



MARCH 2017

HER HEALTH, HER LIFETIME, OUR WORLD

Unlocking the Potential of
Adolescent Girls and Young Women

COCHAIRS

Helene Gayle

John Hammergren

CSIS

CENTER FOR STRATEGIC &
INTERNATIONAL STUDIES

THE CSIS TASK FORCE ON
WOMEN'S & FAMILY HEALTH

Charting a Vision for U.S. Global Leadership

MARCH 2017

HER HEALTH, HER LIFETIME, OUR WORLD

Unlocking the Potential of
Adolescent Girls and Young Women

COCHAIRS

Helene Gayle

John Hammergren

THE CSIS TASK FORCE ON
WOMEN'S & FAMILY HEALTH

Charting a Vision for U.S. Global Leadership

ROWMAN &
LITTLEFIELD

LANHAM • BOULDER • NEW YORK • LONDON

CSIS | CENTER FOR STRATEGIC &
INTERNATIONAL STUDIES

ABOUT CSIS

For over 50 years, the Center for Strategic and International Studies (CSIS) has worked to develop solutions to the world's greatest policy challenges.

Today, CSIS scholars are providing strategic insights and bipartisan policy solutions to help decisionmakers chart a course toward a better world.

CSIS is a nonprofit organization headquartered in Washington, D.C. The Center's 220 full-time staff and large network of affiliated scholars conduct research and analysis and develop policy initiatives that look into the future and anticipate change.

Founded at the height of the Cold War by David M. Abshire and Admiral Arleigh Burke, CSIS was dedicated to finding ways to sustain American prominence and prosperity as a force for good in the world. Since 1962, CSIS has become one of the world's preeminent international institutions focused on defense and security; regional stability; and transnational challenges ranging from energy and climate to global health and economic integration.

Thomas J. Pritzker was named chairman of the CSIS Board of Trustees in November 2015. Former U.S. deputy secretary of defense John J. Hamre has served as the Center's president and chief executive officer since 2000.

CSIS does not take specific policy positions; accordingly, all views expressed herein should be understood to be solely those of the author(s).

ACKNOWLEDGMENTS

This report was made possible by the generous support of the Bill & Melinda Gates Foundation.

PHOTO CREDITS:

Cover: Sala Lewis

p. 2: Sala Lewis

p. 20: Caitlin Healy

p. 30: Sala Lewis

p. 40: Salman Saeed

p. 47: Anne Jennings

p. 50: Pink Ribbon Red Ribbon

p. 60: Rick Bloom

© 2017 by the Center for Strategic and International Studies. All rights reserved.

ISBN: 978-1-4422-7999-5 (pb); 978-1-4422-8000-7 (eBook)

Center for Strategic & International Studies
1616 Rhode Island Avenue, NW
Washington, DC 20036
202-887-0200 | www.csis.org

Rowman & Littlefield
4501 Forbes Boulevard
Lanham, MD 20706
301-459-3366 | www.rowman.com

TABLE OF CONTENTS

p. IV

Members of the CSIS Task Force on
Women's and Family Health

p. V

Cochairs' Preface

p. 2

SECTION 01 A Dynamic U.S. Initiative—a New Way
of Doing Business

p. 20

SECTION 02 Improving Maternal and Newborn Health

p. 30

SECTION 03 Expanding Access to Voluntary Family Planning

p. 40

SECTION 04 Reducing Anemia

p. 50

SECTION 05 Expanding Access to the Human Papillomavirus
(HPV) Vaccine

p. 60

SECTION 06 Governance and Implementation

p. 70

Appendix: Country Selection Criteria and Key Data

MEMBERS OF THE CSIS TASK FORCE ON WOMEN'S AND FAMILY HEALTH

Helene Gayle, CEO of McKinsey Social Initiative; and John Hammergren, chairman, president, and CEO of McKesson Corporation, chaired this effort. They were joined by a distinguished and diverse group of individuals, including:

Lisa Carty

Director, U.S. Liaison Office, UNAIDS

Sen. Susan Collins (R-ME)

Steve Davis

President and CEO, PATH

Rep. Daniel M. Donovan, Jr. (R-NY-11)

Christopher Elias

President, Global Development,
Bill & Melinda Gates Foundation

Ezekiel Emanuel

Vice Provost for Global Initiatives and Chair of
Department of Medical Ethics and Health Policy,
University of Pennsylvania

Patrick Fine

CEO, FHI 360

Julie Gerberding

Executive Vice President and Chief Patient Officer,
Strategic Communications, Global Public Policy,
and Population Health, Merck & Co., Inc.

Michael Gerson

Senior Adviser, ONE Campaign

Former Rep. Richard Hanna (R-NY-22)

Former Sen. Mark Kirk (R-IL)

Vanessa B. Kerry

CEO, Seed Global Health, Faculty, Massachusetts
General Hospital and Harvard Medical School

Asma Lateef

Director, Bread for the World Institute

Rep. Barbara Lee (D-CA-13)

Kathleen McLaughlin

President, Walmart Foundation and
Chief Sustainability Officer, Walmart

Afaf Ibrahim Meleis

Dean Emerita and Professor of Nursing and Sociology,
University of Pennsylvania School of Nursing

J. Stephen Morrison

Senior Vice President and Director,
Global Health Policy Center, Center for Strategic
and International Studies (CSIS)

Rep. Mike Quigley (D-IL-5)

Diane Rowland

Executive Vice President, Kaiser Family Foundation

Sen. Jeanne Shaheen (D-NH)

Debora Spar

President and CEO, Lincoln Center for
the Performing Arts, and former President,
Barnard College

Jeffrey L. Sturchio

President & CEO, Rabin Martin

Phil Thomson

Senior Vice President, GlaxoSmithKline

Christy Turlington Burns

Founder & CEO, Every Mother Counts

The following members of the CSIS secretariat were essential to the research and writing of the final report, with active input from Task Force members and several key external partners: J. Stephen Morrison, Sara M. Allinder, Katherine E. Bliss, Janet Fleischman, Katey Peck, and Cathryn Streifel.

The report represents a majority consensus document among the Task Force members who participated in their individual capacity, not as representatives of their respective organizations. No member is expected to endorse every single point contained in the document. In becoming a signatory to the report, members affirm their broad agreement with its findings and recommendations. Organizations are listed for identification purposes only.

COCHAIRS' PREFACE

In October 2015, the Center for Strategic and International Studies (CSIS) launched a Task Force on Women's and Family Health, in the belief that there is a timely opportunity—and pressing need—for U.S. leadership in this critical area. The Task Force has generated a bold vision, detailed in this report, for a major U.S. initiative by the Trump administration to unlock the potential of adolescent girls and young women in select low-income countries. It is a call for a new and innovative U.S. approach to foreign assistance: one that creatively integrates key health interventions—improving maternal and newborn health, increasing access to voluntary family planning, reducing anemia, and expanding access to the human papillomavirus (HPV) vaccine to prevent cervical cancer—with education and other development efforts. It promises to embrace new technologies, draw in the private sector, deliver concrete and enduring returns on investment, firmly establish adolescent girls and young women as a pillar of long-term economic growth and opportunity, and bring vital benefits to Americans. It offers a clear answer to what the United States can do to address the “youth bulge” that, if unchecked, can generate high unemployment and instability in low-income countries that matter significantly to U.S. national interests.

We are especially indebted to the 24 distinguished, diverse, and highly active opinion leaders who generously agreed to be members of the CSIS Task Force on Women's and Family Health. They were supported by the CSIS expert secretariat, along with our valued partner institutions—the Bill & Melinda Gates Foundation, the Institute for Health Metrics and Evaluation at the University of Washington, the Kaiser Family Foundation, PATH, and the strategy consulting firm Rabin Martin—upon whom we relied from day one for their careful analyses and advice. Numerous other experts, inside and outside government, provided invaluable assistance, sharing their knowledge of the issues and helping refine estimates of the costs, concrete targets, and ex-

pected impacts for the proposed initiative's key elements. And, in our travel to countries across sub-Saharan Africa and Central America, we depended on the generosity and insights of civil society and faith leaders, nongovernmental implementers, national government officials, and U.S. embassy personnel.

We believe the time is ripe for this proposal—at the beginning of the Trump administration and the new Congress. There is a hunger for change and innovation in the U.S. approach to advancing global health, wellbeing, and economic opportunity.

Such an approach will yield a clear and robust return on investment. When women and girls in low-income countries are healthy, educated, and employed, they become skilled, productive leaders, capable of seizing opportunities and promoting economic growth. Over the full span of their lives, they create stronger families, more secure communities, and expanded markets. In turn, we as a nation benefit from a safer, more prosperous world that reinforces our security and prosperity while enhancing America's reputation and influence.

Our proposal builds on the bipartisan American tradition of investing strategically to spur economic growth and promote health and development in low-income countries, a tradition that reaches back to the post-World War II birth of modern U.S. foreign aid. The less than one percent of the U.S. budget invested annually in foreign assistance—which includes agriculture, health, education, water, and governance, as well as humanitarian response—has saved the lives of millions of women and children, and has helped millions more escape extreme poverty, enabling many countries to become a source of new markets and trade opportunities for U.S. businesses.

The Task Force's proposed initiative leverages the historic gains in global health achieved over the past 15 years. In 2003, President George W. Bush launched the President's Emergency Plan for AIDS Relief (PEPFAR), followed by the Pres

ident's Malaria Initiative (PMI) in 2005, with expanded U.S. support for maternal, newborn, and child survival programs and continued support for family planning and reproductive health. His administration also supported multilateral institutions and new and effective international instruments including the Global Fund to Fight AIDS, Tuberculosis, and Malaria; and Gavi, the Vaccine Alliance. The Obama administration subsequently continued and further developed each of these critical efforts.

The returns have been profound. The \$72 billion investment since 2003 by the United States in HIV/AIDS in priority, low-income countries has saved millions of lives of children and adults and slashed mother-to-child transmission of HIV. Today the United States supports life-sustaining therapy for nearly 11.5 million persons living with HIV and is advancing the very promising DREAMS (Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe) partnership to prevent HIV infection among highly vulnerable young women and girls in hotspots of the epidemic—a platform we can enlarge. Over the past decade and a half, the massive, historic U.S. mobilization in HIV/AIDS has undergirded stability, improved governance, and sustained economic growth worldwide.

In the period 2000–2015, U.S. government funding for maternal and child health also saved the lives of an estimated 2.5 million children and 1 million mothers and newborns. U.S. family planning programs have also helped prevent tens of thousands of women from dying during pregnancy and childbirth every year.

We believe we have devised a formula for success that fits our times. At its core is high-level diplomacy—specifically the secretary of state's leadership and oversight—to empower U.S. ambassadors to drive implementation and create new partnerships. Diplomacy is central to delivering more-robust commitments from our international and national partners. It calls for a disciplined, systems-based approach that mea-

sures the return on investment and that holds our government and its partners to account. The initiative calls for USAID to be central to operations and expertise, and for the private sector to play a critical role in delivering health services and commodities, participating in public-private partnerships, and investing in research and development. America leads the world in innovations that will equip us with better data, twenty-first-century technologies, and creative approaches to achieve greater impact. We are seeing unprecedented engagement by the private sector, which can be harnessed to devise pragmatic solutions to address the needs of adolescent girls and young women.

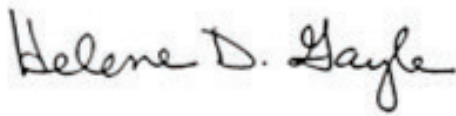
We are proud of the Task Force's work and are convinced that the proposed U.S. initiative provides a timely, forward-looking platform that Americans across the political spectrum have consistently supported and builds on the record of longstanding global health leadership by the United States. Even in the midst of our current budget environment, we believe this initiative is affordable and can be advanced with sustained high-level leadership, without sacrificing support for high-impact, worthy global health and development programs. It holds the promise of driving truly important, innovative, distinct, and inspiring gains—a signature achievement for the Trump administration, for the United States, for young women, and for the world. Our sincere hope is that all sectors of society will rally behind this vision and help it become reality.

With warmest regards,

Helene Gayle and John Hammergren

Cochairs, CSIS Task Force on
Women's and Family Health

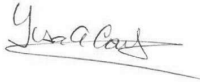
TASK FORCE MEMBERS



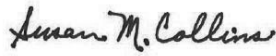
HELENE GAYLE



JOHN HAMMERGREN



LISA CARTY



SUSAN COLLINS



STEVE DAVIS



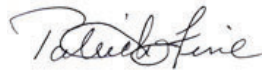
DANIEL M. DONOVAN, JR.



CHRISTOPHER ELIAS



EZEKIAL EMANUEL



PATRICK FINE



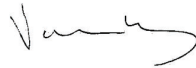
JULIE GERBERDING



MICHAEL GERSON



RICHARD HANNA



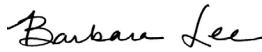
VANESSA B. KERRY



MARK KIRK



ASMA LATEEF



BARBARA LEE



KATHLEEN MCLAUGHLIN



AFAF IBRAHIM MELEIS



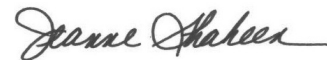
J. STEPHEN MORRISON




MIKE QUIGLEY



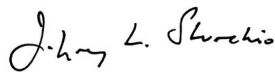
DIANE ROWLAND



JEANNE SHAHEEN



DEBORA SPAR



JEFFREY L. STURCHIO



PHIL THOMPSON



CHRISTY TURLINGTON BURNS

SECTION 01



A Dynamic
U.S. Initiative—
a New Way of
Doing Business

**A DYNAMIC
U.S.
INITIATIVE—
A NEW WAY
OF DOING
BUSINESS**

She is a 12-year-old who needs to stay in school, be adequately nourished, learn how to keep herself safe and healthy, and be vaccinated against HPV to protect her from cervical cancer later in life. She is a single 16-year-old who seeks to complete her secondary education and find a job, while meeting her needs for voluntary contraceptive choices and protection against HIV. She is a married 24-year-old who wants to provide for her family, control the timing and spacing of her pregnancies, survive childbirth, live a healthy full life, and have strong, well-nourished children.

As the adolescent girl becomes a young woman, her life prospects and those of her children will rest on access to several vital interventions that are commonplace in the United States: information and services on voluntary contraceptive choices, access to education and prevention of early child marriage, basic nutrition, vaccines to prevent cervical cancer, economic opportunities, and reliable protections against violence. How her life evolves will rely on access to quality care, informed decisions, and critical support structures.

We have a historic opportunity to make a difference—for her future, for the future of her family and community, and for our own—by providing the tools that allow her to realize her full potential.

RECOMMENDATION

The CSIS Task Force recommends that the Trump administration, in concert with Congress, launch a signature health initiative that targets not a single disease or global health challenge, but rather an important population: adolescent girls and young women (ages 10–24).

The Goal: To secure the health and future of adolescent girls and young women in 13 low-income countries. Doing so will generate vital returns over the course of their lives and the lives of their children, significantly strengthening families, communities, and societies at-large.

The Strategy: Concerted U.S. high-level leadership over the next four years will expand proven interventions that advance maternal and newborn health, family planning and reproductive health, nutrition, and prevention of cervical cancer. It will build upon the PEPFAR structures that have achieved dramatic gains in reducing the risk of HIV infection. Success will be aided by a tight geographic focus on 13 target countries, and a careful, systematic approach that joins the expansion of health-related services with improved access to education, economic empowerment, and gender-based violence prevention and response programs. The strategy will rely on innovative approaches to technology, lessons learned from the business community, systematic use of existing investments, strong governance and accountability, engagement of men and boys, and aggressive mobilization of diverse financial resources, including expanded contributions by the private sector.

THE RATIONALE

Why this population now?

A Period of Immense Change for Young Women:

Early adolescence (10 to 14 years) is a critical time to build on previous investments in child health, nutrition, HIV prevention, and education, and to lay the foundation for continued cognitive and physical development. The onset of puberty is an important time to reach girls with information about reproductive health, nutrition, gender-based violence, and gender equality.

Late adolescence (15 to 19 years) represents an important period to build and expand health and education gains. In the developing world, the average adolescent girl often becomes sexually active, marries, and has her first child in this period—one of many reasons why only 18 percent of young women complete secondary school across the 13 target countries.

