Score Card](#). The WHO data portal also has an [Adolescent SRH data page](#), which contains a number of indicators. Indicators proposed in this Paper were also adapted from the [Updated Family Planning Indicators for Quality Care Measurement in PBF](#) produced by a working group of international experts organized by Collectivity.

Case study 10: Aligning financing levers in Liberia to strengthen delivery of ASRHR

Among the PDO indicators for the Liberia Institutional Foundations to Improve Services for Health project (2020–2026), financed through an IPF operation, there are several which explicitly target adolescent SRH including: the proportion of new adolescent users of modern contraception (10–19 years); and, the number of adolescent girls (10–19 years) leaving selected health facilities having had two FP counselling sessions. An intermediate outcome indicator measures the number of students counselled by female counselors in high schools.

These indicators have been tagged as Performance-Based Conditions which means that the disbursement of funds is conditional upon achieving them. DLIs complement these conditions with one DLI indicator incentivizing the development of an ASRHR training module to be incorporated into curriculum for the school-based female health counsellors, and another linking fund disbursement to a percentage increase in adolescent girls leaving a hospital or health center after delivery with two counseling sessions on contraceptive methods. A PBF intervention (yet to be designed) will support strategic purchasing of services. In this way, the project's results framework and the financial-linked indicators reinforce each other, resulting in a coherent approach and stronger focus on adolescent outputs and outcomes. [P169641](#)

Suggestions for results-linked indicators are provided below that can be used at different levels. Their selection is based on the key drivers set out above. Examples of finance-linked indicators which link disbursements to specific adolescent health actions, outputs and outcomes already in use by WB and GFF supported programs can be found in Annex 4. Some of these are also included in the relevant sections below. All indicators suggested below will require definition and adaptation to the specific context for program implementation.

Indicators by system level

National level financing levers – laws & policies

The principal results-based approaches that serve as policy levers at national level fall under the umbrella of what can be called Results-based Aid (see Annex 2). The World Bank's DPF instrument where funds disbursement is conditional upon Prior Actions is an example. DLIs can also be used in this way in IPF and PforR operations. It is particularly important that Prior Actions are tailored to, and address the specific challenges in each country context, strengthening the direction of desired legal, policy and system changes. DLIs can be tailored to provide stronger or weaker incentives depending on the stage in the project results chain and the importance of the activity for the achievement of outputs and outcomes. Some examples of national level indicators are provided below:

- ❖ Existence of supportive adolescent and youth sexual and reproductive health policies (including HIV/STI)
- ❖ Existence of national laws, regulations, or policies that do not restrict access to effective contraceptive services for unmarried and/or young people (see below list of policy areas highlighted by Population Reference Bureau (PRB)²⁶)
- ❖ A policy on user fee exemptions exists for adolescent [insert service or product]
- ❖ Ministerial order allowing adolescent girls to remain enrolled in school in the event of pregnancy or marriage (see also Case study 1)

²⁶ A similar indicator (Prior Action) is used in the Niger First Laying the Foundation for Inclusive Development Policy Financing ([P169830](#)) (see Case study 1), "Ministerial order allowing access to FP assistance for married adolescent girls without parents' or husband's mandatory accompaniment".

- ❖ Existence (and functioning) of a multisectoral group for oversight of adolescent health and wellbeing
- ❖ Regular government budget allocation for national adolescent health program (or SRHR more specifically, or school health or)
- ❖ At least one designated full-time person for national adolescent health program
- ❖ Existence of contracts between government agencies and national CSOs supportive of health and adolescent wellbeing

The PRB has also developed a set of [Youth Family Planning Policy Scorecards](#) for different countries in French and English, which break down the existence of supportive policies into: parental and spousal consent; provider authorization; restrictions based on age; restrictions based on marital status; access to a full range of contraceptive methods; CSE; and youth-responsive contraceptive service provision. These components of a youth responsive policy environment could be used to develop national level indicators, according to the context of the program.

National level RBF – health & education system reforms

WB financing instruments (i.e. DLIs used in IPF and PforR) can be used to link funds disbursement to health and education system reforms that are known to support improvements in adolescent health outcomes. These actions should be aligned with national plans, have a high-level of support within recipient government agencies, and reinforce the direction of systems reform through the provision of financial incentives. Examples of indicators to incentivise and measure change include:

- ❖ The HMIS and/or Education Management Information System (EMIS), [other data systems as appropriate], disaggregate data by sex and age and type of service
- ❖ National guidelines for competencies of health workers in adolescent health
- ❖ National standards and package for health service delivery to adolescents
- ❖ Incorporation of adolescent SRH or adolescent health checks in the basket of essential health services, including for social health insurance schemes
- ❖ National standards for 'health-promoting' schools or where relevant CSE
- ❖ Number of private sector interventions established, expanded or strengthened that increase the supply of quality contraceptive products (or wider SRH services) to adolescents
- ❖ Number/percent of schools offering CSE (or other school health program)
- ❖ Number of adolescents receiving CSE outside of schools
- ❖ Percentage of secondary schools offering SRH services on-site (information and contraceptive methods) in the last X months²⁷
- ❖ National minimum curriculum standards on CSE (for in and out-of-school) and life skills education are developed and published (for DPF)
- ❖ Number of secondary schools with functional referral systems in place to refer young people to ASRHR services (in health facilities or communities)

