ADOLESCENT AND YOUTH HEALTH AND WELLBEING IN THE MENA REGION
“YOUTH AT PROMISE”

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November 2017
BACKGROUND:

There are over 184 million adolescents (10-24 years) in the Eastern Mediterranean region, ranging from 16% of the population in the UAE to over 30% in Afghanistan, Djibouti, Iraq, Pakistan, Palestine, Somalia, Sudan, Syria, and Yemen. As succinctly stated in the report of the Lancet Commission on Adolescent Health and Wellbeing: “Investment in adolescent health and wellbeing brings a triple dividend of benefits, now, into the future, and for the next generation of children.” (Patton et al., 2016). Figure 6 from the Lancet adolescent wellbeing report highlights the life course approach to adolescent health suggesting that wellbeing in adolescence is affected by wellbeing as children; and affects adult wellbeing; and further confirms the notion of the triple dividend through the red focus on adolescence itself, as well as the arrows pointing to adulthood and the next generation.

The ‘tooth’ in Figure 6 includes health determinants and figure 2 from the Lancet report expands on these potentially supporting and empowering systems. This figure points to the continued or changing importance in an adolescent’s life of systems such as family, education, employment, peers and the media. What is less focused on in that figure is the blue background. The blue background represent the “Community and structural determinants (which) remain consistently influential” throughout the life course. These determinants (sometimes called ‘Social Determinants of Health of SDH) - are critical pathways to health and disease, and lead to differences in health status and outcomes between people based on characteristics other than biology – this rendering these differences unfair and unjust and preventable.

The report of the World Health Organization’s Commission of the Social Determinants of Health stated: “Where systematic differences in health are judged to be avoidable by reasonable action they are, quite simply, unfair. It is this that we label health inequity. ..Reducing health inequities is, for the Commission on Social Determinants of Health .., an ethical imperative. Social injustice is killing people on a grand scale.”3 Braveman and colleagues4 present one of several models (figure 1 below) that identify some of the social and structural determinants of health and suggest policies that would tackle them to decrease inequities. We will return to these concepts later.

HEALTH ISSUES AND RISKS FOR YOUNG PEOPLE OF THE REGION

With that general backdrop in mind, what are the health issues and risks for young people in the region? The evidence comes from a recently published article using Global Burden of Disease data 2015.\(^1\)

Overall, many countries of the region are experiencing states of uncertainty, instability, war, conflict, displacement and failing states. Young people are particularly vulnerable to the effects of conflict and civil unrest through a variety of mechanisms including lost trajectories of education and general growth, morbidity and mortality, mental wellbeing.\(^1,5\)

More specifically, the GBD 2015 analyzed 249 causes of death, 310 causes of diseases and injury, and 79 behavioral and environmental risks. The data was disaggregated by gender and 5-year age-bands between 10 and 24 years of age. The analysis found that all-cause mortality in the Eastern Mediterranean region (EMR) in 2015 ranged from 63.3 per 100,000 for females aged 10–14 years to 253.2 per 100,000 for males aged 20–24 years. Also, in 2015, war and legal interventions (law enforcement) was the leading cause of death for adolescents of both sexes, accounting for 27.7% (ranging between 14.2–38.4) of deaths amongst male 20- to 24-year olds and 7.2% (ranging between 3.1–10.9) amongst female 20- to 24-year olds. In terms of morbidity, overall, all-cause years of life with a disability (YDL) rates were similar for males and females in the region; and have seen little improvement since 1990. From 1990 to 2015, iron deficiency anemia was the leading cause of disability for females aged 10–14 and 15–19 years, and for males aged 10–14 years. In addition, in 2015 alone, NCDs - particularly mental health disorders, migraine, asthma, skin conditions, and musculoskeletal disorders - were major contributors to YLDs for both sexes. Also, in 2015, major depression emerged as the leading cause of morbidity amongst males aged 15–19 and 20–24 years and for females aged 20–24 years. And among older males, opioid use disorders and war were important causes of disability. The paper further notes that adolescents living in Syria, Afghanistan, and Somalia experience amongst the largest burdens of disease and injury of all adolescents globally.

The reports states that since 1990, there have been reductions in mortality and morbidity in the EMR from communicable disease, maternal disorders, and natural disasters. These reductions are likely the result of socioeconomic growth and development, educational participation, and interventions through the health system. However, wars and civil conflict threaten the gains that have been made, and resurgence of these conditions is likely. The report further finds that unintentional injury (including motor vehicle-related injuries), mental health, sexual health, substance use, and self-harm are increasingly important health issues for adolescents in the EMR. But that religious and cultural sensitivities result in many of these issues being ignored in the region with grave consequences for young people. Further analysis on GBD 2015 data shows the structural determinants and inequities discussed above. Figures A, 1&2. Figure A indicated that the death rate for 15-19 year old female living in a high income country of the region is 28.10/100,000 in 2015; as opposed to a death rate for a similar female aged 15-19 and living in a low income country of the region or 154.25 – 5.5 times higher. In addition, figure 1&2 indicates that for males living in countries of conflict in the region, life

expectancy has actually decreased between 2000 and 2015, a shocking finding – whereas for their counterparts in non-conflict countries of the region, life expectancy has expectantly increased.