Young adulthood (20 to 24 years) is a critical time for young women to sustain health gains and realize their full earning potential. In developing countries, many young mothers quickly become pregnant again, which increases the risks for mother and newborn of dying during childbirth, as well as illness and other complications during and after delivery. It also decreases their access to social and economic opportunities.

An Urgent Need: The adolescent and young adult population in low-income countries is at a historic high and will continue to rise in the coming years.¹ This demographic phenomenon, a central dimension of the “youth bulge,” threatens to lead to high unemployment and instability, including in countries that matter significantly to U.S. national interests.² Recent progress in reducing deaths among children under the age of five means there are more young women than ever in history who need to be reached with critical services. As these



HELENE GAYLE

“The work of the CSIS Task Force exemplifies how people with different perspectives can unite behind a common mission and work to create positive change.

We were fortunate to have the insights of leaders from Congress, industry, foundations, universities, the faith community, and nongovernmental organizations, among others, all committed to building on the impressive American legacy in global public health. The resulting vision of improving the health and well-being of adolescent girls and young women, and in doing so, unleashing their economic and social potential, will resonate throughout our society and can be realized with the determined leadership of both Congress and the administration.”



JOHN HAMMERGREN

“As a global health leader, the United States has a unique ability to help improve the lives of girls and women in developing nations. Through the partnership of government, businesses, and nonprofits, and by leveraging the innovation and technology that America is known for, together, we can truly help change lives in a powerful and lasting way.”

young women navigate the journey between childhood and adulthood, they and any children they bear face perilous health risks that can both compromise their potential and impose grave costs to society.

Too often, adolescent girls and young women, especially those living in poverty, fall through the cracks: they live with high risks of early marriage, unintended pregnancy, gender-based violence, and exploitation, which in turn leave them at high risk of maternal mortality and serious illness, birth complications, HIV infection, and cervical cancer. Within the household, they are often the last to eat, putting them at increased risk of malnutrition.

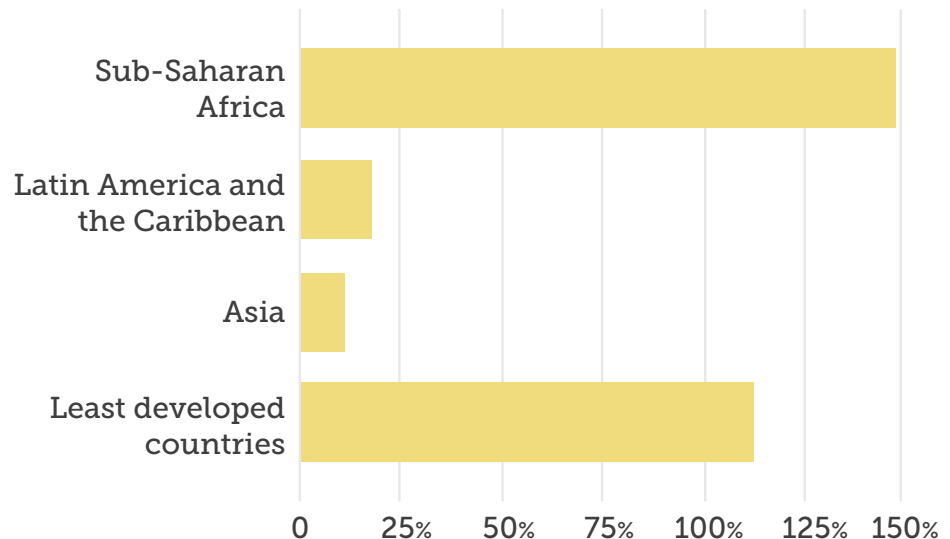
As these risks intensify, lifetime educational and economic opportunities slip away.³

A High-Yield Opportunity: Investing in adolescent girls and young women, we now know, has a triple impact: on the lifetime of that individual; on the lifetime of her children, the next generation; and on the broader prosperity of her community.⁴ According to the World Bank, improving health outcomes for women can increase labor productivity by as much as 25 percent in some countries.⁵ By supporting young women today and assisting them to become productive members of society tomorrow, the world economy stands to grow by as much as \$12 trillion, should women

WORKING AGE POPULATION TO DOUBLE IN SUB-SAHARAN AFRICA

Percent change in the working-age population (ages 15–64) between 2015 and 2050

Source: UNFPA, The Power of 1.8 Billion: Adolescents, Youth, and the Transformation of the Future, State of the World Population 2014, p 17. http://www.unfpa.org/sites/default/files/pub-pdf/EN-SWOP14-Report_FINAL-web.pdf



MAJOR GLOBAL HEALTH INITIATIVES

BUSH YEARS | OBAMA YEARS

2000

Millennium Development Goals adopted.
GAVI Alliance launched.

2001

2002

Global Fund to Fight AIDS,
Tuberculosis and Malaria established.

2003

PEPFAR authorized.

2004

Millennium Challenge Corporation launched.

2005

President's Malaria Initiative is launched.

2006

2007

2008

2009

Global Health Initiative is launched.

2010

Feed the Future program launched.
UN Every Woman Every Child initiative launched.

2011

Pink Ribbon Red Ribbon launched.

2012

Child Survival Call to Action Summit.
Saving Mothers, Giving Life launched.
FP 2020 launched at London Summit on family planning.

2013

U.S. endorses Global Nutrition for Growth Compact.

2014

PEPFAR's DREAMS partnership launched.
Global Health Security Agenda launched.

2015

Sustainable Development Goals adopted.
Global Financing Facility launched.

2016



EZEKIEL EMANUEL

“The United States has the requisite institutional capacity, leadership, and economic resources to lead a high-yield global health initiative that would spur economic and social development. Our proposal highlights the scale and urgency of the challenge and lays out a strategic guide path for achieving an ambitious set of health care goals for young women.”

be permitted to play an equal role in labor markets as men.⁶ Achieving a fraction of that increase through these interventions will help to improve economic outcomes in the 13 target countries.

A Chance to Make History: The Sustainable Development Goals (SDGs), *The Lancet* commission on adolescent health and wellbeing, Family Planning 2020, and the UN Secretary General’s Global Strategy for Women’s, Children’s and Adolescent’s Health have generated considerable global momentum in support of adolescent girls. U.S. policy has recently added a significant new dimension with the launch of the landmark, ambitious PEPFAR DREAMS partnership, which concentrates efforts to reduce the extreme risks of HIV infection faced by adolescent girls and young women in “hot spots” in 10 sub-Saharan African countries. Other related U.S. policy efforts include the Let Girls Learn initiative, the Global Strategy to Empower Adolescent Girls, and the USAID goal of ending preventable child and maternal deaths. Meanwhile, important public-private partnerships such as Saving Mothers, Giving Life have demonstrated the possibility of achieving concrete gains in reducing maternal mortality,⁷ while Pink Ribbon Red Ribbon has done the same for preventing and treating cervical cancer.⁸

What is missing today is a viable, integrated plan to meet the unique needs of adolescent girls and young women that has substantial finan-

cial backing from diverse sources and can deliver concrete gains in health and educational and economic prospects. Making better use of data and surveillance tools will allow us to target services where they are most needed. *This is what the proposed U.S. signature initiative seeks to achieve under the Trump administration.*

THE ACTION PLAN

1) Focus on 13 target countries.

The initiative will focus on adolescent girls and young women in 13 low-income countries with great needs and substantial existing U.S. investments in health and related development areas, through both direct bilateral programs and multilateral agencies. The suggested target countries include Bangladesh, Ghana, Kenya, Liberia, Malawi, Mozambique, Nepal, Nigeria, Rwanda, Senegal, Tanzania, Uganda, and Zambia.⁹ Given the large populations of Nigeria and Bangladesh, we propose an initial effort to reach 20 percent of adolescent girls and young women in these two countries.

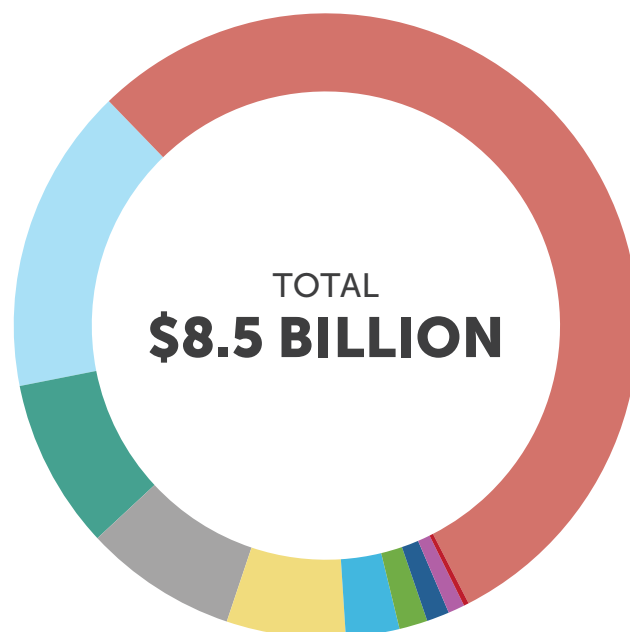
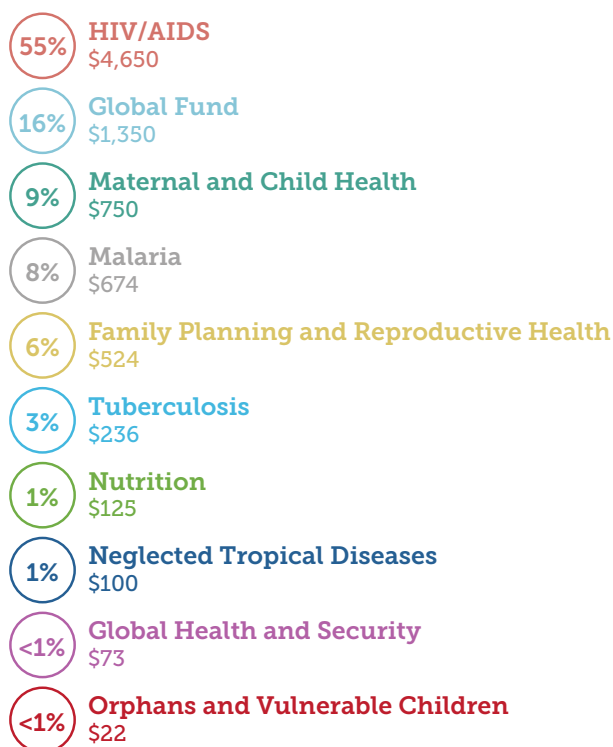
2) Build on existing U.S. investments.

The target population is diverse and includes sub-cohorts (e.g., in- and out-of-school, married and unmarried, pre- sexual debut and sexually active). Engaging with this group requires an ap-

GLOBAL HEALTH FUNDING

As a Share of the U.S. Federal Budget, FY2016

*Dollars in millions



Global health funding, one-quarter of foreign assistance, represents 0.25 percent of the annual federal budget.

proach that spans health and non-health sectors and special care in oversight, coordination, and delivery. Health providers will need to be trained and supervised to provide this population with quality and respectful care.¹⁰ Adolescent girls and young women and their communities will need to play an active role in the design and execution of programs.

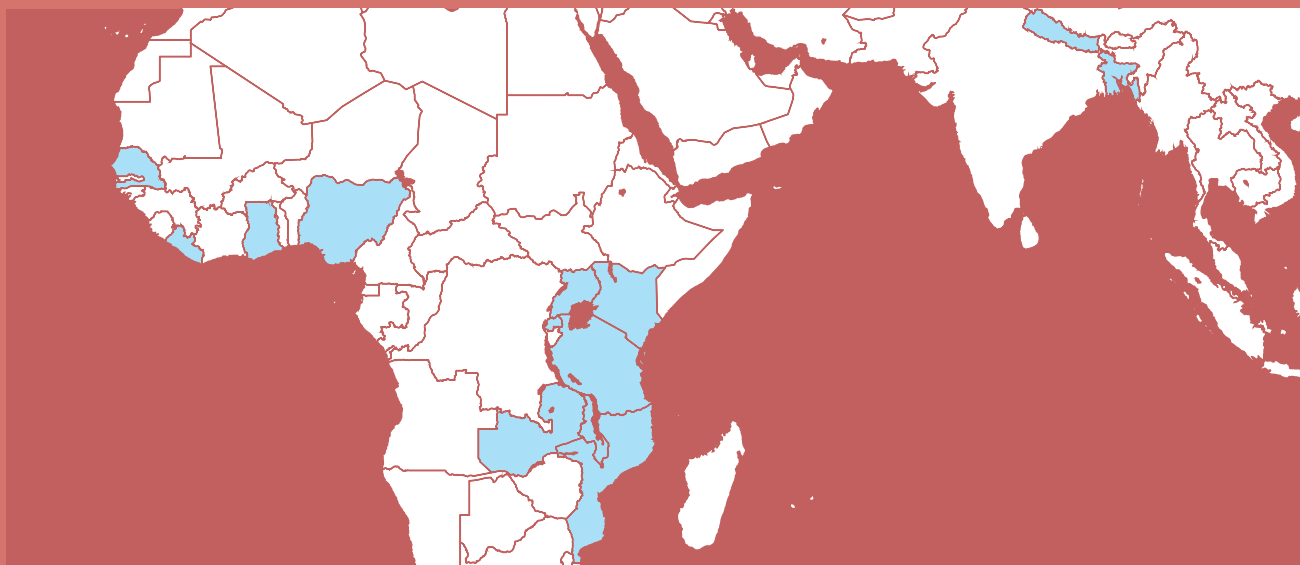
The proposed approach takes full advantage of global health and related development investments in each country to target the special needs of adolescent girls and young women. That means systematically leveraging the DREAMS partnership (active in six of the target countries); its platforms offer exceptional opportunities for incorporating the initiative's core health and development activities. It means tapping existing health investments in family planning and reproductive health; maternal, newborn, and child health; immunizations; and nutrition. It means taking full advantage of

PEPFAR's major capacities; investments in primary and secondary education; evolving work in food security; and programs to strengthen women's empowerment, address gender-based violence, and prevent child marriage.

3) Spearhead new, ambitious goals in four key areas.

- **Maternal and newborn health:** Increase by 25 percent the proportion of adolescent girls accessing high-quality care (antenatal, intrapartum, and postpartum) to address the health and social risks associated with adolescent pregnancy and childbirth, and improve newborn outcomes.
- **Family planning:** Increase access to voluntary family planning with the goal of meeting 50 percent of the current unmet need for modern methods of family planning among 15- to 24-year-olds who desire to avoid, space,

13 TARGET COUNTRIES



AVERAGE MATERNAL MORTALITY

423 PER **100,000**
Deaths Live births

HOME TO

97.8
MILLION ADOLESCENT
GIRLS & YOUNG WOMEN

22%

OF ADOLESCENT GIRLS
ARE PREGNANT BY AGE 19

48%

OF UNMARRIED
ADOLESCENT GIRLS
AND YOUNG WOMEN
HAVE AN UNMET NEED
FOR FAMILY PLANNING

AVERAGE
ADOLESCENT GIRL
IS MARRIED BY
THE AGE OF

19

39%

OF WOMEN AGES 15 TO 49
ARE ANEMIC

18%

OF ADOLESCENT
GIRLS COMPLETE
SECONDARY SCHOOL

Sources: Kerry MacQuarrie, "Unmet Need for Family Planning among Young Women: Levels and Trends," DHS Comparative Reports No. 34 (Rockville, MD: ICF International, 2014); UNICEF, "Data on Primary Education – Completion Rates," <http://data.unicef.org/topic/education/primary-education/>; UN Population Division, "Population by Age Groups – Female," World Populations Prospects, the 2015 Revision (New York: United Nations, 2015), <https://esa.un.org/unpd/wpp/Download/Standard/Population/>; World Bank, "Adolescent fertility rate (Births per 1,000 women ages 15–19)," 2016, <http://data.worldbank.org/indicator/SP.ADO.TFRT>; World Bank, "Maternal mortality ratio (modeled estimate, per 100,000 live births)," 2016, <http://data.worldbank.org/indicator/SH.STA.MMRT>.