In countries where schools are permitted to provide CSE, it may also be useful to integrate questions into annual, national, and standard assessments administered to adolescents to

²⁷ This indicator has been used by a World Bank project in Mozambique - [P163541](#).

assess the quality of CSE and test adolescents' knowledge of key topics covered in order to monitor a program's impact.^{xxxiii}

Sub-national level: PBF and PBC with health Facilities, schools and communities

PBF Quantity Indicators

The WB PBF Toolkit recommends three key factors to consider when selecting quantity indicators for PBF:

- ❖ Buy services which are cost effective²⁸
- ❖ Be cautious in selecting services because the choice sends important signals to health workers about priorities; and
- ❖ Be aware that preventive services are often under-provided and may need special consideration.^{xxxiv}

As with all indicators, they should be specific, measurable, attributable, realistic and timebound (SMART). Given that indicators are tied to funding, verification is needed to follow clients and to ascertain whether they exist and received the service registered. However, as confidentiality is a major concern for adolescents, verification of SRHR services will need to be designed carefully and through consultation with young people on the most appropriate verification methods (see below).

In nationwide PBF schemes, indicators are usually selected at national level by the ministry responsible (e.g. the Ministry of Health in Rwanda is responsible for selecting, adding or modifying indicators for the PBF scheme), while in sub-national schemes, this may be a local government agency. In all cases, the process of selecting indicators should be highly participatory, involving health or education providers and managers, client representatives (in this case young people) and relevant accountability mechanisms.

Possible quantity indicators for purchasing adolescent SRH services through PBF include:

- ❖ Utilization of SRH services by adolescents (disaggregated by gender and age)
- ❖ Number of adolescents who leave a facility having received SRH counselling
- ❖ Percent service delivery points providing youth friendly services
- ❖ Percent service delivery points making use of outreach to take youth friendly services to adolescents where they are (i.e. school, workplace)
- ❖ Number of adolescents at [primary/secondary] school participating in age-appropriate CSE in a defined period
- ❖ Number of adolescents successfully referred from schools to a health facility or other service outlet (measured through a referral card, voucher or other means)
- ❖ Number of adolescents attending SRH counseling services (in a defined period/in a defined location) – this could be by lay counsellors, trained teachers or medically trained personnel
- ❖ Number of adolescents receiving SRH services onsite at the school by medically trained personnel (with services to be defined according to context)
- ❖ Number of out-of-school (and/or in-work) adolescents receiving SRH counselling and services (in a defined period/defined location)

²⁸ Contraception is one of the most cost-effective investments in health (see for example, the Guttmacher report [Adding it up: investments in SRH 2019](#)).

Verification of age and quantity indicators

Where programs are purchasing ASRHR services on behalf of a defined group of young people (say 15 – 19 years) some form of verification of the age of the beneficiaries may be needed. This can be done at the time of referral of the adolescent, during the consultation or through exit interviews. There is some (limited) experience of using 'proxy questions', such as questions related to year of birth, or the year in which the adolescent finished certain schooling levels to ascertain the real age of the young person. However, these questions are highly context-dependent, and guidance and tools to support verification of specific adolescent services are yet to be developed. A balance is needed between the costs of detailed verification (in terms of human and financial costs) and the need to exclude those who are not being incentivized by the program.

Privacy and confidentiality are important rights for adolescents and it is important that verification activities do not infringe them. There is little program learning or evidence in this area, and the most appropriate way to ensure confidentiality for adolescents in the verification process will differ for each setting. One option may be to train and contract youth organizations to carry out verification using exit interviews at the health facility as opposed to through household visits. In contexts where this is feasible the provider can ask all adolescents or a subgroup of adolescents (i.e. married or older age groups) to give their consent to be contacted at home or by phone. However, such an approach may have unintended consequences in different settings. Verification systems should always be developed with the active engagement of adolescents, piloted before being implemented, and be periodically re-assessed and refined.

An alternative approach could be to undertake an in-depth review of the client's documentation at the health facility or other outlet (client cards, clinical files, registers, etc.). This should ideally be accompanied by trend analysis looking at the adolescent service data, in order to identify potential gaming (so-called risk-based verification). PBF programs, including those supported by the WB, have been experimenting with risk-based verification^{xxxv} in order to reduce costs and to tailor verification to the specificity of the service users (i.e. different groups of adolescents). Risk-based verification seeks to identify healthcare providers with a higher potential risk of gaming, often using digital programmes.²⁹ This approach is likely to require training for data analysts.

Furthermore, practice has shown that adolescent care seeking patterns do not always follow uniform trends because adolescents often prefer to visit services in groups, or on particular days. Consequently, where there is some suspicion of gaming, it is important not to consider providers as fraudulent before a case has been investigated.

PBF Quality Indicators

Quality indicators, which measure the quality of adolescent-responsive care provided by a health facility, school or other outlet, should be integrated into the quality assessment tools used to adjust payments in PBF programs. Most of these tools predominantly measure structural quality with some assessment of the quality of processes.^{xxxvi} The same, or similar tools can be used in assessing health facilities participating in PBF, PBC or voucher programs. In voucher schemes, it would be possible to increase the reimbursement rates for those health facilities and/or other outlets providing better quality care, according to an assessment score (but this has not been tried and tested).