**Figure A - Death Rates per 100,000, 15-19 age group, females by country income category**

WHAT WORKS?

Keeping the data in mind, what do we know about what works in programming for adolescents and young people?

Generally, evidence has suggested that meaningful and effective adolescent and youth participation/engagement works to enhance thriving and prevent risks. The report of the Lancet Commission on Adolescent Health and Wellbeing stated: “Adolescents are biologically, emotionally, and developmentally primed for engagement beyond their families. We must create opportunities to meaningfully engage with them in all aspects of their lives.” And the report confirmed that: “The idea that meaningful engagement of adolescents and young adults contributes to improvements in health [policies and services], and in turn improves health and broader societal outcomes is well
established.”

Documents produced for this symposium further emphasize this fact, and provide the evidence.

Related to programming in specific content areas, UNICEF MENARO and the Faculty of Health Sciences Center for Public Health Practice – supported by the UNIATTYP6 - recently assessed 221 interventions in the region and globally to identify ‘good practices in adolescent programming’. The overall purpose of the review was to recommend evidence proven ‘best buys’ in adolescent and youth programming that respond to the needs of adolescents and young people in the MENA region. More specifically, the review aimed at (i) identifying, rating and documenting global and regional good practices that have had positive outcomes on adolescent and youth development and well-being; and (ii) identifying preliminary push factors that lead to successful programming of these good practices; and (iii) recognizing the requirements for scaling up of adolescent and youth programming in MENA/Arab States Region & Identify partners to facilitate training/scaling up.

The review focused on the 12-24 year old age group, and on programs that aimed on civic engagement, skills development, resilience, and health (a few programs outside of these areas were also reviewed). The full report describing the comprehensive methodology and results is available and accessible.7 Once identified, each of the programs was rated on criteria, which included:

1. **Effectiveness**: Presence of an evaluation that measures the extent to which the project attained its objectives/outcomes
2. **Sustainability**:
   a. Program was implemented more than once
   b. Program is ongoing
   c. Programs was absorbed within NGO or government structure
   d. **and/or Replication**: with another group, in another region, in another setting
3. **Equity analysis**: Programs targets most at risk / vulnerable populations
4. **Innovative**: Programs adds value, is different than the ‘usual’ programming – does not have to be new, but new in this context
5. **Evidence base**: The program is based on previous experience, or on a theory, or on an identified need
6. **Values orientation**: The program promotes dignity and implements a human rights based approach to programming
7. **Youth involvement**: The program involves youth in planning, implementation and/or evaluation

Only 22 of the 221 (UN and non-UN) reviewed programs met the criteria to be judged as a ‘good practice.’ An additional 49 program were judged as ‘promising.’ The analysis of the 22 good practices led to the identification of 13 over-arching elements of success described below.

- **Forging partnerships with the involvement of stakeholders**: All 22(4) good practices forged partnerships with or involved stakeholders in the implementation of their programmes. For example **Al Nayzak** is collaborating with the Palestinian Ministry of Education to adapt the

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6 UN inter-agency technical task team for young people
7 https://goodpracticesite.files.wordpress.com/2016/03/1-good-practices_compressed1.pdf
curriculum to schools. This element is likely related to being a good practice as it is an indicator of potential for sustainability, as well as impact.

- **The intervention is delivered through existing institutions** (in already available spaces): 21 (4) good practices were delivered through existing institutions such as schools, homes and NGO spaces. This element is probably related to being a good practice in that it decreases the resources needed to ensure sustainability. It is likely also that it promotes an identity linked to the intervention programme, which also supports its institutionalization and replicability.

- **Utilizing existing community ‘human’ resources in programme implementation**: 21 (4) good practices utilized community human resources during programme’s implementation. This is likely linked to being identified as a good practice as it suggests availability of human resources, cost savings as well as the seeds of sustainability.

- **Skills-building**: 21 good practices included skills-building as part of their activities. The skills-building components were tailored to youth, parents and/or teachers. This element of success is likely related to being a good practice in that it indicates an approach of positive youth development and empowerment of youth. Evidence also suggests that skills-building is much more likely to result in impact than transmission of knowledge alone.