KATHLEEN MCLAUGHLIN

"When young women thrive, they strengthen their families and communities. Investing in them demonstrates American leadership and foresight, and drives returns in global health, security, and economic stability."

or delay pregnancy. Girls between the ages of 10 and 14 require information and education to build their awareness.

- **Nutrition:** Reduce anemia by 25 percent among adolescent girls and young women by providing iron and folic acid supplementation, as well as nutrition education and counseling, to at least 75 percent of 10- to 24-year-olds.
- **Vaccination against HPV:** Prevent cervical cancer by achieving 50–75 percent coverage of HPV vaccine among 9- to 14-year-old girls. This effort would seek to fully immunize 40 million girls.

Each of these efforts addresses an area of acute, unmet need. Each creates a bridge to this difficult-to-reach population. Each builds on mounting international and country-level action, accumulating evidence, and programmatic knowledge.

The four efforts reinforce one another. Improved access to family planning, for instance, assists in averting teenage pregnancy, which also helps maintain a girl's physical and cognitive growth and lowers the odds she will die while giving birth.¹¹ The introduction of HPV vaccines creates an opportunity to reach adolescent girls with additional sexual and reproductive education to further reduce the risks of early pregnancy and sexually transmitted infections (STIs).¹² An investment in one area can stimulate investment in the others, while a platform designed for one program can potentially be used to advance the others.

SUMMARY OF HEALTH IMPACTS OF PROPOSED INITIATIVE

- **Maternal and newborn health:** 26,300 maternal and 493,000 newborn deaths averted.
- **Family planning:** 5.4 million users reached, 1.3 million unintended pregnancies averted, and 3,600 maternal deaths averted.
- **Nutrition:** 25 percent reduction in anemia among adolescent girls and young women, contributing to the global goal of 265 million fewer women with anemia and 800,000 child deaths averted.
- **Vaccination against HPV:** 235,000 lives saved and 650,000 cases of cervical cancer averted.

4) Align U.S. government leadership and oversight.

- **The secretary of state** should be responsible for the initiative's overall strategic design and direction, including both shaping the U.S. budgetary process in Washington, D.C. and winning greater ownership by partner governments: e.g., encouraging legal and policy changes, along with higher budgetary commitments. The secretary should designate a deputy to track developments and convene an interagency steering committee comprising the executive branch departments and agencies with programs targeting adolescent girls and young women.

- **USAID:** Operations and programmatic decisionmaking need to be centered at USAID, which implements most health, education, economic strengthening, and agriculture programs that impact adolescent girls and young women. A senior figure—the equivalent of a deputy administrator—should be charged with day-to-day leadership and management, including developing strategies, budgetary allocations, staffing, monitoring and evaluation, support to missions, testimony before Congress, liaison to the White House, and quarterly and annual reporting.

The USAID deputy administrator and the secretary of state's designated deputy should share responsibility for relations with Congress and coordination of high-level diplomacy with host governments, U.S. corporate leadership, foundations, and international and multilateral organizations, and other donors.

- **U.S. missions:** In each of the 13 target countries, the chief of mission should be responsible for political leadership in-country and management of relations with the host government, including all formal collaborations with partner governments. A senior coordinator should be responsible for day-to-day in-country management and coordination across U.S. government programs.

5) Sustain high-level diplomacy.

Led by the secretary of state, the United States has to think a decade or more into the future, while putting in place adequate metrics; insisting upon innovation; bringing to scale partnerships with governments, the private sector, multilateral institutions, civil society, and others that are both dynamic and catalytic; and systematically building coalitions committed to meeting the needs of adolescent girls and young women. Success will take time and requires strong, resilient, and innovative partnerships and approaches.

Diplomacy will be integral to encouraging partner governments to adopt policies that address the needs of adolescent girls and young women and invest at high levels in new partnerships. Diplomacy can shape markets to lower product costs and influence political and business decisionmaking. It can encourage businesses to invest in health services and in research and development (R&D) of appropriate technologies. It can also enlist civil society groups and faith-based organizations, foundations, international organizations, and other donors into the initiative.

6) Put innovation at the center.

- **Invest in data.** America leads the way in innovation, but that power is currently underleveraged in global health programs. A special



CHRISTOPHER ELIAS

“Clearing the barriers that keep adolescent girls and young women from reaching their full potential cannot be addressed by one sector alone. Developing smart, multisectoral partnerships will give us the greatest chance to achieve our bold ambitions to improve the lives of adolescent girls and young women around the world.”

effort is needed to better target and track unreached adolescent girls and young women and increase the impact of programs. In order for these proposed health interventions to succeed, better information is needed: e.g. data disaggregated by sex, age, marital status, and economic standing. Deeper knowledge is also needed in a number of key areas: e.g., how best to address gender-based violence, change norms around harmful practices such as early marriage, and how best to engage boys and men.¹³ This requires a significant investment in research to accelerate development of standard indicators and understanding of adolescent health outputs and outcomes. We are at a moment where these tools are becoming more available.

- **Spur research and development.** Many promising technologies and innovative approaches can have major impact, specific to the needs of adolescent girls and young women, in maternal and newborn health, family planning, nutrition, and HPV vaccines.¹⁴ Digital health solutions, such as handheld devices and electronic reporting systems, have the potential

to address the needs of adolescent girls and young women and significantly improve their health outcomes in low-resource settings. Many of these solutions will be generated through partnerships with the private sector.

To speed products from development to delivery, the secretary of state should create a high-level expert panel to advise on technological opportunities and public-private partnerships. USAID should create a dedicated mechanism to provide finances and technical expertise to emerging innovators in the 13 target countries.

- **Incentivize integration.** In their country planning, U.S. missions should be systematically incentivized to combine programs in education, economic empowerment, gender-based violence, food security and reducing child marriage with their core health interventions, along with the operational research described above. An Integration Fund should be established at USAID that supports creative program alignments through results-based financing, founded on the outstanding quality of country plans that seek to demonstrate



SEN. SUSAN COLLINS (R-ME)

"Promoting the health of women and girls is one of the most effective ways to save lives and protect families in developing countries. If we succeed, it would also lead

to more stable societies and improve our own national security, which are goals shared by Republicans and Democrats alike. As we continue to work with the private sector, nonprofits, the faith community, partner countries, and others in implementing this proposal, it is my hope that this bipartisan proposal will be embraced by policymakers on both sides of the aisle."

U.S. INVESTMENTS IN 13 TARGET COUNTRIES

	Maternal and Child Health	Family Planning	Nutrition & Reproductive Health	Feed the Future	Gavi Support	PEPFAR	DREAMS	Global Financing Facility	President's Malaria Initiative
BANGLADESH	●	●	●	●	●			●	
GHANA	●	●	●	●	●	●			●
KENYA	●	●	●	●	●	●	●	●	●
LIBERIA	●	●	●	●	●			●	●
MALAWI	●	●	●	●	●	●	●		●
MOZAMBIQUE	●	●	●	●	●	●	●	●	●
NEPAL	●	●	●	●	●				
NIGERIA	●	●	●		●	●		●	●
RWANDA	●	●	●	●	●	●			●
SENEGAL	●	●	●	●	●			●	●
TANZANIA	●	●	●	●	●	●	●	●	●
UGANDA	●	●	●	●	●	●	●	●	●
ZAMBIA	●	●	●	●	●	●	●		●

progress in achieving higher cost effectiveness and improved health outcomes.

- **Expand the role of the private sector.** The U.S. country teams in the 13 target countries should partner with the local private health sector to expand access to high-quality family planning and maternal health services to adolescent girls and young women. The U.S. should draw on the private sector's expertise,

investment capacity, and special knowledge of local customs and market conditions.

The Trump administration and Congress should support legislative action that authorizes and funds matching resources for public-private partnerships, including through innovative financing mechanisms¹⁵ that work to meet the specific needs of adolescent girls and young women.¹⁶



MICHAEL GERSON

"Confronting the challenges of adolescent girls and young women would leverage large gains in nearly every other field of health and economic development.

It is impossible, for example, to take the next vital steps in HIV/AIDS prevention without empowering adolescent girls—helping them find more knowledge, skills, and influence over their own lives and futures. This has been, and should be, an entirely bipartisan matter. The Task Force report not only describes an urgent need, it provides a rigorous, detailed, costed-out policy framework to address that need. If the Trump administration pursues this type of initiative, it will find strong support across the ideological spectrum, including from critics on other matters. And such an initiative could unite members of Congress in an important shared mission at a time when unity of national purpose is all too rare. The implementation of these proposals would save the lives of countless mothers and newborns, reduce the risk of cervical cancer, and prevent many abortions. For myself, I regard this as a pro-life cause."

7) Mobilize robust financing from multiple sources.

The aggregate, new additional cost of the proposed initiative for adolescent girls and young women is approximately \$634 million, comprised of the estimated annual cost of \$176 million for maternal and newborn health, \$144 million for family planning and reproductive health, \$22 million for nutrition and nutrition-focused research, and \$105 million for vaccination against HPV. It also includes \$15 million for data and metrics, \$25 million for innovation, and \$100 million per year to add additional

programs such as education, reward outstanding integrated country plans, and advance operational research, all financed through a results-based approach. Detailed cost analyses for each of these efforts follow this synopsis.

To be effective, the initiative will need guaranteed resources for at least the duration of the new administration, 2017 through 2021, with the expectation that funding will extend through 2025.

There are different options for phasing this initiative and for bringing adequate resources to

bear. The Trump administration, in concert with Congress, will be responsible for determining the most appropriate approach.

Mobilizing resources and covering the additional costs of this initiative rests on four elements.

- **Leverage existing U.S. bilateral investments.**

The 13 target countries were selected, in part, because they already feature ongoing U.S. investments in family planning, maternal and child survival, immunizations, and nutrition, along with HIV/AIDS, tuberculosis (TB), and/or malaria. A first step is to map how to build on current programs to prioritize outreach to adolescent girls and young women by detailing what programmatic capacities and resources can be tapped, and mapping U.S. country-level investments by program and site. The DREAMS partnership, funded through PEPFAR at an initial level of \$385 million, is active in 6 of the 13 target countries, and could contribute to the program goals.¹⁷

- **Leverage multilateral agencies,** particularly in those areas where we are confident that greater U.S. commitments will bring other donor dollars to the table. At present, all 13 countries remain eligible for support from Gavi.¹⁸ As Gavi accelerates access to the HPV vaccine, the United States can contribute to this effort confident that other

donors will help to cover the remaining costs.¹⁹

The World Bank's Global Financing Facility has considerable potential to incentivize partner countries to invest International Development Association (IDA) resources.²⁰ UN agencies, including UNICEF, UNAIDS, and UNFPA have a major role to play across most of these programmatic areas. The Global Fund, which invests in each of the 13 countries, can potentially further align its investments to more directly and reliably benefit adolescent girls and young women.

- **Leverage industry and foundation partners.**

There are considerable opportunities to bring to scale select public-private partnerships—DREAMS; Pink Ribbon Red Ribbon; Saving Mothers, Giving Life—that are already hard at work in many of the activities recommended by the Task Force.

- **Increase U.S. bilateral investments** across all four programmatic areas (maternal and child health, family planning and reproductive health, nutrition, and immunizations). This will require careful sustained consultations with Congress, in the context of the overall changes the Trump administration will seek in the federal budget and within the constraints of the Budget Control Act.



PATRICK FINE

"We know that investing in women and their families leads to healthier, better educated, and more prosperous communities that strengthen our allies and make us more secure at home. The proposed signature initiative provides a clear and compelling way to advance U.S. interests through traditional American values. It's like a barn raising for women and families. Now is the time to act."

Conclusion

We recognize that this proposed initiative is exceedingly ambitious and complex. Its launch by the Trump administration in concert with Congress could take a variety of forms under different scenarios. But whichever path is chosen to bring this initiative to life, it will require sustained high-level political will, matched by the support and good faith of the many other actors who will play critical roles. The sections that follow provide a deeper look at the four priority programmatic areas, governance and implementation, as well as extensive detail on costing and the selection of target countries.

Summary of Goals and Costs

Overview: A signature initiative to accelerate progress on the health and wellbeing of adolescent girls and young women in 13 low-income countries where needs are greatest and U.S. investments are substantial.

FOCUS AREA	ANNUAL INVESTMENT	BRIEF DESCRIPTION OF GOAL
Maternal and newborn health	\$176,000,000	Increase by 25 percent the proportion of adolescent girls (10–19) accessing high-quality care (antenatal, intrapartum, and postpartum) to address the health and social risks associated with adolescent pregnancy and childbirth, and improve newborn outcomes.
Family planning and reproductive health	\$144,000,000	Increase access to effective family planning, with the goal of meeting 50 percent of the current unmet need for modern methods of family planning among 15- to 24-year-olds who desire to avoid, space, or delay pregnancy. The 10 to 14 age group is to be reached with information and education to build their awareness and access.
Nutrition	\$22,000,000	Reduce anemia by 25 percent among adolescent girls and young women by providing iron and folic acid supplementation, as well as nutrition education and counseling, to at least 75 percent of 10- to 24-year-olds. Through dedicated operational research, fill gaps in knowledge of this cohort's nutritional status.
Vaccination against HPV	\$105,319,690	Prevent cervical cancer by achieving 50–75 percent coverage of HPV vaccine among 9- to 14-year-old girls. This effort would seek to fully immunize 40 million girls.
Integration Fund	\$100,000,000	The fund will underwrite combining education and other development activities (e.g., empowerment, gender-based violence, child marriage) with core health programs, make use of results-based financing, and support operational research.
Innovation	\$25,000,000	Support emerging innovators in the target countries.
Data and metrics	\$15,000,000	Ensure that the United States and its partners adopt common metrics that ultimately demonstrate programmatic impact.
Management and operations	8 percent of sub-total	Support headquarters and in-country operational costs needed to successfully implement the initiative.
TOTAL	\$634,305,265	

SECTION 02



Improving Maternal and Newborn Health

IMPROVING MATERNAL AND NEWBORN HEALTH

The proposed goal is to increase by 25 percent the proportion of adolescent girls (10–19) accessing high-quality care (antenatal, intrapartum, and postpartum) to address the health and social risks associated with adolescent pregnancy and childbirth and improve newborn outcomes.²¹

Achieving this goal will require several different adolescent-focused interventions in order to reach both married and unmarried girls with information and services delivered through health facilities (public and private), schools, and communities. Programs to empower adolescent girls to delay marriage and first pregnancy, to determine the timing and spacing of future pregnancies, and to stay in school will be vital.²²

Providing quality care would significantly reduce adolescent pregnancies, as well as maternal and child deaths associated with adolescent pregnancy. Reaching this goal would result in an estimated 26,300 maternal and 493,000 newborn deaths averted. We estimate that the costs associated with achieving this goal in the 13 target countries would be approximately \$176 million per year.