²⁹ See for example the work of [BlueSquare](#).

Many of the measures of quality of care for adolescents are the same as those for all clients, while certain aspects of quality of care are particularly important to adolescents. Boxes 7 and 8 provide sample lists of adolescent-specific questions on structural quality and process quality that can be adapted and integrated into a broader quality assessment tools or frameworks.³⁰ Given that PBF programs on the whole do not measure quality of care for adolescent-responsive services, these indicators have not been tried and tested within the context of PBF. However, they reflect the key drivers for improving ASRHR outcomes.

Box 8: Questions for assessing the process quality of adolescent SRH as part of a PBF QA tool

- ❖ Were adolescents consulted during the process of making the services more adolescent-responsive?
- ❖ Are staff welcoming and friendly towards adolescents?
- ❖ Has the facility made necessary arrangements for adolescents to be attended quickly without disrupting the flow for other clients?
- ❖ Are all staff of the health facility and service points aware of standard guidelines and protocols for SRH, including where relevant for ASRHR?
- ❖ Does the facility/service point have a full range of contraceptives available at the time of verification and the previous month according to stock cards?
- ❖ Has the facility integrated the ASRHR service package into other services?
- ❖ Are all members of medical staff competent to offer comprehensive ASRHR counseling and referral?
- ❖ Has all staff (including support staff) participated in value clarification sessions related to ASRHR?
- ❖ Does the facility or service points make efforts that adolescents can be assisted for their health care needs on the same day, if that is feasible and the adolescents would prefer this?
- ❖ Does the facility obtain feedback from adolescents on their experience of using the services and incorporate this feedback in the organization of service delivery where possible?

Box 7: Questions for assessing the structural quality of adolescent SRH as part of a PBF QA tool

- ❖ Does the facility/service point provide all elements of the adolescent service package?
- ❖ Are the opening hours at facility and related service points convenient for adolescents?
- ❖ Has the facility organized sufficient service points (i.e. in the community) to ensure adolescents in the catchment area of the facility can reach at least one service point?
- ❖ Is there sufficient space and privacy for waiting that is appropriate for adolescents?
- ❖ Does the facility/service point offer sufficient visual and audio privacy for adolescents during registration and consultation?
- ❖ Can the facility/service point maintain confidentiality of records, forms and data for adolescents?
- ❖ Are all members of medical work force trained to provide ASRHR counselling and refer to ASRHR specific services when needed?
- ❖ Does the facility or service point have a system in place for tracking adolescents who miss follow-up appointments?

For the above questions, a Likert scale could be used to score responses: bad, not so bad, neutral, good, very good and icons or other visual means can be used such as smiley faces to assist with the scoring. This approach is being trialled in a WB-supported PBF in Kyrgyzstan where patient satisfaction surveys are conducted on a random sample of women who delivered at 63 hospitals participating in the PBF scheme. Women are contacted by mobile phone by trained supervisors, and after obtaining consent are asked five questions. Four of the five questions have responses on a five-point Likert scale, while

³⁰ Further definition and explanation of these quality indicators can be found in Annex 6.

one final question is binary seeking to clarify whether the patient paid providers informally.^{xxxvii}

In addition to indicators linked to financial incentives, non-financial rewards may also be considered, such as certificates for being 'youth responsive' where facilities meet more than, say, 80 percent of the quality criteria selected.

A tool for taking feedback from adolescents through a client exit interview can also be developed to ascertain the views of adolescents on the services being provided and to seek suggestions for improvements. These forms should ideally be administered by an independent person such as a health facility advisory committee member or a teacher or someone with standing in the community.³¹ It is also possible to use PBF incentives to motivate health facility teams to incorporate findings from the feedback forms during their regular meetings. These tools should encompass questions on:

- ❖ Waiting times for adolescents
- ❖ Friendly and welcoming environment
- ❖ Sufficiency of time taking for the consultation
- ❖ Clarity and relevance of explanations to the adolescent
- ❖ In case of contraceptives, did the adolescent feel able to make an informed choice, was s/he encouraged to return for follow-up consultation to discuss side-effects, method continuation, method switching and so on?

It is also important to develop one or two indicators that will encourage and incentivize support for the health facility teams, such as supportive supervision from the district health team or relevant education structures.

Community level:

At the community level, the following indicators could be considered:

- ❖ Number of community health workers (CHWs) (or other relevant community agents) active in the health facility catchment area who are trained in ASRHR services and implementing ASRHR community activities
- ❖ Number of successful referrals made by CHWs (or other relevant community agents) of adolescents to ASRHR services
- ❖ Number of CHWs (or other relevant community agents) who participated in value clarification sessions related to ASRHR
- ❖ Number of community and/or religious leaders who participated in value clarification sessions related to ASRHR
- ❖ Number of communities/villages/areas who have participated in community dialogues related to ASRHR

³¹ See also the WHO's [Quality Assessment Guidebook: a guide to assessing health services for adolescent clients](#), which includes adolescent client interview tools that can be adapted.