- **A documented need**: 20 good practices were developed and implemented as a result of a clearly documented local (or regional) need. Documenting need is probably related to being a ‘good practice’ as it allowed the programme to be very clear in its objectives and the activities required to achieve those objectives, which made monitoring and evaluation more focused.

- **Flexible programming**: 20 good practices identified as good practices had flexible programming. Flexible programming may be related to identification of a good practice – particularly in combination with clear and detailed implementation plans – as it allows for innovations where needed for replicability and scalability.

- **Creating safe spaces for youth**: 19 good practices in one way or another created safe spaces for youth to share their thoughts and feelings, have dialogues and learn. This element is most likely related to being a good practice for adolescents in that it indicates clear commitment to listening to youth and acknowledging their value, assets and promise.

- **Clear and detailed implementation guides for sessions**: 17 good practices included this element of success. This element is probably related to being a good practice as it allows for a clear identification of the content provided as well as the conceptual thinking behind the programme (and often provided guide to the pathways of success).

- **Had thought about institutionalization or had a plan in place**: 16 good practices exhibited this element of success. Thinking about institutionalization and putting plans in place early in the history of the project decreases the probability that factors such as reduced funding influence a programme’s continuity.

- **Youth ‘presence and voice’**: 16 good practices exhibited this successful element. Youth ‘presence and voice’ is a term intended to indicate that the programmes identified as good practices tended to be youthful either through the active and direct involvement of youth as programme implementers or as facilitators and mentors. This element of success is likely related to being a good practice in that it indicates an approach of positive youth development and empowerment of youth. It also is likely linked to sustainability.

- **Diversified funding**: 14 good practices had diversified funding. Diversified funding is likely linked to being a good practice by ensuring that the programme is not tied to one funding stream, thus enhancing sustainability. In addition, diversified funding often means some
aspect of the programme is funded by local resources, enhancing ownership and sustainability.

- **Progressed and adapted through phases:** 13 good practices progressed through different phases. *A programme's progression through various phases is probably related to being a good practice in that it indicates a process of applying lessons learned and continuous improvement, as well as longevity (sustainability).*

- **A pilot test:** 12 good practices started with a pilot phase. *The pilot phase is probably related to being a ‘good practice’ as it allows the testing of an intervention at a small scale, for glitches to be fixed, and for lessons learned and adjustments to be implemented prior to scaling-up.*

Based on the analysis of over-arching elements of success, the report further identifies ‘best bets for successful youth programming.’ Programs that are best bets for success and can be implemented and supported without hesitation are those that:

1) Approach young people from an assets based perspective convinced of their promise and focusing on their strengths.

2) Ensure that skill-building and experiential learning is a key component of any intervention.

3) Encourage and emphasize that the intervention is conducted with participatory engagement of the ‘community’: three of the overarching elements of success that were most common are related to participatory engagement:
   - use of available community human resources,
   - use of already existing facilities as sites for intervention, and
   - forging partnerships with community stakeholders. This participatory engagement strengthens and reinforces connectedness to caregivers, community members and mentors

4) Require that the program respond to needs and priorities of youth: Almost all good practices were built on a solid identified need

5) Flexible programming: ability to be flexible and adapt programming to context

**WHERE TO FROM HERE?**

There is currently a lot of global momentum for and attention to adolescent and youth health. As one example, the UN Every Women Every Child (EWEC) Strategy has recently added Every Adolescent to its purview; and the 2016-2030 strategy for EWEC addresses adolescent health. Lots of promises are being made. Accountability is paramount, and independent oversight for accountability is critical. The Lancet Adolescent Commission report\(^2\) included an accountability framework (figure 19) that suggested (i) sharing the account, (ii) holding to account, (iii) responding to the account, and (iv) taking action. Adolescetn and young adult engagement occurred throughout this model.
In addition, an independent accountability panel (IAP) has been established to track progress on the objectives of the EWEC strategy. Their second annual report (2017)\(^8\) was focused entirely on adolescents. The 2017 report recommendations included:

- Lock in Accountability to Achieve the Global Strategy and the SDGs
- Make Adolescents Visible and Measure What Matters
- Foster Whole-of-Government Accountability to Adolescents
- Make Universal Health Coverage Work for Adolescents
- Boost Accountability for Investments, including for Adolescents’ Health and Well-Being
- Unleash the Power of Young People, Move Away from Tokenism

**CONCLUSION**

Adolescents and youth in the Arab region are assets and can be agents of change towards more prosperous present and future for themselves and their communities. For this to occur, a significant paradigm shift needs to take place, from viewing young people as problem to viewing them as assets and solutions. From a youth at risk paradigm to a youth at promise paradigm. We have the evidence we need, we need to take this evidence to scale, all the while, actively and meaningfully engaging young people in the process.

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\(^8\) [https://iapewec.org/reports/2017report/]