RATIONALE

Adolescent girls, who have aged beyond the critical focus years of child survival programs but are not yet prepared to become mothers, are frequently left behind in the context of maternal and newborn health activities. Yet some 16 million adolescents ages 15–19 give birth every year, and 95 percent are in low- or lower-middle-income countries. Of these, 10 percent are age 16 or younger, particularly in sub-Saharan Africa and South and Southeast Asia. Adolescent girls account for more than 50 percent of births in sub-Saharan Africa.²³ Girls who are poor, uneducated, rural, and lack autonomy and access to

family planning and reproductive health services are more likely to become pregnant.²⁴ According to the World Bank, child marriage is the main factor leading to early child-birth, with one assessment of 25 countries showing that an estimated 84 percent of mothers under the age of 18 had been married as children.²⁵

The risks of adolescent pregnancy for both mother and child have been well documented. Pregnancy in adolescence is associated with a range of negative health issues, including anemia, HIV and other sexually transmitted infections, postpartum hemorrhage, and mental health issues, and is also closely linked to obstetric fistula.²⁶ Adolescent mothers are 50 percent more likely to have their pregnancies end in stillbirths and see their newborns die within the first week after birth than 20- to 29-year-olds. Pregnancy in adolescence is also linked to higher rates of preterm birth and asphyxia.²⁷

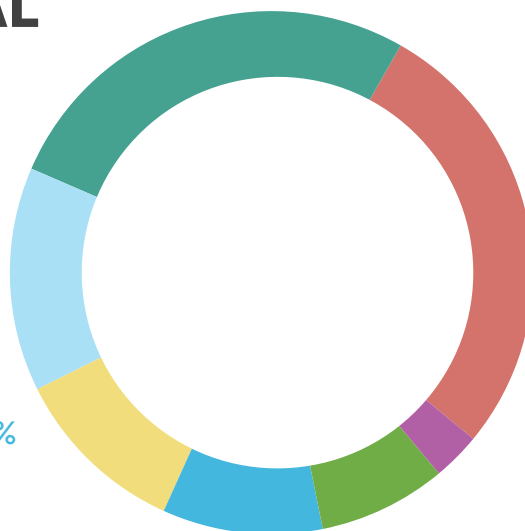
Younger mothers are more likely to go into early labor and to deliver babies with low birth weight, in part because of their own physical immaturity, the greater likelihood that they will develop eclampsia, and their vulnerability to infections.²⁸ For young, unmarried mothers, the absence of a strong family or community support systems further endangers the health of their newborns.²⁹

Although the data are not available on what proportion of unattended births are among adolescents, experts believe that it is significant.³⁰ Adolescent girls are often made to

MOST MATERNAL DEATHS ARE PREVENTABLE

Direct Causes

- Hemorrhage 27%
- Hypertension 14%
- Sepsis 11%
- Obstetric complications 10%
- Abortion 8%
- Embolism 3%



Indirect Causes 28%

This includes diseases during pregnancy.

Source: UNICEF, "Maternal mortality fell by almost half between 1990 and 2015," updated April 2016, <http://data.unicef.org/topic/maternal-health/maternal-mortality/#>.

feel unwelcome in the health system, and those who seek antenatal services may be shamed by health care providers and may not receive respectful care if they come forward with their pregnancies, which further undermines their access to quality maternal health services.

Improving the access of pregnant adolescents and young women to high-quality antenatal care, encouraging them to deliver their babies at health care facilities attended by a skilled provid-

er, and ensuring they receive appropriate postpartum support, including postpartum family planning and advice regarding newborn care, will help protect their health, as well as the health of their children. High-quality antenatal care visits can enable a pregnant adolescent or young woman to learn about the symptoms of early labor and to be assessed for symptoms associated with eclampsia.³¹



CHRISTY TURLINGTON BURNS

"If you wish to address the health and well-being of humankind, the best place to start is with mothers. There is no greater opportunity to save the lives of newborns and children than to ensure that women are healthy before they become mothers and have access to quality and consistent health care before, during, and postpartum. The health of every nation depends on the care and respect of the world's mothers."



REP. MIKE QUIGLEY (D-IL-5)

“When the United States invests in women and girls, the return on that investment is unparalleled. These are among the smartest and most impactful investments we can make. Adolescent girls around the world possess an untapped potential that deserves to be nurtured—and once unleashed, it will change the world.”

During the postpartum period, adolescent-friendly community programs focused on supporting young mothers with information and advice for caring for newborns can also improve health outcomes for this vulnerable population. Postpartum care also provides an important opportunity to discuss postpartum family planning, in order to space births or avoid subsequent unintended pregnancies.

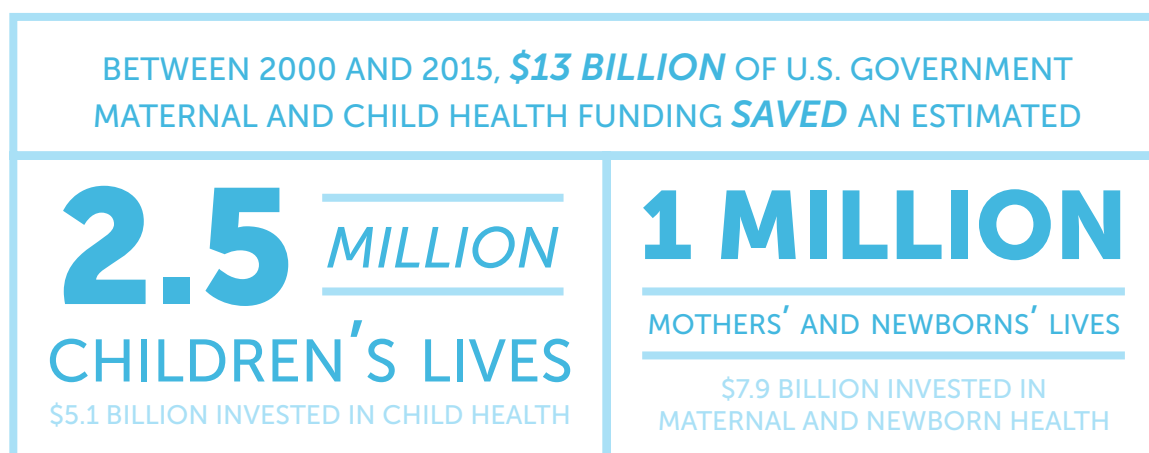
The social risks that adolescent girls face contribute directly to adverse outcomes, such as early marriage and early age of first birth, pregnancy compelling girls to drop out of school, and closely spaced pregnancies. In each of these areas, interventions that specifically target these risks are essential.

Most adolescent pregnancies take place in the context of early marriage. *The Lancet* series on adolescent health and well-being noted that “girls who marry young face diminished opportunities for education, greater sexual exploitation, and violence that can sometimes extend to enslavement. Child brides are also exposed to health risks from early pregnancy, have greater maternal and infant mortality, and heightened vulnerability to HIV/AIDS and other sexually transmitted diseases.”³²

For unmarried girls, the chances are much higher that their pregnancy is unintended and will be

terminated by unsafe abortion,³³ with the potential for complications resulting in illness, disability, or even death. Unintended pregnancy can also be the result of sexual violence against adolescent girls, and national-level data show that about one out of every three girls experiences violence as a child.³⁴ Unintended pregnancies are more common for those adolescent girls whose first sexual experience was forced or coerced, and data from the Violence Against Children Surveys showed that this ranged from 20 to over 50 percent in the countries where surveys were conducted.³⁵

Adolescent mothers are forced to drop out of school and often prohibited from returning to school, which increases their social isolation, decreases their educational and economic prospects, and perpetuates cycles of poverty. *The Lancet* series on adolescent health and well-being highlighted the strong negative correlation between pregnancy-related maternal mortality and education: “For young women 15–24 years, pregnancy-related maternal mortality was strongly associated with education. Each additional year of education for young women was associated with 0.4 fewer maternal deaths per 100,000 girls per year in 15–24 year olds after accounting for national wealth.”³⁶ A World Bank study estimates that the economic opportunity costs associated with adolescent pregnancy and dropping out of school, in terms of lost income, is as high as 30



percent of gross national product (GNP) in countries such as Uganda, Malawi, and Nigeria.³⁷

U.S. AND GLOBAL INITIATIVES

A number of important global initiatives have focused attention on maternal and newborn health, including the issue of adolescent pregnancy. These include former UN secretary general Ban Ki-Moon's Every Woman Every Child Initiative (2010), and the associated Global Strategy for Women's, Children's, and Adolescents' Health, as well as the Every Newborn Action Plan (2014). In 2015 the World Bank and others launched the Global Financing Facility (GFF), which is working in 63 high-burden countries to coordinate and mobilize domestic and donor resources, as well as funding from the private sector, to advance the health of women and children.

The United States has been a proud leader in supporting international maternal and child health programs since the 1960s. No government in the world commits a greater amount of funding to support global maternal and child health programs than the United States.³⁸ With the launch of the 2012 Child Survival Call to Action, USAID established ending preventable child and maternal deaths by 2035 as a key global health goal, with a focus on 25 priority countries in sub-Saharan Africa, Asia, and Latin America. The strategy calls on USAID to adopt a "holistic approach" to ad-

olescents aimed at delaying early marriage and pregnancy, while also addressing gender, education, and other barriers,³⁹ as well as advancing quality, respectful care for adolescents.

There is no specific U.S. funding targeting adolescent pregnancy and childbirth. Total funding for U.S.-supported maternal and child initiatives in fiscal year 2016 was \$1.37 billion, including nutrition, Gavi, and global polio eradication efforts. In 2015, the United States supported the first-ever Global Maternal Newborn Health Conference, but adolescents were not a specific focus. The United States has committed to supporting the GFF by providing \$50 million of redirected bilateral program funds, and the GFF is intended to address the continuum of reproductive, maternal, newborn, child, and adolescent health, based on each country's investment plan. The 2016 U.S. Global Strategy to Empower Adolescent Girls acknowledges the importance of addressing child and early forced marriage, improving the access of adolescent girls to HIV prevention and treatment activities, and ensuring girls are able to access sexual and reproductive health information and services. However, no new funding was attached to that strategy.

KEY CONSIDERATIONS

Increasing the quality of maternal and newborn health care for adolescent girls will be challenging. There is a critical need to identify interventions tai-

lored to adolescents, both to meet their health care needs before and after childbirth, to expand their access to basic and comprehensive emergency obstetric and newborn care, and to provide access to emergency transportation when necessary. Special attention must be given to ensuring care is equitable, accessible, and affordable, and takes account of the particular needs of adolescents. This includes enhancing provider attitude and competence and ensuring that facilities are welcoming and respect the rights of young people.

Ultimately, adolescent girls and young women will only be able to stay in school and contribute more to their families, communities, and economies if appropriate investments are made to empower them to delay marriage and childbearing beyond the age of 18 and to reduce closely spaced pregnancies through postpartum family planning and social support.

Critical constraints will have to be addressed systematically. This requires a specific focus on the health and social needs of pregnant adolescents, and steps that will keep girls in secondary school, address gender-based violence, promote economic empowerment, and provide mental health services. The broader problem of national and community attitudes toward adolescent girls, which often involve negative attitudes about girls' autonomy, cultural practices, and government policies that discriminate against them, will also need to be addressed.

Unfortunately, there is a lack of data in general—and age-disaggregated data in particular—related to adolescent childbearing. Official estimates of adolescent fertility, and maternal mortality and morbidity, are often inadequate.⁴⁰ These data challenges highlight the need to establish clear standards and metrics, including a composite indicator for maternal and child health, that can be measured and standardized across countries.

Of note, the Reach Every Mother and Child Act of 2015 (S. 1911 and H.R. 3706) proposed a series of reforms to enhance U.S. efforts to end preventable maternal and child deaths. These included steps to articulate measurable goals, scale up evidence-based interventions, and increase transparency and accountability at all levels. This bill had over 200 bipartisan cosponsors in the last Congress.

METHODS

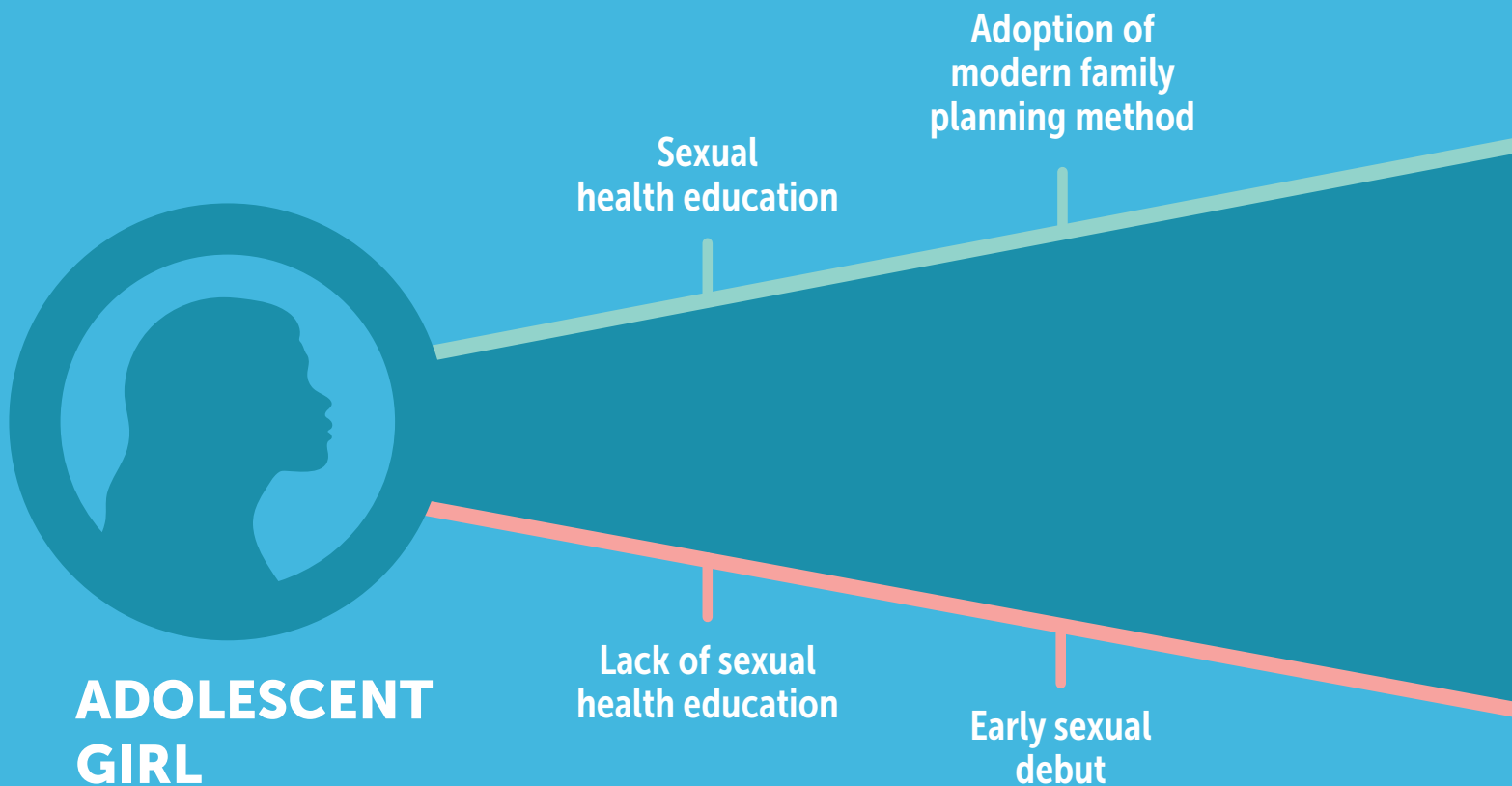
We developed the goal and estimated costs with the assistance of Avenir Health, an organization that develops economic models and tools for long-range global health planning. We also conducted extensive interviews with experts in maternal and newborn health, adolescent health, and global health. However, the costs are difficult to assess with certainty given the serious lack of data available, in terms of both estimates of adolescent pregnancy and availability and use of quality care.



FORMER SEN. MARK KIRK (R-IL)

“As U.S. intelligence reports have highlighted, very high fertility and lack of access to health care among young women in developing countries can contribute to political instability that affects U.S. national security interests. America’s interests are served when we focus on these health and development needs.”