Annex 1: A rights-based approach to ASRHR

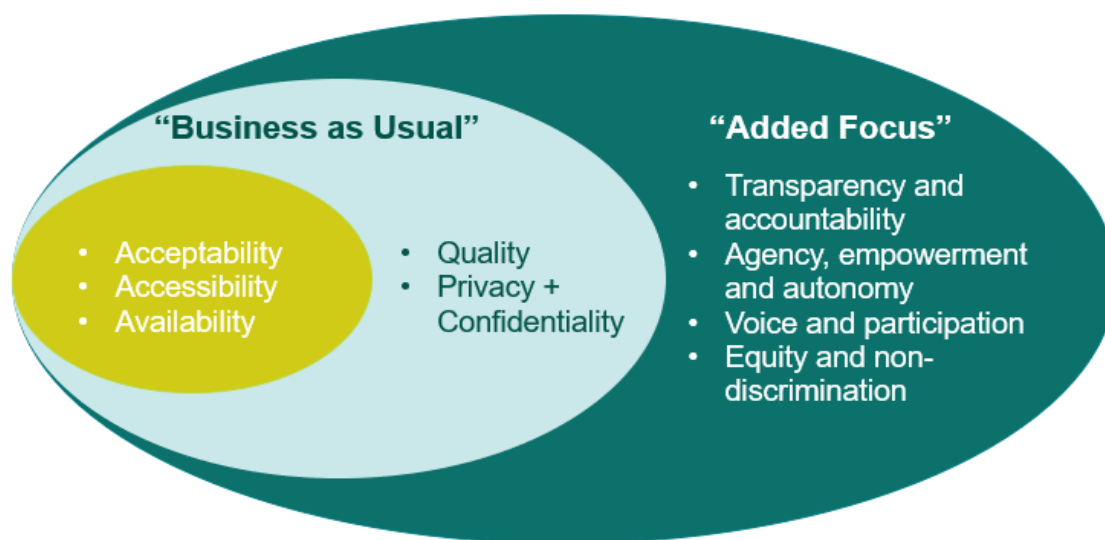
A rights-based approach to program design and implementation can improve adolescent health outcomes for hard to reach groups

There is an urgent need to reach all adolescents, regardless of their age, gender, marital status, parity, location, physical ability, and socio-economic circumstances. The different principles enshrined in a rights-based approach help to identify and address specific barriers for different groups of adolescents (Figure 4).

Adolescents need access to valid and relevant information, and affordable and developmentally appropriate, high-quality, welcoming health services, care and support, including for self-care.^{xxxviii} And they need to be enabled and empowered to act on the information they receive. A rights-based approach helps to identify the barriers to accessing good quality information and services for different groups of adolescents (the 'intersectional' barriers), and to focus on addressing these barriers through a combination of financing and program approaches.

A rights-based approach is also useful for examining the intended and potential unintended consequences of different financing mechanisms and approaches and for mitigating risks associated with these.³²

Figure 4 Applying a human rights lens to adolescent sexual and reproductive health



Modified from WHO, 2014, Rights-based Contraceptive Services; and FP2020, 2014, Rights and Empowerment Principles

³² See for example, FP2030's [Rights and empowerment principles](#) (2021), and The Collectivity's [Updating family planning indicators for quality care measurement in performance-based financing programs](#) (2019).

Annex 1, Table 2: Definitions of rights-based principles for adolescent sexual and reproductive health

Rights-based principles	Definitions	Example questions for the review
Acceptability	The right to choose a health service that suits the needs and preferences of different groups of adolescents (i.e. services that are responsive to their needs)	<ul style="list-style-type: none"> • How are services and information successfully tailored to the needs and preferences of different groups of adolescents (e.g. opening hours, discreet access etc.)?
Accessibility	The right to receive clear information about services and to get the services they want that are affordable, convenient and available	<ul style="list-style-type: none"> • What are the main barriers for adolescents in accessing public health facilities and other service outlets? • What are the best practices for linking adolescents to different types of health service, differentiating by age, gender, location, etc.?
Availability	The right to a range of services (particularly SRH services) and products that are always available when and where they need them	<ul style="list-style-type: none"> • How can programs ensure that health facilities, trained providers, medicines and supplies are available when/ where adolescents need them (i.e. manage their reproductive health)?
Quality	The right to respectful and safe services of high technical and perceived quality in a clean and comfortable setting and which are (i.e. positive provider attitudes, highly adolescent-responsive)	<ul style="list-style-type: none"> • How to ensure providers have the environment, knowledge, skills, and tools to ensure good quality information, counselling and services can for adolescents? • What approaches (from the policy level downwards) work to foster positive attitudes to adolescent health among providers and other gatekeepers?
Transparency and Accountability	The right to meaningful information on the services they need and want, and the right to speak up if their rights have not been fulfilled and to expect action will be taken	<ul style="list-style-type: none"> • How can programs improve access to meaningful information on SRH and other services for adolescents? • What are the mechanisms for adolescents to make their views known and to hold others accountable (gate keepers, policy makers etc.)?
Agency, Empowerment and Autonomy	The right to make and act on their own decisions related to their health without pressure and obstacles. Includes the right to reproductive self-determination.	<ul style="list-style-type: none"> • To what extent do laws and policies ensure that adolescents can access and use the services of their choice without third-party authorization? • How do programs effectively address community norms and service providers' attitudes which form a barrier to reproductive autonomy of adolescents?
Voice and Participation	The right to accurate and complete information to support decision making on when/how to access a health service. The right to meaningfully participate and lead efforts in ASRHR design, implementation and evaluation.	<ul style="list-style-type: none"> • How do adolescents effectively engage in the development, implementation and monitoring of policies which impact on their health? • How to enable effective participation of adolescents in the design, implementation and monitoring of relevant programs?
Equity and Non-discrimination	The right to be treated fairly, without discrimination based on who they are or their circumstances	<ul style="list-style-type: none"> • What are the lessons for ensuring that all adolescents can access information and services regardless of age, location, language, ethnicity, disability, HIV status, sexual orientation, wealth, marital or other status?
Privacy and Confidentiality	The right to receive ASRHR services in a setting which is private and limits the possibility that adolescent is observed by family or other community members. This is particular important in environments with restrictive norms.	<ul style="list-style-type: none"> • Are there useful lessons on what different groups of adolescents need in terms of privacy and confidentiality? • How do programs ensure that privacy and confidentiality of adolescents are respected and how do they communicate this to adolescents?

Annex 2: Description of selected financing levers at different levels

Table 3: Definitions of selected key approaches that link financing to results

Approaches using financing levers	Description
National level legal and policy levers	<p>Financing instruments which link funds disbursement to achievement of results can be used for national level reforms: the principal is a donor government, a multilateral organization or other funding agency, and the agent is a national government or sub-national government entity. Funds disbursement is linked to conditionalities, tying aid flows to results which may be outcomes, outputs or actions. The World Bank Development Policy Financing (DPF), Program for Results (PforR) and the introduction of performance-based conditions in Investment Project Financing (IFP-PBC) are examples of instruments which use financing levers. Other examples include the Cash on Delivery (COD) model developed by the Centre for Global Development and the GAVI vaccine alliance which links funding to impact at the national level (i.e. children vaccinated).</p> <p>The levers can be used to introduce adolescent-responsive legal and policy changes (i.e. removing the requirement for adolescents to be accompanied to health services by their spouse or parent or raising the legal age for marriage).</p>
Performance-based financing (PBF)	<p>PBF is a set of financing instruments that pay for performance, usually based on a combination of measures that are quantitative (i.e. service utilization) and qualitative (i.e. a measure of service quality). Typically, PBF is implemented at the sub-national level down to the community level and incentive recipients may be a project implementer, service manager or provider, education provider, community group or CSO. Payments are usually in addition to budgeted funds and act as incentives to provide more, better quality care.</p> <p>PBF can be used as a strategic purchasing approach to improve the coverage and quality of a defined basket of services (including to specific population groups such as adolescents), to channel funds to lower health and education system levels and to introduce system reforms such as</p>
Performance-based contracting (PBC) and other approaches to contract with the private sector based on outputs	<p>Sometimes used synonymously with PBF, performance-based contracting (PBC) is used to refer to contracts with private sector providers (both for-profit and not-for-profit providers) which pay based on results (i.e. a fee-for-service, or payment for pre-determined outputs or outcomes). Like PBF, PBC can be used as a strategic purchasing tool to purchase a defined set of services (health and education services, community-based services, and so on) on behalf of a target group, and may be used to deliver subsidies to this group in the form of reduced fees.</p> <p>PBC can be a useful approach for increasing the number of service channels for adolescents by enabling their access to a range of non-state providers. Service providers can be quality assured and/or accredited as a condition of the contract, which can also specify they share data with national systems.</p>
Conditional cash transfers (CCT)	<p>Conditional cash transfers (CCTs) provide payments to individuals or typically to households in exchange for engaging in a specific health improving action (e.g. vaccinating children or keeping girls in school). Conditionalities must be defined, agreed and understood by all parties and then monitored, and payment systems must be established. CCT payments may be tied to the costs of engaging in the desired behavior (e.g. payments made to a woman on arrival at a health facility to cover costs</p>

Approaches using financing levers	Description
	<p>related to her transport and stay at the facility), or they may provide more general financial incentives to cover the basic needs of a household.</p> <p>CCTs are widely used to provide incentives for adolescents (or their families) to remain in school and can facilitate adolescent and other types of participation in activities or groups.</p>
Vouchers	<p>Vouchers are a demand-side financing approach, which have a strong impact on the supply of services. Subsidies (usually from government and/or donor agencies) are used to stimulate demand for priority health goods, often among under-served groups (i.e. adolescent SRH services). Voucher schemes can contract public and private providers, and quality is assured through a quality assurance or accreditation process. The voucher is distributed to a target group, providing an invitation to take the service that is free at the point of delivery. The financial subsidy goes to the provider in the form of reimbursement payments made in return for claims made to the voucher scheme manager, similar to an insurance scheme.</p> <p>Voucher schemes have been successfully used to increase demand for and access to ASRHR services in a number of countries including Kenya, Madagascar, Nicaragua, Uganda, and Zambia.</p>
Combined or hybrid approaches	<p>Different financing levers are often combined to good effect in order to introduce different types of incentive at different levels of the system (i.e. adolescent vouchers with social franchising, or a PBF combined with a CCT or a voucher). The aim is to address multiple barriers to accessing good quality information and care for different groups of adolescents, and the evidence is growing that multipronged and multisectoral approaches bring the best results.</p>

Annex 3: PBF and vouchers in combination – a brief explanation

There is growing acknowledgement among the PBF implementing community that PBF requires additional efforts to strengthen demand for and access to services among hard-to-reach groups. Although PBF incentive structures can be designed to address known barriers to access, such as through higher PBF payments to staff in remote rural locations or for health services that are underutilized by specific groups, this is not sufficient to enable and empower under-served groups to access services. This is particularly true for adolescent SRH services. Some PBF interventions have therefore been accompanied by conditional cash transfers to provide additional demand-side incentives.