UNLOCKING HER POTENTIAL



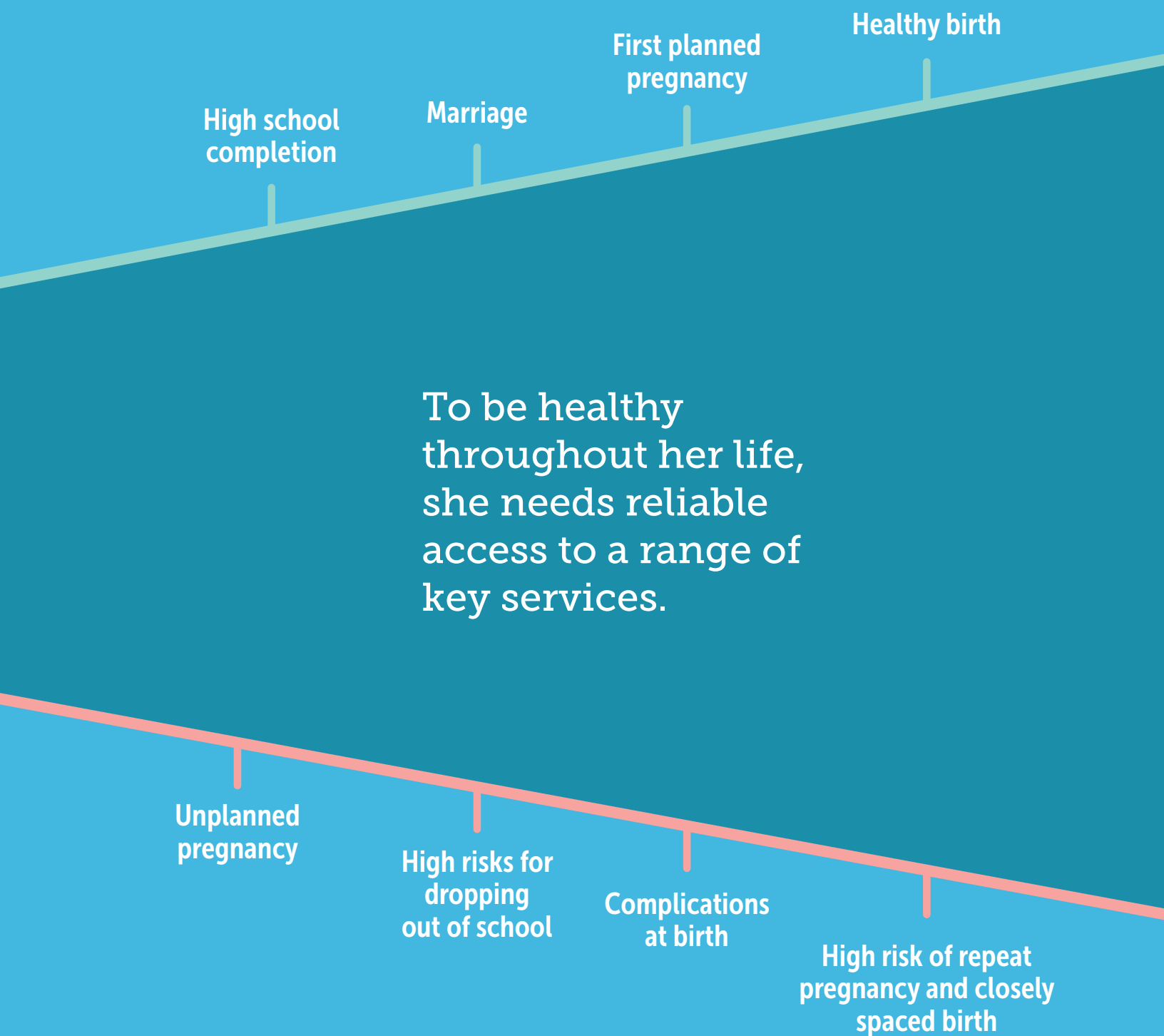
This underscores the importance for the United States and its partners to undertake a multiyear effort to upgrade data and operational research about adolescent pregnancy and how best to address the associated health and social risks.

High-quality care would be measured by the percentage of pregnant adolescents who receive confidential, routine maternal health services at primary health facilities that meet the WHO's standards for good medical practices.

Measurements of care would include the proportion of adolescent girls receiving the recommended four antenatal visits as well as postnatal visits with skilled providers, the proportion of births attended by skilled personnel, and the

proportion of adolescent girls who received quality antenatal counseling according to WHO standards for adolescents.⁴¹ For 10- to 14-year-olds, measurements would include reduction in adolescent birth rate, increase in age of marriage, and increase in age of first birth to over 18, measured through the Demographic and Health Surveys (DHS), Multiple Indicator Cluster Surveys (MICS), and Performance, Monitoring and Accountability 2020 (PMA2020).

This goal focuses on women ages 10–19, since the relative risks in pregnancy and childbirth for this younger age cohort are higher than for women over 20. This is due to a combination of physiological risk, as well as their lack of social



and economic empowerment, which increases their risks during pregnancy and childbirth.

The increase of 25 percent in access to quality maternal health services is based on evidence that a very low proportion of adolescent girls access the full range of quality maternal and newborn health services. On average, only 50 percent of adolescent girls receive standard maternal and newborn health care, based on indicators such as four antenatal visits, delivery in a facility, and

a postnatal checkup within two days. While this shows the high levels of unmet need for the recommended maternal and newborn health services, low-income countries have shown the capacity to absorb investments in maternal and newborn health and improve the quality of care. Despite considerable differences among countries, recent data from the target countries show a rate of increase (around 25 percent on average) in certain maternal health indicators.

SECTION 03



Expanding Access to Voluntary Family Planning

EXPANDING ACCESS TO VOLUNTARY FAMILY PLANNING

The proposed goal is to increase access to voluntary family planning with the aim of meeting 50 percent of the current unmet need⁴² for modern methods of family planning among 15–24 year olds who desire to avoid, space, or delay pregnancy.

The 10–14 age group has to be reached with information and education to build their awareness and access to services. These family planning services must be respectful, free from coercion or discrimination, and include quality, confidential access to a full range of family planning methods, including modern and traditional contraceptive methods.⁴³

Reaching this goal is estimated to result in 1.3 million unintended pregnancies averted, 400,000 unsafe abortions averted, 3,600 maternal deaths averted, and 5.4 million users reached. This would amount to an estimated direct and indirect healthcare cost savings of \$249 million.⁴⁴

The total costs for reaching this goal would be an additional \$144 million per year, based on current unmet need for family planning among 15- to 24-year-olds in the 13 target countries. This includes the cost of providing improved access to contraceptives and counseling for adolescent girls and young women with unmet need, and information and education programs for 10- to 14-year-olds.⁴⁵ Accomplishing this goal will be facilitated by taking advantage of opportunities for linkages and integration with other U.S. health and development programs.

U.S. funding for international family planning does not include abortion because it is prohibited by U.S. law governing foreign assistance, including the 1973 Helms amendment. The successful implementation of the Task Force's recommendations does not de-

pend upon any changes to these long-standing laws.⁴⁶

According to the WHO, family planning is defined as the ability of individuals and couples to anticipate and attain their desired number of children and the spacing and timing of births. Reproductive health encompasses a woman's overall physical, mental, and social well-being, along with minimizing disease and infirmity. It speaks to her needs across her entire lifespan.⁴⁷

RATIONALE

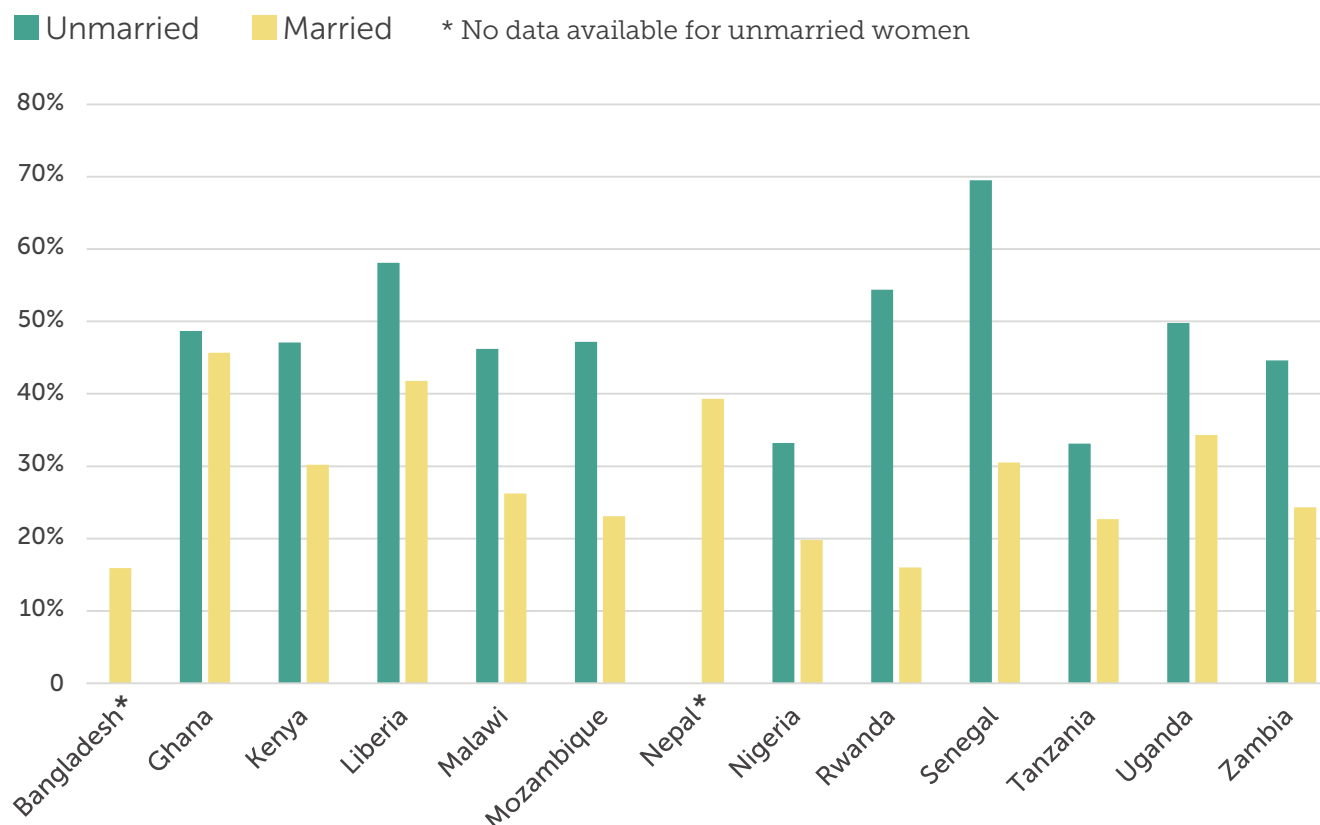
Family planning and reproductive health programs are high-impact, cost-effective interventions that improve maternal, newborn, and child health outcomes; promote healthy timing and spacing of pregnancies and avert millions of unintended pregnancies and abortions; help prevent sexually transmitted infections, including HIV/AIDS; and reduce the risk of obstetric fistula.

This is an urgent moment for intensified high-level U.S. diplomatic leadership and financial commitment to expand access to voluntary family planning and reproductive health programs—with a focus on adolescent girls and young women. An estimated 225 million women and girls, both married and unmarried, have an unmet need for family planning; among them, an estimated 23 million adolescent girls in developing countries want to avoid or space pregnancies but do not have access to contraception.⁴⁸

For an adolescent girl in particular, pregnancy and childbirth can be hazardous for herself as well as

UNMET NEED FOR FAMILY PLANNING

Percentage of Adolescent Girls and Young Women Ages 15–24



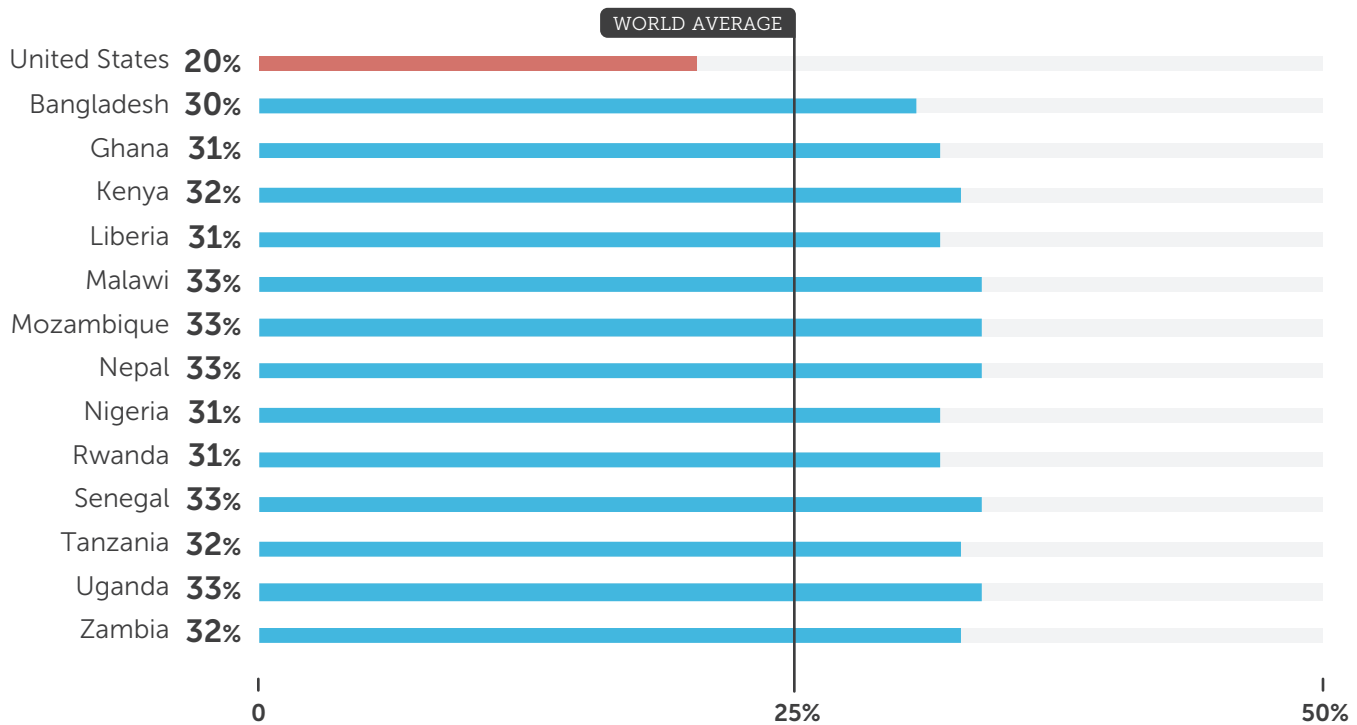
Source: Kerry MacQuarrie, "Unmet Need for Family Planning among Young Women: Levels and Trends," DHS Comparative Reports No. 34 (Rockville, MD: ICF International, 2014).

for her newborn, and require high-quality, integrated programs that address her needs.⁴⁹ Data show that early childbearing increases the risk of death and illness for the mother and her child during pregnancy and childbirth.⁵⁰ Adolescent girls (15- to 19-year-olds) in developing countries were expected to have 21 million pregnancies in 2016, with nearly half being unplanned, resulting in 12 million births.⁵¹ Weak access to family planning information and services and socio-cultural barriers contribute to the fact that complications due to pregnancy and childbirth are a leading cause of death for teenage girls in developing countries,⁵² despite the fact that such deaths are largely preventable and rare in the United States.⁵³

Meanwhile, the population of adolescent girls and young women is growing at an unprecedented rate, accounting for four out of every 10 women of reproductive age (15–49) in some of the world's poorest countries,⁵⁴ demonstrating that the global need for effective services is rising significantly. The outbreak of Zika virus has highlighted the need to strengthen the ability of women to time and space their pregnancies due to the risk of microcephaly and other congenital defects in children born to women infected with the virus during pregnancy. Similarly, the world's refugee and migrant crisis shines a spotlight on a growing population of vulnerable adolescent girls and young women with important family planning and reproductive health needs.

THE YOUTH BULGE

Percent of Total Population Ages 10–24



Source: Somini Sengupta, "The World Has a Problem: Too Many Young People," *New York Times*, March 5, 2016, <https://www.nytimes.com/2016/03/06/sunday-review/the-world-has-a-problem-too-many-young-people.html>.

Family planning investments are proven to significantly decrease maternal mortality and morbidity rates, improve newborn and child survival, and prevent millions of unintended pregnancies and abortions. According to *The Lancet*, by reducing unintended pregnancies and closely spaced and ill-timed births, family planning could reduce adolescent pregnancy, prevent one-third of maternal deaths,⁵⁵ reduce infant deaths by 10 percent, and eliminate one of every five deaths in children under the age of five.⁵⁶ Family planning services also help HIV-infected women who decide to have children to do so as safely as possible.