Although there is almost no programming experience to date,³³ it is also possible to combine PBF with vouchers, since each of these schemes brings different strengths to the table. In order to accelerate access, provision and uptake of services to adolescents, a combination of these two approaches could provide important synergies that are not apparent when implementing each approach alone.

While PBF provides incentives across a range of important supply-side factors (i.e. by improving quality for a basket of services, strengthening motivation of facility teams, enabling decentralized decision making and improving financial management and autonomy), vouchers schemes provide a personal invitation to the adolescent to take a service, as well as opportunities through voucher distribution to deliver face-to-face counselling and practical information on the 'what, why and where' of SRH services. Vouchers have also been shown to help overcome the fear and stigma often associated with receiving SRH information and services by incentivizing community health workers to assist adolescents to access the services. These aspects of voucher schemes are important ways to bring adolescents into ASRHR care and are missing in PBF interventions.

As PBF vouchers are also an output-based payment system, even though often for a narrower set of services, and therefore incentivizes the provider to improve their health services and cater to the needs of the voucher clients.

Some pointers are set out below for how the two approaches could be combined in practice, assuming that a PBF scheme is already in place:

- ❖ Develop a **voucher scheme targeting adolescents** with a package of ASRHR services:
 - Design the voucher distribution strategy: i.e. who to target and in what locations, the type of voucher (adolescents prefer a physical token), who will distribute the vouchers (i.e. identify voucher distribution agents), and how voucher distributors will be rewarded for successful referrals to ASRHR services.
 - Decide at which outlets the vouchers can be used (i.e. only the PBF participating facilities or also at other health providers in the private sector).
- ❖ Re-assess the basket of services that is purchased through PBF and consider extending this to include a defined package of SRH services specifically for adolescents in line with the voucher scheme
- ❖ Where adolescents show a preference for accessing SRH services through the private sector, and the PBF intervention does not include private health providers, **consider the most appropriate approach for extending access to SRH care for adolescents by contracting selected, quality assured health providers from private sector**. This will depend on the context, taking into consideration factors

³³ A PBF program in Bungoma County in Kenya combined vouchers for transport to a health facility with a PBF to improve the quality of care at participating facilities. See this [link](#) for more information.

such as the number of available public providers in the program area and availability of private sector providers of sufficient quality.

- The voucher scheme can be used to contract private providers (i.e. in addition to the PBF), or alternatively the PBF scheme can be extended to include private providers.
- If the voucher scheme is used to contract private providers, this would then be designed as a traditional voucher scheme and aligned as far as possible with the PBF intervention. The voucher scheme would identify and quality assure private providers willing to participate in the scheme, design a service package, contract the providers, and reimburse service costs through a claims processing system.
- ❖ For providers included in both the PBF and the voucher scheme, use the PBF scheme to reimburse participating facilities for the voucher services.
 - Consider structuring the incentives so that vouchers are targeted at particularly vulnerable groups of adolescents and are reimbursed at a higher rate than the non voucher services. However, bear in mind that this requires effective targeting which also has a cost, and may set up unintended consequences related to the care of non voucher clients.

According to strategy selected, this could result in two different options:

1. Where the participating facilities in the PBF and voucher scheme are the same, the voucher will act as a referral mechanism, and should include a reward to the referral agents for each successful referral to an ASRHR service to bring adolescents into the PBF facilities;
2. Where the voucher scheme is used to extend service delivery points to new public and private sector facilities, additional voucher systems will be needed that run alongside the PBF intervention with separate reimbursement mechanisms. However the synergies between the two approaches will result in efficiencies (i.e. by adapting the existing PBF contracting and quality assessment processes to the voucher scheme and aligning reimbursement rates for specific services).

Annex 4: ASRHR indicators used in World Bank health and education sector projects

Table 4: Incentives for ASRH drawn from a review of WB health and education portfolio of projects