PEPFAR has recognized the importance of access to family planning counseling and services as a component of HIV services, especially for prevention of mother-to-child transmission of HIV (PMTCT). In sub-Saharan Africa, adolescent girls and young women account for 75 percent

of all new HIV infections among adolescents.⁵⁷ PEPFAR's investments have helped strengthen linkages between HIV services and maternal and child health care and voluntary family planning services, when those activities are shown to meet an HIV prevention, treatment, or care purpose. However, PEPFAR funds cannot be used to purchase contraceptive commodities other than male and female condoms.⁵⁸

Beyond the immediate health benefits of improved access to contraceptives and counseling for family planning, these services can strengthen adolescent girls' and young women's social and economic opportunities. Accordingly, interventions that improve access to family planning information and services should be part of a multisectoral approach that includes advancing education for girls, enhancing economic development and gender equality, eliminating child

marriage, and preventing and responding to gender-based violence. *The Lancet* series on adolescent health and well-being aptly summarized the long-term impact of avoiding adolescent pregnancy: “Sexual health risks that result in teenage pregnancy have profound effects on the health and wellbeing of young women across the life course. Pregnancy (and early marriage) typically denotes the end of formal education, restricts opportunities for employment, heightens poverty, and can limit growth in undernourished girls.”⁵⁹

In too many cases, adolescent girls and young women want to avoid, delay, or space pregnancy but simply lack the knowledge or resources to access contraception. This unmet need is often highest among the poorest and most marginalized adolescent girls and young women, including those in rural areas or urban slums, those living with HIV, refugees and those displaced from conflict areas, and child brides. Adolescent girls who get pregnant are usually compelled to drop out of school, greatly diminishing their prospects for further education and economic empowerment.

CALL FOR INTENSIFIED U.S. LEADERSHIP

A signature U.S. initiative focused on family planning for adolescent girls and young women would leverage existing political and financial momentum around the world. The Sustainable Development Goals call for 75 percent of demand for family planning to be satisfied with modern contraceptive methods by 2030. And FP2020, launched at the London Summit in 2012 by the UK government and the Bill & Melinda Gates Foundation, with USAID and UNFPA as core conveners, aims to provide access to family planning to 120 million more women and girls in the world’s poorest countries by 2020.

In addition, the UN’s Global Strategy for Women’s, Children’s and Adolescents’ Health calls for meeting all women’s needs for modern methods of contraception and reducing adolescent birthrates in low-income countries. However, none of the aforementioned global efforts have a specific goal for improving access to modern methods of family planning among adolescent girls and



SEN. JEANNE SHAHEEN (D-NH)

“As our report points out, an estimated 23 million adolescent girls in developing countries want access to modern methods of contraception but do not have it.

Not only do the unintended pregnancies that result often end in abortion, approximately half of those abortions are unsafe. And, those adolescent girls who do carry to term face far greater health risks in pregnancy and childbirth compared to adult women. Expanding access to voluntary family planning in the 13 target countries will both save lives and empower adolescent girls to make reproductive health decisions with their own best interests in mind.”



AFAF IBRAHIM MELEIS

“Girls and young women are the future treasure of any country. They are at the center of creating healthy families and communities and more productive societies. It is not only a moral obligation to invest in them, but it is also imperative and of vital value for the developed and developing world. Our country must lead the way!”

young women. A U.S.-led initiative would fill a key gap for reaching broader global goals on family planning, maternal and child health, and HIV because those goals will be harder to reach unless young women’s needs are directly addressed.

The United States is already well-positioned to lead in the promotion of access to contraception and healthy timing and spacing of pregnancies for adolescent girls. As the global leader in family planning and reproductive health through its technical and financial assistance, U.S. funding—\$608 million for FY 2016 and \$620 million was requested by the president for FY 2017⁶⁰—focuses principally on 31 countries in sub-Saharan Africa and South Asia. Family planning is an element of USAID’s strategy to end preventable child and maternal deaths by 2035, and PEPFAR has increasingly recognized the important linkages between HIV/AIDS and family planning and reproductive health, including to prevent and treat cervical cancer. The U.S. Strategy to Empower Adolescent Girls promotes an approach to reach girls in and out of school to increase awareness of and access to family planning methods.⁶¹ While focused on HIV outcomes, PEPFAR’s DREAMS partnership recognizes the importance of improving access to family planning information and services for vulnerable adolescent girls and young women as part of its core activities.⁶²

KEY CONSIDERATIONS

Providing adolescent girls and young women with voluntary family planning and reproductive health services represents a challenge on a number of fronts.

Most critically, programs must involve adolescent girls and young women themselves to understand what girls actually need, how married adolescents negotiate family planning, and how to reach married and unmarried 15- to 24-year-olds. Reaching this population requires expanded resources and partnerships to strengthen contraceptive supply chains, expand available contraceptive methods, and enhance access to quality, confidential services. It is also important to develop supportive policies and improved systems for data and research and promote innovation. At the facility level, training and supervision for healthcare providers can help to address bias, create facilities that are more welcoming to teenage girls and young women, and ensure that family planning services are voluntary, based on informed choice of a contraceptive method.

There are longstanding and well-known differences in Congress and elsewhere over U.S. funding approaches for international NGOs working in family planning, captured in debates over what is commonly referred to as the Mexico City policy.⁶³ That notwithstanding, there has



DEBORA SPAR

“Now, more than ever, the world needs to focus on the health and well-being of young women and girls.

By giving them the resources to thrive, we make their communities—and our planet—safer, saner, and more prosperous.”

been progress in recent years in forging bipartisan common ground and continued, significant U.S. funding of international family planning programs. Moving ahead, it remains critically important to carefully preserve that baseline consensus through continuous good-faith dialogue and a sustained focus on pragmatic, programmatic innovations.

There are significant data gaps for adolescent girls and young women. Little data are available on private-sector use and measuring quality services for this population. The SDG goal of satisfying 75 percent of demand for family planning by 2030 focuses on all women of reproductive age and women who are married or in union. But this underscores the need for age-disaggregated data on unmet need among unmarried adolescent girls and young women, many of whom are subjected to sexual and gender-based violence, coercion, and child marriage. The lack of data on 10- to 14-year-old girls is especially difficult, and suggests the need to develop other ways to gather information. This highlights the importance of reorienting programs, communities, and health systems to address the needs of adolescent girls and young women who are excluded from care, and provide respectful, quality family planning counseling and services.

Some of the areas for greater research include how to reach married adolescents with family planning information and services; create awareness and demand for family planning us-

ing social media and innovative approaches; use education platforms and incorporate sexuality education in schools; and target behavior change activities to adolescent girls, men, and boys. Increasing access to contraceptives will also require better understanding of private-sector health services, social marketing, mobile outreach, and task-shifting to community health workers.

Innovation in new contraceptive methods to meet the needs of this population is also critical, such as multipurpose contraceptives that would prevent pregnancy and STI transmission and female-controlled methods, such as the vaginal ring⁶⁴ and Sayana Press.⁶⁵ Securing price guarantees will be an important component, given the issue of affordability for adolescent girls and young women.

METHODS

This goal was derived from extensive interviews with a range of experts in global health, family planning, and adolescent health,⁶⁶ as well as a review of the literature. The estimated costs were developed with the assistance of Avenir Health, based on an analysis of available data.

Costing is based on an analysis of the modern contraceptive prevalence rate and the estimated unmet need for family planning among adolescent girls and young women in each target country for four subgroups: age 15–19 married, age 15–19 unmarried, age 20–24 married, and age 20–24 unmarried.

Modern contraceptive users would be measured through modern contraceptive prevalence rates and reduction in pregnancies in 15- to 24-year-olds through the Demographic and Health Surveys (DHS)⁶⁷ and Multiple Indicator Cluster Surveys (MICS). To measure awareness and access for 10- to 14-year-olds, the indicators would include delayed age of first birth, delayed age of marriage, and reduction in adolescent birthrate. Quality services would include training and supervision to address healthcare worker bias and competence in adolescent health and to ensure that facilities are welcoming. Other indicators to monitor quality of services for this population include affordability and availability of services, confidentiality, and respectful and equitable care. Meeting 50 percent of the current unmet⁶⁸ need will vary by country, but generally translates into an increase in modern contraceptive prevalence by 12.5 percentage points. Given that family planning programs in several low-income countries have been able to achieve a 2-percentage-point increase annually in modern contraceptive prevalence use, a concerted effort with quality programming to increase access, compounded over four years (2017–2021), could reasonably achieve a 12.5-percentage-point increase in use. As such, this is a specific, realistic goal the U.S. government can achieve.

Improving the quality of information and services offered to contraceptive clients would likely increase effectiveness of use. This could be achieved by providing a broad choice of contraceptive methods, continuous supplies, counseling and education regarding side effects and health concerns, and training health care providers to help young women switch methods upon request. Meeting the needs of married and unmarried young women requires innovative efforts, including improving information and services targeting these groups, offering a full selection of methods that respond to their sometimes sporadic contraceptive needs, changing providers' attitudes toward this group, and implementing broader education campaigns.

SECTION 04



Reducing Anemia

REDUCING ANEMIA

The proposed goal is to reduce anemia by 25 percent among adolescent girls and young women by providing iron and folic acid supplementation, as well as nutrition education and counseling, to at least 75 percent⁶⁹ of 10- to 24-year-old adolescent girls and young women.

Through this effort, the United States will be a key partner in realizing the World Health Assembly (WHA) global goal of a 50-percent reduction in anemia among women of reproductive age by 2025.

The estimated cost of weekly iron and folic acid supplementation for the 13 target countries is approximately \$12 million per year or \$48 million over four years, which includes \$1 million per year required for capacity building, monitoring and evaluation, and policy development.

An additional \$10 million per year (\$40 million total) is included for operational research to fill knowledge gaps on the nutritional needs of adolescent girls and young women and how best to intervene, which includes understanding food intake and ways to improve dietary diversity.

OPERATIONALIZATION

All of the 13 target countries are members of the Scaling Up Nutrition (SUN) Movement and have committed by 2020 to establish costed nutrition plans with national targets, increase domestic and external funding for nutrition, regularly and transparently track budget allocations, and put in place data systems.⁷⁰ USAID was one of the initial partners in creating the SUN Movement, and its Multi-Sectoral Nutrition Strategy and the U.S. Global Nutrition Coordination Plan aim to align with and support SUN country plans. The U.S. government has platforms in place to bring nutrition interventions to scale. In addition, the U.S. government is expected to purchase criti-

cal commodities and provide technical assistance to governments, health providers, and others in the health and education sectors.

RATIONALE

Adolescence is a critical period of physical and cognitive growth,⁷¹ and targeted interventions can improve cognitive development⁷² and maximize height attainment.⁷³ In recent years, there has been a global commitment to address the 1,000-day period from conception to a child's second birthday.⁷⁴ However, the preconception period is also now recognized as critical for addressing a woman's nutritional needs and for preventing childhood stunting and poor birth weight in her future children. Only addressing nutritional needs once an adolescent girl or young woman is pregnant is too late, as many nutritional risks, such as obesity, cannot be quickly reversed.⁷⁵ Given high rates of unintended pregnancies among adolescent girls and young women, interventions should start in late childhood and early adolescence to achieve optimal nutrition.

Nonpregnant adolescent girls and young women of reproductive age and postpartum women have largely been excluded from programs and research,^{79,80} but adolescent diets are known to be deficient in crucial micro-nutrients such as iron, iodine, folic acid, and vitamins A and C.⁸¹ Of these, iron deficiency remained (from 1990 to 2013) the leading global risk factor for Disability-Adjusted Life Years (DALY)⁸² for 10- to 14-, 15- to 19-, and 20- to



ASMA LATEEF

“We are at an exciting point in the fight against malnutrition. We have evidence-based, cost-effective interventions ready to be scaled up. For every dollar invested, there is a \$16 return. With a focus on adolescent girls, we can begin to envision a future in which young women are empowered with knowledge and good health, and malnutrition no longer halts nor limits the potential of future generations. What could be a better investment?”

24-year-old females,⁸³ the sixth leading risk factor for death for 10- to 14-year-old girls, and the seventh for 15- to 19- and 20- to 24-year-old adolescent girls and young women.⁸⁴

Iron deficiency is also the most common cause of anemia⁸⁵ accounting for 50 percent of cases.⁸⁶ Globally, anemia affects more than 500 million women 15 to 49 years old.⁸⁷ In 2015, iron-deficiency anemia caused 54,200 deaths.⁸⁸ It also affects cognitive function and causes fatigue and lethargy, which impairs one’s ability to go to school and work and thus has economic consequences for the adolescent girl or young woman, her family, and her community. When an adolescent girl or young woman is pregnant, anemia puts her and her child at special risk, as both need iron for growth and survival. It also increases the risk of adverse maternal and newborn outcomes such as miscarriages, stillbirths, prematurity, and low birth weight.⁸⁹

The United States has in recent years elevated the priority it attaches to nutrition in line with the Sustainable Development Goals and revised international malnutrition targets. On April 1, 2016, the UN General Assembly proclaimed 2016–2025 the Decade of Action on Nutrition and called “on governments to set national nutrition targets for 2025 and milestones based on internationally agreed indicators.”⁹⁰ In 2012, the WHA adopted six

global goals, including to reduce the rate of anemia by 50 percent in women of reproductive age by 2025. Reducing anemia can facilitate progress toward the other five global nutrition targets to reduce the prevalence of stunting, wasting, low birth weight, and childhood overweight, and promote exclusive breastfeeding.⁹¹

Unfortunately, most countries are not on track to reach the anemia target.⁹² In the 13 target countries, anemia prevalence ranges from 17 to 58 percent. Only one of the countries, Kenya, is among the countries closest to being on track with respect to anemia targets.⁹³

The World Bank estimates that \$12.9 billion is needed to meet the global anemia reduction goal by 2025.⁹⁴ If the global community, including the United States, was able to make this investment, it would have exceptional impacts. Achieving the 50-percent reduction (from a 2011 baseline prevalence of 29 percent to 15 percent) would lead to 65 million fewer women suffering from anemia, 800,000 child lives saved,⁹⁵ and increased economic productivity of \$110 billion over 10 years in low- and middle-income countries.⁹⁶ Each \$1 invested in the set of interventions⁹⁷ required to meet the goal (including iron and folic acid supplementation) is estimated to yield \$12 in returns.⁹⁸

MALNUTRITION affects one in three people globally and, along with poor diet, is often the largest risk factor for disease in low-income countries.⁷⁶ Nutrition is a critical issue in its own right with significant and widespread individual, economic, and societal impacts. *The Lancet* estimates that 45 percent of preventable child deaths are attributable to malnutrition. The issue is complex, as undernutrition, food insecurity, and obesity often occur at the same time and in the same places. Nutrition is also deeply intertwined with other health issues, such as infectious and noncommunicable diseases, family planning, safe pregnancy outcomes, and interventions such as staying and succeeding in school. In recognition of the central importance of good nutrition to the achievement of the Sustainable Development Goals, goal 2 includes a target to end malnutrition in all its forms, including achieving the World Health Assembly targets on stunting and wasting. Indicators in 12 of the 17 goals are directly related to improving nutrition outcomes. Nutrition interventions also are not only very cost effective but such investments can reduce and even eliminate gross domestic product losses resulting from malnutrition, with the return estimated at between \$4 and \$35 for every \$1 invested.^{77,78}

KEY CONSIDERATIONS

Anemia is complex and has multiple causes. Iron supplementation alone may not be enough to reduce anemia rates. There are many underlying causes of malnutrition, including lack of dietary diversity, poor water and sanitation, gender inequality, inadequate education and income-generating opportunities, absence of sufficient social protection and human rights, and insufficient healthcare. Addressing anemia and other forms of malnutrition requires a multisectoral approach.

More needs to be learned about anemia and its associated factors in adolescent girls and young women. Beyond addressing anemia itself, the U.S. government needs to invest in operational research on the nutritional status and behavior of adolescent girls: e.g., what, when, and how they eat in different settings. Research should also address the knowledge gaps in how best to design and implement nutrition programs as part of broader multisectoral efforts and how to evaluate their impact on malnutrition.⁹⁹

Operational research will help identify how different platforms can be leveraged to improve nutrition outcomes for adolescent girls. The challenge and the opportunity is to reach adolescents in truly relevant and meaningful ways that resonate



REP. BARBARA LEE (D-CA-13)

"Empowering adolescent girls and young women is not only the right thing to do, but it's the smart thing to do.