Financing instrument	Country (period) ³⁴	Project name	Channel	Examples of finance-linked indicators related to ASRHR and CSE	Parent Project number
DLIs	Bangladesh (2018-2023)	Health Sector Support Project	Schools	DLI: School-based adolescent HNP program developed and implemented, with 4 milestones including 'Orientation of teachers and peer girl students is completed in at least 30% of public secondary schools in each targeted district in Sylhet and Chittagong divisions'	P160846
DLIs	Mozambique (2018-2022)	Mozambique Primary Health Care Strengthening Program	Schools	DLI: % of secondary schools offering SRH services, with 4 milestones including: Approval of updated training tools; approval of the adolescent and youth friendly services guidelines	P163541
DLIs	Liberia (2019-2023)	Improving Results in Secondary Education Project (IRISE)	Schools	DLI: Increased girls' access, retention and completion in secondary education, with 6 milestones including: At least 2,700 female students enrolled in Grade 10, 11 or 12 in Selected Counties received Scholarships under the Updated Girls' Education Scholarship Program Guidelines	P164932
DLIs PBF	Liberia (2020-2026)	Institutional Foundations to Improve Services for Health Project	Schools	DLI: Improved adolescent health, with 4 milestones including: ASRHR training module incorporated into curriculum for the female health counsellors in schools being recruited by MOE PBF: Provision of essential package of health services (no specific adolescent services)	P169641
DLIs	Ethiopia (2013-2022)	Ethiopia Health Sustainable Development Goals Program for Results	Schools and health facilities	DLI: Improved quality of adolescent health services, with 4 milestones including: Development of a package of health services for schools; and, Increase in PHCs providing adolescent health services from baseline 60% to 75%	P123531

³⁴ The project period is based on the most recent Additional Financing agreement.

Financing instrument	Country (period) ³⁴	Project name	Channel	Examples of finance-linked indicators related to ASRHR and CSE	Parent Project number
DLIs	Niger (2015-2022)	Population and Health Support Project	Health Facilities and Schools	DLI: Increase in new accepters (girls <20) using modern contraceptives (Percent), with payment triggered based on percentage improvement CCT: Adolescent girls kept in school (case provided to mothers of adolescent girls)	P147638
DLIs	Bangladesh (2017-2022)	Transforming Secondary Education for Results	School and vocational training	DLI: MOE has approved the Adolescent Girls' Program (AGP) (that includes among others separate girls' toilets, counseling/awareness) including action plan (Year-1) 8 other DLIs related to adolescent education	P160943
DPF	Madagascar (2020)	Investing in Human Capital Development Policy Financing	Policy	Prior Action: Parliament has enacted a law related to combatting GBV: Loi N° 2019-008 relative à la Lutte contre les Violences Basées sur le Genre, promulgated 16 January 2020 and published in the Journal Officiel of the Recipient on 17 February 2020	P168697
DPF	Niger (2019)	Niger First Laying the Foundation for Inclusive Development Policy Financing	Policy	Prior Action: The Recipient, through its Ministry of Public Health, has issued a Ministerial Order (Arrêté) allowing access to family planning assistance to married adolescent girls without parents or husbands' mandatory accompaniment, to improve their access to health services. 2 other Prior Actions relevant to adolescent health and wellbeing	P169830
DLIs PBF	Nigeria (2018-2023)	Accelerating Nutrition Results in Nigeria	Community, non state health providers	DLI: Communication for social and behavior change focused on adolescent nutrition and health, with 9 milestones; and, Evidence of new knowledge for nutrition and adolescent health results, with 5 milestones PBC: Provision of specific interventions to counsel adolescent girls on health and nutrition and provide quality services to married adolescent to enable birth spacing.	P162069
DLIs	Tanzania (2019-2026)	Secondary Education Quality Improvement Project (SEQUIP)	Schools and vocational training	DLI: Percentage of female secondary school drop-outs completing Alternative Education Pathways, 4 other DLIs also incentivize adolescent education.	P170480
PBF	Uganda (2016-2021)	Uganda Reproductive Maternal and Child Health	Health Facilities	Referral for adolescent care, sexuality and life skills education, adolescent responsive services at facility, school and community level	P155186

Financing instrument	Country (period) ³⁴	Project name	Channel	Examples of finance-linked indicators related to ASRHR and CSE	Parent Project number
		Services Improvement Project		at HC II level; and provision of an adolescent-friendly package of health services (including BCC and IEC materials) at HCIII level	
PBF PBC	DRC (2019-2025)	Multisectoral Nutrition and Health Project	Health facilities, non state health service providers, community	PBF: Provision of nutrition sensitive services for adolescents PBC: Provision of FP services to adolescents by non state actors through alternative channels; Support to community health workers to provide community nutrition and health services including FP and referrals	P168756
CCT	Senegal (2019-2024)	Investing in Maternal, Child and Adolescent Health	Schools and vocational training	CCT: Access and retention of adolescent girls in secondary school or vocational training	P162042

Annex 5: Resources for Further Reading

General

- ❖ [WHO](#) (2017). *Global Accelerated Action for the Health of Adolescents (AA-HA!): guidance to support country implementation*. Geneva
- ❖ [WHO](#) (2019). *Accelerated action for the health of adolescents (AA-HA!): a manual to facilitate the process of developing national adolescent health strategies and plans*.
- ❖ [Knowledge SUCCESS](#) (2021), website to support learning, and create opportunities for collaboration and knowledge exchange, within the family planning and reproductive health community. Johns Hopkins University, Baltimore, USA.