This report and our recommendations underscore what I saw firsthand when I traveled with the Task Force to Ghana: when you invest in women and families, whole communities thrive. Now more than ever, the United States must maintain its commitment to foreign assistance and global health programs."

with them, equipping this generation with increased knowledge and skills for sustained, improved nutrition. Health clinics and schools will reach some girls but not all. Piloting food-system approaches, education and social protection platforms, and creative marketing and messaging will strengthen the evidence for what works to reach adolescent girls and young women and at what cost. Options include working across sectors with Feed the Future to ensure minimum dietary diversity among adolescent girls in rural areas and the McGovern-Dole Food for Education Program that provides nutritious meals to girls and nutrition education to girls and their parents.

Monitoring progress will be crucial to ensure that the countries are on track to reduce anemia. The SUN Movement Information System should be used for ongoing monitoring and evaluation. It contains dashboards with up-to-date quantitative and qualitative information to track progress. The SUN Movement includes as one of its strategic objectives transparently costing, tracking, and assessing spending on nutrition to make existing resources more effective and mobilize new funding.¹⁰⁰

The U.S. government needs both a concerted and well-funded effort to address the critical gaps in adolescent nutrition and a focal entity that has the authority to work across agencies and bureaus. The lack of clear ownership and accountability by any one U.S. government agency or office and the absence of strong coordination have created fragmentation of financing, strategic planning, and program implementation. Currently, USAID nutritional technical staff and leadership are spread across three bureaus, reducing the potential for influence, accountability, and effectiveness. Further, there is little consistent and transparent data on funding, program activities, and impact.

Through the Global Nutrition Coordination Plan, the U.S. government has improved accountability. However, the plan must be effectively implemented, which includes prioritization within the Trump administration as well as adequately dedicated resources in both personnel and funding.

METHODS

The priority focus is upon anemia because it profoundly impacts the health of adolescent girls and young women, and the interventions to cor-



VANESSA KERRY

“Investing in the health of a girl or woman is foundational to her success. It requires a comprehensive approach to health from building a skilled health workforce, ensuring quality care for her at all ages, and increasing access to nutrition and education. In turn, she is more likely to be healthy and economically productive, having a lasting impact on her family, community, and country. This report provides a compelling path forward for the current administration to make innovative, sustainable, legacy-building investments.”



rect it are exceptionally cost-effective. Achieving the proposed goal is ambitious, but the impact is significant and the return on investment in anemia is \$12 for every \$1 spent.¹⁰¹

Weekly supplementation of 60 mg iron and 0.4 mg folic acid is required to achieve the WHA global anemia goals for nonpregnant women.¹⁰² These supplements can be delivered through schools, community health workers, health facilities, and the private sector as appropriate.¹⁰³ The required interventions for pregnant women include micronutrient supplementation delivered for approximately 180 days per pregnancy during antenatal care (also for stunting reduction), in the form of iron and folic acid supplementation and at least one additional micronutrient.¹⁰⁴

Although the WHO recommends daily iron and folic acid supplementation in countries with anemia prevalence greater than 40 percent,¹⁰⁵ according to the World Bank, weekly supplementation is more feasible than daily supplementation.

The unit costs used in this analysis are therefore derived from a weekly model, which was used in the global costing.¹⁰⁶

Anemia prevalence in women of reproductive age was used to approximate anemia prevalence in the 10- to 24-year-old adolescent girls and young women cohort (nonpregnant and pregnant adolescent girls and young women were included in the calculations). Country-specific anemia prevalence¹⁰⁷ was applied to each target country's adolescent girl and young women population to estimate the total number of anemic adolescent girls and young women.¹⁰⁸ The estimated number of anemic adolescent girls and young women ages 10–17 who are in school and would thus receive school-based delivery was determined by calculating 57 percent (8 of 14 years) of 10- to 24-year-old adolescent girls and young women in each country (which assumes equal numbers of girls at every age within the range) by the net secondary school attendance in each country.¹⁰⁹ For the remaining adolescent

girls and young women not in school, those expected to be anemic was calculated by applying the country's anemia prevalence and using the World Bank's methodology that 70 percent of the out-of-school population would receive iron supplementation through community health services and 30 percent from a nurse or health facility. The target coverage rate of 75 percent of the number of girls in and out of school was used to determine the number of girls who would be targeted in each country.

The World Bank's unit costs for three delivery platforms—school-based program, community health services, and health facility or nurse—were used and multiplied by the target number of adolescent girls and young women to determine the individual intervention costs.¹¹⁰ Where possible, country-specific unit costs were used.¹¹¹ For those countries without specific unit costs, the lowest unit cost for the intervention was selected. In addition to the sum of the individual intervention costs by country, overhead costs for capacity development (9 percent), monitoring and evaluation (2 percent), and policy development (1 percent)¹¹² were added to get the final sum.

SECTION 05



Expanding
Access to the
Human Papillomavirus
(HPV) Vaccine

EXPANDING ACCESS TO THE HUMAN PAPILLOMA- VIRUS (HPV) VACCINE

The proposed goal is to prevent cervical cancer by achieving 50–75 percent coverage of the HPV vaccine among 9- to 14-year-old girls.¹¹³ Cervical cancer is the first cancer we are poised to eliminate.

This effort would seek to fully immunize 40 million adolescent girls at a cost of \$843 million between 2017 and 2021. The U.S. share, we propose, should come from multiple sources and amount to approximately 50 percent of the total costs to achieve this goal.

The HPV vaccine, a highly effective means to prevent cervical cancer, is a long-term strategic investment in the future health of young women. Global deaths from cervical cancer are on the rise, and have surpassed 266,000 annually; if these trends continue, cervical cancer deaths are likely to surpass maternal deaths in the coming years.¹¹⁴

The projected impact of this initiative would be 235,000 lives saved, and nearly 650,000 cases of cervical cancer averted. By definition, these extraordinary benefits will only be realized years later, when these women—as cancer-free adults at the peak of their productive lives—are able to realize their full potential as mothers, members of their communities, and contributors to the economy.

National HPV vaccine programs also generate an important early, concrete benefit: the establishment of a new service delivery platform that reaches both in- and out-of-school adolescent girls, often for the first time since childhood. That platform can be potentially used to bring other important health services to this difficult-to-reach population (e.g., de-worming; nutritional services; sexual education, including instruction on gender-based violence prevention and response; and testing and counseling for HIV).¹¹⁵

There are powerful equity gains to national HPV vaccine programs: they bring a major health benefit to young adolescent girls, a population that is often overlooked. And that gain is even more pronounced whenever there are concerted efforts to reach the poorest, most disadvantaged young women in the 13 target countries.

OPERATIONALIZATION

What is proposed is a historic push to expand access to this cancer-preventing vaccine in 13 low-income countries that are of interest to the United States and have demonstrated need, interest, and capacity to deliver the HPV vaccine.

Essential U.S. Leadership

Success requires high-level, sustained U.S. diplomatic leadership. This will be essential to win the active buy-in, budgetary support and partnership of the 13 national governments (many of which will approach the launch of a national HPV program with caution, given the cost involved).

Further, high-level leadership will help to significantly expand the lead role played by Gavi. The recent commitments made by the Gavi Alliance Board to reboot its HPV vaccine strategy represent a fresh decision that should be actively complemented and expanded upon (see Gavi's HPV Vaccine Reboot).

Continuous diplomatic engagement with vaccine manufacturers, partner governments, Gavi, foundations, and others will lower the cost of the HPV vaccine and create a long-term pathway to fiscal sustainability.

It will also help to raise the political and financial commitment of donors, foundations, industry, and others. The United States currently accounts for 12 percent of Gavi's aggregate budget, the balance covered by a small nucleus of the UK, the Bill & Melinda Gates Foundation, Norway, and others.¹¹⁶ Expanded U.S. support to Gavi can catalyze significant additional funding from other important sources. Pink Ribbon Red Ribbon, launched by the George W. Bush Institute, PEPFAR, Susan G. Komen, and UNAIDS, has succeeded in building bipartisan support for these efforts.

Senior levels of the administration will need to position USAID, working alongside the U.S. Centers for Disease Control and Prevention (CDC) and other parts of U.S. Department of Health and Human Services such as the National Vaccine Program and the National Institutes of Health, as a critically important source of U.S. technical expertise and financial support. They can work to address both the policy and institutional requirements of launching national plans, and to support civil society and independent groups including Pink Ribbon Red Ribbon in their programs. USAID's Maternal and Child Survival Program has helped 13 Gavi-eligible countries prepare for the introduction of 24 vaccines, assisting with Gavi

applications, multiyear plans, vaccine introduction strategies, launches, and monitoring and evaluation.¹¹⁷ As national plans advance in the 13 target countries, demand will increase sharply for this form of U.S. government external support.

Last, but arguably most important, high-level leadership is required to build bipartisan support in Congress and among interest groups.

The Ultimate Power of Partner Countries

Scale-up of the HPV vaccine is ultimately the decision and responsibility of the partner country. Introduction of a new vaccine to an adolescent population departs from traditional immunization programming, which typically serves children under five years old. That decision requires national political will, careful financial planning and budgetary commitments, and sufficient health infrastructure. A frequent impediment to HPV demonstration projects has been the lack of coordination across government ministries, which is essential to reach adolescent girls through several channels: schools, clinics, community centers, and immunization campaigns. Success rests on intensified engagement, communication, and planning across the Ministries of Health, Education, and Finance.

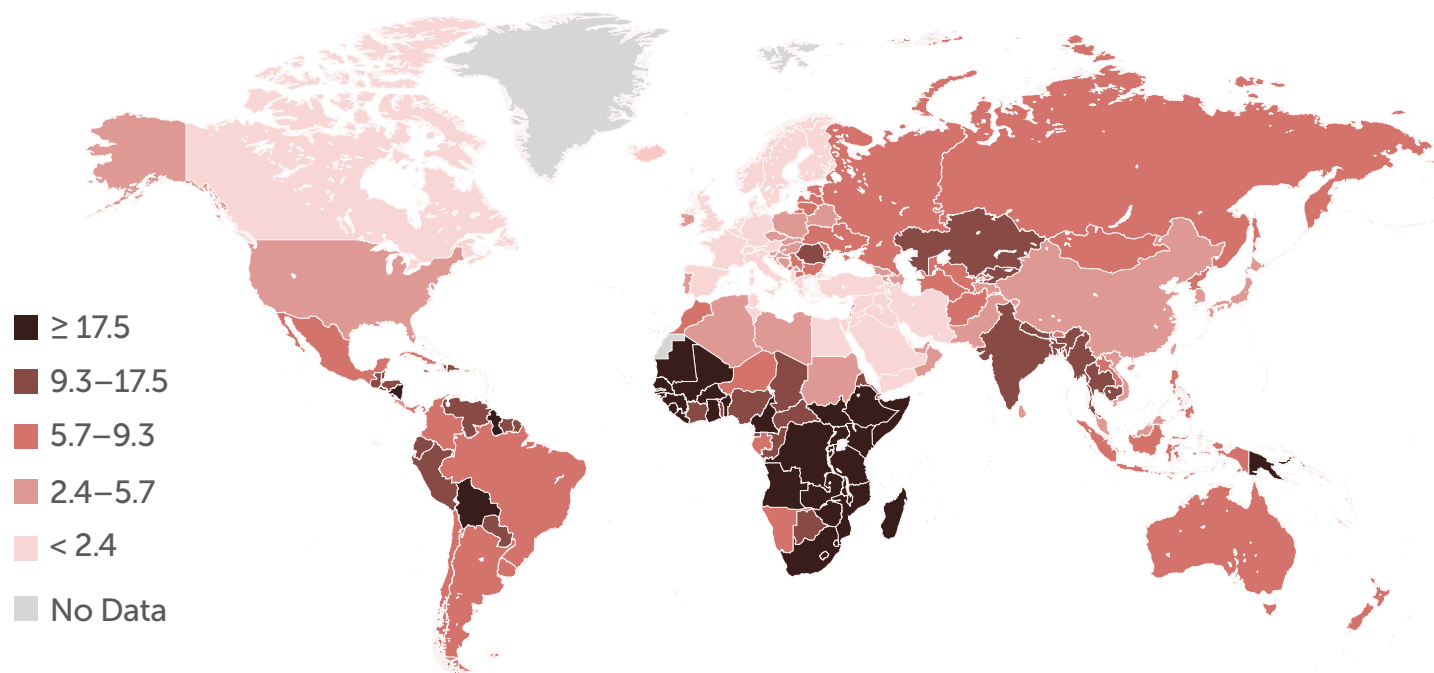


JULIE GERBERDING

"Cervical cancer affects nearly 530,000 women around the world every year, robbing them, their families, and their communities of their most productive years. More than a quarter million women die annually—730 each and every day—nearly all of them in less developed nations. We can eliminate cervical cancer just as we eliminated smallpox and polio. America can lead the way to realize this achievable goal by committing to HPV immunization for girls and screening and treatment for women."

CERVICAL CANCER WORLDWIDE

Estimated Deaths per 100,000



Source: International Agency for Research on Cancer, WHO, "Cancer Today," http://gco.iarc.fr/today/online-analysis-map?mode=cancer&mode_population=continents&population=900&sex=0&cancer=29&type=0&statistic=0&prevalence=0&color_palette=default&projection=natural-earth.

GAVI'S HPV VACCINE REBOOT: In 2013, Gavi embraced an ambitious aim of reaching 30 million girls in low-income countries with the HPV vaccine by 2020. Since then, it has helped to fund and oversee demonstration projects in 23 countries, and has successfully vaccinated 1 million girls. It has also recently launched a \$10 million partnership with Girl Effect to address negative social norms and unlock demand for the vaccine. However, countries have been slow to establish national programs. To better incentivize national governments to institute and sustain national programs, Gavi's Board recently approved two major programmatic changes with strong consensus at its December 7–8 meeting. The first will encourage countries to move rapidly and directly to national programs, bypassing an often-lengthy demonstration phase. The second will encourage

vaccination of multiple cohorts of adolescent girls ages 9 to 14 in the first year of the program, in line with the decision taken in October at the Strategic Advisory Group of Experts (SAGE) on Immunization meeting in Geneva. As a result, Gavi's projected HPV-vaccine related costs over the next four years will rise from \$350 million to \$422 million.

The Centrality of Gavi

Gavi is well-positioned to accelerate national programs. It already has in place a global strategy to expand HPV vaccine access and has provided HPV-related support to all of the target countries.¹¹⁸ Expanded U.S. support to Gavi (and its primary implementing partners CDC, UNICEF, and WHO)¹¹⁹ would be the natural multilateral channel by which the United States can expedite support to target countries in the scale-up of vaccine purchase, distribution, and delivery, as well as related costs associated with national introduction.¹²⁰



REP. DANIEL M. DONOVAN JR. (R-NY-11)

"The greatest influence the United States has is its capacity to save lives. With a continued focus on ending preventable child and maternal deaths, we can capitalize on the successes made by past administrations and pave the way for even bigger victories that reinforce our place on the global stage. My daughter was lucky: she was born in the United States with access to infant care and vaccinations. I consider it an obligation to work toward providing mothers and children all over the world with similar care."

NGOs Fill Critical Gaps

Public-private partnerships like Pink Ribbon Red Ribbon can mobilize parents and communities to demand vaccination for their girls against cervical cancer, assist with the planning and logistics of vaccination, introduce media and communication strategies to overcome barriers to vaccine uptake, and link adolescent girls to related services, including for HIV prevention.

RATIONALE

The moment is ripe to press for expanded access to the HPV vaccine in low-income countries.