Output 1: Adolescent-responsive laws and policies are youth-informed, available, accepted and operationalized at all levels

- ❖ [Population Reference Bureau](#) (2021). *Youth Family Planning Policy Scorecard: Measuring Commitment to Effective Policy and Program Interventions*, Washington DC.
- ❖ [Efevbera et al.](#) (2020). Multisectoral Programming for Adolescent Health and Well-being in Sub-Saharan Africa. Insights From a Symposium Hosted by UNICEF and the Bill & Melinda Gates Foundation. *Journal of Adolescent Health*. 67:24-25
- ❖ [Brazee et al.](#) (2021). *Intergenerational Mentoring Guide: How to Mentor Youth to Advocate for SRHR*. Washington, DC, Health Policy+

Output 2: Communities, key gatekeepers and providers have the knowledge, attitudes and social norms to support adolescents to access the information and services

- ❖ [High-Impact Practices in Family Planning](#) (HIPs) (2016). *Community engagement: changing norms to improve sexual and reproductive health*. Washington, DC.
- ❖ [The Challenge Initiative](#) – TCI (2021). *Community Dialogue, chapter in East Africa Toolkit on AYSRH Demand Generation*. Johns Hopkins University, Baltimore, USA.
- ❖ [Institute for Reproductive Health, Georgetown University](#). *Passages Project: Theory of Change* and other resources on norms-shifting, Whitehaven St NW, USAID
- ❖ [Population Reference Bureau](#) (2021). *PACE: Policy, Advocacy, and Communication Enhanced for Population and Reproductive Health*. Washington DC, USA.
- ❖ [Pathfinder International](#) (2021). *Beyond Bias: Human Centered Design (HCD)*. Resources using HCD to develop effective, scalable ASRHR interventions.

Output 3: Health and education service providers are trained and have the resources to provide quality adolescent responsive services and CSE

- ❖ [WHO, UNAIDS](#) (2015). *Global standards for quality health-care services for adolescents: a guide to implement a standards-driven approach to improve the quality of health care services for adolescents*. Geneva.
- ❖ [WHO](#) (2015). *Core competencies in adolescent health and development for primary care providers*. Geneva.
- ❖ [UNESCO](#) (2021) *The journey towards comprehensive sexuality education Global status report*. Paris, France
- ❖ [WHO, UNESCO](#) (2021). *Making every school a health-promoting school – implementation guide + global standards and indicators*. Geneva.
- ❖ [WHO, UNESCO](#) (2021). *WHO guideline on school health services*. Geneva.
- ❖ [UNFPA](#) (2020). *International Technical and Programmatic Guidance on Out-of-School Comprehensive Sexuality Education*. New York

Output 4: Adolescents & Communities are agents of change in functioning accountability mechanisms

- ❖ [GFF-CSO and youth engagement framework](#) 2021-2025 (2020).
- ❖ [Global Consensus Statement on Meaningful Adolescent & Youth Engagement](#) (MAYE) (2021). Annex has many relevant resources.
- ❖ [UNICEF](#) (2020). *Engaged and heard. Guidelines on adolescent participation and civic engagement*. Has many relevant resources, including social norms and attitudes
- ❖ [Alvarado et al.](#) (2017). *A Systematic Review of Positive Youth Development Programs in Low- and Middle-Income Countries*. YouthPower Learning, USAID, Washington, DC

Output 5: Adolescents know what information and services they are entitled to and are enabled and empowered to seek them

- ❖ [High-Impact Practices](#) (2021). *Adolescent-Responsive Contraceptive Services: Institutionalizing adolescent-responsive elements to expand access and choice*
- ❖ [High-Impact Practices](#) (2021). *Family Planning Vouchers: A tool to boost contraceptive method access and choice*
- ❖ [Cutherell and Cole](#) (2019). *Supporting Sustainable, Youth-Powered Programming at the Community Level in Ethiopia: The Case of Smart Start*. Adolescents 360 (A360), Population Services International, Washington, D.C.

Output 6: Disaggregated, quality, timely data and research are available which monitor who is reached with services and information

- ❖ [Newby et al.](#) (2021). A Scoping Review of Adolescent Health Indicators. *Journal of Adolescent Health*. 69:365-374. Has list with most relevant resources.
- ❖ [Track 20 project](#) (2021). Website pages monitoring progress in Family Planning. *Access: Youth*. Avenir Health, Glastonbury, USA.

Annex 6: List of key informants

Key Informant	Organization	Title	Date of Key Informant Interview
Rifat Hasan,	World Bank	Senior Health Specialist	06.10.21
Bruno Meessen	WHO	Senior Health Financing Advisor, Health Systems Governance and Financing Department	16.09.21
Valentina Baltag	WHO	Head of Department of Maternal, Newborn, Child and Adolescent Health	23.09.21
Beverley Johnston	USAID	Division Chief, Office of Population and Reproductive Health	15.09.21
Amy Uccello	USAID	Senior Youth and Reproductive Health Technical Advisor, Office of Population and Reproductive Health	15.09.21
Cory Wornell	USAID	Youth and Reproductive Health Advisor, Office of Population & Reproductive Health	15.09.21
Gwyn Hainsworth	Bill and Melinda Gates Foundation	Senior Program Officer, Family Planning	23.09.21
Danielle Engel	UNFPA	Technical Specialist, Adolescent and Youth	29.09.21
Kozi Izundu	GFF	CSO Youth Representative to the GFF Investors Group	16.09.21

[Note to designer. The list of endnotes will need a heading as follows: Work Cited]

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