First, the vaccine has become a viable global tool since its introduction in 2006, and its impacts are profound. The WHO recommends that girls aged 9 to 13 receive two doses of the vaccine,¹²¹ while Gavi has negotiated a price of \$4.50 per dose (compared to \$130 per dose in the United States).¹²² It is projected to be one of the most-high-impact vaccines in Gavi's portfolio between 2016–2020 in terms of lives saved.¹²³

Second, the burden of HPV and cervical cancer in low-income countries is enormous. In sub-Saharan Africa, this is largely because women living with HIV/AIDS are at least five times more

likely to develop cervical cancer.¹²⁴ Even though the vaccines Gardasil and Cervarix are proven to prevent 70 percent of cases, global deaths due to cervical cancer are on the rise.¹²⁵ While nearly 120 million women were targeted through HPV immunization programs between 2006 and 2014, only 1 percent were from low-income or lower-middle-income countries, where 85 percent of deaths due to cervical cancer occur.¹²⁶ The regions with the highest incidence of HPV and the largest burden of cervical cancer—sub-Saharan Africa followed by South and Southeast Asia—remain largely unreached by the vaccine.¹²⁷

Though the number of low-income countries that have taken the vaccine to national scale is still limited, there have been numerous demonstration projects and a growing body of literature detailing lessons learned.^{128, 129} PATH and the London School of Hygiene and Tropical Medicine (LSHTM) reviewed delivery experiences across 46 low- and middle-income countries, finding that "HPV vaccine delivery is feasible and can be delivered with high coverage."¹³⁰

Seriously expanding access to the HPV vaccine in low-income countries can build on burgeoning programmatic engagement, partnerships, and interest among organizations and national

governments. All of the 13 target countries are eligible for support from Gavi, and all but Nigeria have already successfully delivered the vaccine through demonstration projects.¹³¹ Two, Rwanda and Uganda, have introduced the vaccine through a national program. It is anticipated that eight of the target countries will soon submit applications to Gavi requesting support to roll out the vaccine nation-wide.¹³²

A coalition of interests is increasingly promoting expanded access to the vaccine, including the American Cancer Society, the Bill & Melinda Gates Foundation, Gavi, Pink Ribbon Red Ribbon, and vaccine manufacturers. PATH, the National Cancer Institute, UNICEF, and WHO have all become important voices.

Cost remains one of the biggest barriers in scaling up access in both Gavi-eligible and non-Gavi-eligible countries, where introducing the HPV vaccine and sustaining national programs can be prohibitively expensive in the face of competing interests.¹³³ Costs could decline if there is a concerted international effort dedicated to expanding the volume of vaccines, eventually bringing forward generic versions, and even perhaps expediting a single-dose regimen.¹³⁴

A platform to deliver the HPV vaccine can also provide adolescent girls, both in and out of school, with critical health interventions. HPV vaccination is often the first time girls are in contact with health-related activities since early childhood. It can be combined with other vital health promotion activities including nutrition supplementation, menstrual hygiene education, and gender-based violence prevention and response.

KEY CONSIDERATIONS

There are a number of serious constraints—limited finances, policy and regulatory issues, competing priorities, lack of experience with wide-scale delivery of the vaccine to adolescent girls, and implementation complexities—that explain many countries' hesitation to commit to scaling up HPV vaccination programs.

Gavi support to several successful school-based HPV vaccine demonstration projects has generated important lessons. It has been well established that reaching adolescent girls with the HPV vaccine is different than reaching children under five: it requires targeted social mobilization and high-level political will, new operational investments, and considerable patience



FORMER REP. RICHARD HANNA (R-NY-22)

"Women's rights are challenged daily around the globe. From the mother who wants access to family planning services to the adolescent girl who needs to be educated

about cervical cancer, this report identifies several key health interventions that the United States can undertake to improve its foreign aid and generate returns on its investment. The United States has long led the way to improve the lives of women and children around the world. Let's accelerate the momentum."

in transitioning from demonstration to national scale-up. Success flows from strong country ownership, either within the routine immunization program or other national programs, and a clear linkage to cancer prevention.¹³⁷

It is also vital to effectively engage communities so they understand the significant benefits of the HPV vaccine and to dispel any misconceptions. As HPV is a sexually transmitted infection, programs to educate and immunize girls ages 9–14, prior to the start of sexual activity, have faced resistance from some communities in the United States and globally that associate the vaccine with promoting promiscuity. Providing accurate information about the vaccine and addressing cultural sensitivities are important aspects of introduction to ensure necessary support from communities, providers, and national governments.

METHODS

The Task Force benefited enormously from the generous assistance provided by several organizations that are deeply involved with efforts to expand HPV vaccine access in low-income countries, including the American Cancer Society, the Bill & Melinda Gates Foundation, CDC, Gavi, LSHTM, the National Cancer Institute, PATH, Pink Ribbon Red Ribbon, and UNICEF.

The target of 50 to 75 percent coverage is ambitious but feasible, and is based on the premise that high coverage levels should be achieved on an accelerated basis.¹³⁶ Gavi only funds national scale-up of programs for countries that have adequate vaccine-delivery infrastructure and experience. Its renewed approach is based on considerable recent experience.¹³⁷

The projected numbers of young women to be vaccinated reflect the recommendation put forth at the October SAGE meeting to immunize multiple cohorts of 9- to 14-year-old girls during national introduction of the HPV vaccine, which was recently adopted by Gavi at its Board meeting on December 7–8, 2016.¹³⁸

This initiative is projected to cost approximately \$843 million between 2017 and 2021. We anticipated that a “fair share” of the U.S. contributions to this effort would represent approximately 50 percent of the total costs. Base cost projections and health impacts were provided by Stephen Resch from the Harvard T.H. Chan School of Public Health, stemming from a recent study commissioned by the American Cancer Society. These assumed an average commodity cost of \$9.71 (for two doses) and average vaccine delivery cost of \$4.51 per girl. These figures further reflected average introduction costs of \$3.13 and operational costs of \$4.23 per girl.¹³⁹ Special consideration was given to introduction and operational costs, which tend to be higher when compared to under-5 vaccines, but are critical in funding necessary technical assistance, reaching communities with information prior to launch, and delivering the vaccine through a number of channels.¹⁴⁰

SECTION 06





Governance and Implementation

GOVERNANCE AND IMPLEMENTATION

HEADQUARTERS GOVERNANCE

The secretary of state should lead. The secretary should be responsible for the initiative's overall strategic design and direction, including both shaping the U.S. budgetary process in Washington, D.C., and winning greater ownership by partner governments. Duties would include actively using global health diplomacy to encourage legal and policy changes, along with higher budgetary commitments.

The secretary of state should designate a deputy to provide political leadership and ensure the departments and agencies are adhering to initiative principles and working in alignment toward the common goals. In addition, the president should appoint a deputy administrator-level position situated within the office of the USAID administrator as the operational head of the Initiative.

The secretary's deputy should convene a Steering Committee (possibly an Interagency Policy Committee) comprised of the designated principals from each of the executive branch departments and agencies implementing foreign assistance programs targeting adolescent girls and young women, including the Departments of State, Health and Human Services, Defense, Education, and Agriculture; USAID; Peace Corps; and the Millennium Challenge Corporation.¹⁴¹

The designated deputy administrator should have (1) budgetary authority to manage and distribute new resources appropriated by Congress aimed at achieving the initiative goals and (2) primary responsibility for the management and operations of the initiative and leading the intra-agency coordination of planning, implementation, and monitoring, as well as serving as the principal liaison to the other relevant departments and agencies. While U.S. government investments targeting adolescent girls and young women should be better aligned between and among agencies, integration will primarily have to come from within USAID, which implements

most health, education, economic strengthening, and agriculture programs that target adolescent girls and young women (see service delivery and implementation section).

The secretary of state's deputy and the USAID deputy administrator should be jointly responsible for creating and implementing a diplomatic engagement strategy with partner countries, Congress, the private sector, the faith community, partner donor governments, multilateral organizations, and civil society.

COUNTRY-LEVEL EXECUTION

Strong leadership and coordination from the ambassador and a senior coordinator is likewise critical within the U.S. diplomatic missions in the target countries. The role of the ambassador in leading political and diplomatic engagement has been demonstrated as imperative to the success of existing health programs, including PEPFAR. The ambassador should be designated as the overall head of the proposed initiative in each of the target countries and ensure the interagency team is planning and executing the initiative effectively. The ambassador should provide critical diplomatic engagement with the host government and other partners to encourage adoption of enabling government policies and catalyze new funding from the host government or private sector.

A senior initiative coordinator should be appointed to serve as the ambassador's designated day-to-day manager within the U.S. team.¹⁴⁴



J. STEPHEN MORRISON

"The secretary of state's leadership is the sine qua non for success. Sustained high-level diplomacy will spur partner country buy-in (including budgets!), motivate other donors to do more, exalt the private sector to play a central role, create a true ethic of innovation, and hold everybody to account."

The initiative coordinator should report directly to the ambassador and ensure accountability to the country-specific adolescent girls and young women strategy and transparency within the U.S. team (e.g., health, education, agriculture, and economic strengthening sectors with representation also from the Political and Economic and Public Affairs offices) and with stakeholders (see service delivery and implementation section). Further, the senior coordinator should serve as the central communication channel for outreach on the initiative to the host government, civil society, and other stakeholders.

In addition, the U.S. government should utilize its diplomacy and technical assistance at all levels to encourage the adoption of adolescent-specific policies and overall policies that support the rights of adolescent girls and young women and create safe environments for the operation of nongovernmental organizations. While there has been global momentum in recent years through establishment of the Global Strategy for Women's, Children's, and Adolescents' Health, WHO guidelines on quality adolescent care,¹⁴³ and various disease or health intervention specific strategies, there are major differences in adolescent health strategies, policies, and legal frameworks across countries.¹⁴⁴ The absence of enabling guidelines can hinder the ability of an adolescent to seek and attain quality, appropriate services, as well as the im-

plementation of certain interventions. There also are additional barriers due to religious or customary laws and/or cultural practices.

AN INTEGRATED SERVICE DELIVERY AND IMPLEMENTATION APPROACH

The Task Force recommends that integration be pursued through (1) aligned planning, implementation, and monitoring of programs—both health and non-health—targeting adolescent girls and young women; (2) coordinated delivery of a range of high-quality services to address the unmet needs of adolescent girls and young women for these critical interventions; and (3) operationally, the combination of health activities with programs that support secondary education, economic empowerment through microenterprise,¹⁴⁵ agriculture, prevention and response to gender-based violence, and prevention of child marriage. When done successfully, integration can contribute to better health outcomes and more resilient, sustainable, and stronger health systems.¹⁴⁶

The U.S. government will need to do business in new and different ways to provide integrated and innovative service delivery to adolescent girls and young women. Ideally services can be provided to patients through a one-stop model to gain efficiencies and maximize impact. The WHO has disseminated quality standards for

adolescent service delivery including that they receive “a package of information, counseling, diagnostic, treatment and care services.”¹⁴⁷ Integrated service delivery should be central to the proposed initiative, with a focus on improving access for the hardest to reach, developing more efficient, effective, and patient-centered approaches, and encouraging innovation.

To align planning and implementation, the U.S. government should create a global level strategy and country-specific strategies setting joint goals and outlining program plans to which the U.S. government team as a whole will be held accountable. U.S. government country teams should develop (or expand on existing) integrated operational strategies or plans outlining common objectives for improving the health and lives of adolescent girls and young women. These operational plans should encapsulate all existing health, education, agriculture (e.g., Feed the Future), economic strengthening, human rights, gender-based violence, small grants, and public diplomacy activities that target adolescent girls and young women as well as specific activities to meet the initiative’s central goals. The Integration Fund outlined below will reward U.S. government country teams and their partners for designing and implementing innovative approaches and create funds for operational research about how best to reach adolescent girls and young women.

The multisector plans should be developed in partnership with host governments, local communities, civil society, bilateral and multilateral organizations, private-sector entities, and adolescent girls and young women themselves. The plans should identify uses for new money that will complement ongoing U.S. and other partner activities and specify important gaps that could be filled by contributions from new partners. Where possible, the plans should be based on existing U.S. program plans and host-government strategies, including those developed for the Global Financing Facility. If host governments do not have a national strategy for adolescent girls and young women, the U.S. team should provide technical assistance toward the development of costed strategies.

To facilitate country-level planning and implementation, the Task Force recommends a \$100-million-per-year Integration Fund be established at USAID that will incentivize U.S. missions to combine the initiative’s core health interventions with programs targeting education, economic empowerment, gender-based violence, food security, and reduction of child marriage, and fund operational research. The Fund should support these creative alignments of programs through results-based financing, founded on the outstanding quality of country plans that seek to demonstrate progress in achieving higher cost-effectiveness and im-



DIANE ROWLAND

“Coordination of services for adolescent girls and young women can advance patient-centered care and lead to improved health outcomes and greater efficiency in the use of limited resources. Providing on-the-ground incentives will help foster programmatic cooperation.”

proved health outcomes through integration. Operational research will evaluate the implementation and create the knowledge base for continuing programmatic improvements.

There is precedent for multisectoral approaches. The 2009 U.S. Global Health Initiative (GHI) stumbled operationally, since its ambitions were too broad and wide-ranging, and its leadership lacked high-level backing, clear goals, and budgetary authority. At the same time, GHI advanced a consensus that integration efforts, when carried out effectively, can strengthen and leverage existing health investments, increase impact through strategic coordination and integration, promote learning and accountability through monitoring and evaluation, and accelerate results through research and innovation.¹⁴⁸

In recent years, promising examples have emerged of successful multisectoral integration across family planning, maternal and child health, nutrition, and HIV programs, with concrete outcomes and proven cost effectiveness.¹⁴⁹

PEPFAR's DREAMS initiative is an exceptionally promising effort to reduce HIV incidence in adolescent girls and young women in key ge-

ographies of 10 target countries. The DREAMS Partnership "is delivering a Core Package of evidence-informed approaches that go beyond the health sector, addressing the structural drivers that directly and indirectly increase girls' HIV risk, including poverty, gender inequality, sexual violence, and lack of education."¹⁵⁰ In the six countries with existing DREAMS programs, the proposed initiative would systematically build upon the DREAMS platforms by including additional health activities and extending the program beyond 2017.

INNOVATIVE IMPLEMENTATION SUPPORT

Expand the Role of the Private Sector

The private sector should play a leading role in the initiative as a partner in financing, leadership, innovative health solutions, and improved service delivery.

Public-private partnerships (PPPs) have demonstrated significant impact in improving the outcomes of global health programs. Through legislative action, Congress should include a provision to incentivize privately generated resources for PPPs to match U.S. global health



JEFFREY L. STURCHIO

"We are at an historic moment for U.S. leadership in global health. Investing in adolescent girls and young women will yield critical benefits for health, economic opportunity, and development—both for their communities and countries and for the United States. The private sector has a crucial role to play in implementing this bold initiative, by contributing its resources and expertise through new partnerships, innovative health solutions, and quality health service delivery."



PHIL THOMSON

“Industry can play a critical role in helping deliver the recommendations set out by the Task Force. With continued U.S. leadership, we have an exceptional opportunity to integrate key health interventions and help improve the lives of millions of adolescent girls and young women.”

investments focused on adolescent girls and young women. PEPFAR’s PPP Incentive Fund¹⁵³ could be adapted to increase the number of partnerships targeting adolescent girls and young women. In addition to matching funds, it is important for the administration to increase the transparency of U.S.-led PPPs, specifically in financing, outcomes, and impact.¹⁵²

Beyond funding, there is an opportunity to capitalize on the private sector’s expertise in reaching this specific population and generating demand for accessible, affordable, and high-quality family planning and maternal health services. Companies can bring to bear their skills in defining consumer preferences, developing targeted community-based marketing campaigns, and using technology innovations and social media to influence health-seeking behaviors.

A special focus should be strengthening private health services to ensure high-quality care, especially for adolescent girls and young women. An overlooked but critical part of countries’ health systems is private health providers—doctors, nurses, midwives, and pharmacies—from whom approximately 40 percent of women in low- and middle-income countries receive maternal health and family planning services. Strengthening the local private health sector is essential to expanding access to quality services, especially as many countries move toward universal health coverage.¹⁵³

Address Data Gaps

Operational research, funded through the Integration Fund, is needed to evaluate the quality of multisectoral interventions pursued by the U.S. government and its partners and better understand the needs of adolescent girls and young women at various ages, in diverse settings, and in different familial relationships (e.g., mar-





LISA CARTY

“Global AIDS programs have shown us how investments in data help target services to save lives. Now we need to do the same for adolescent girls and young women, using the right data to reach them where they are, bringing new opportunities to improve their health and their prospects in life.”

ried or unmarried, living in or out of the family home). More than any other age cohort, adolescence has been neglected in research and implementation science. *The Lancet* Commission on adolescent health and well-being states that this neglect has led to “major gaps in our understanding of adolescent health needs, in the evidence base for action, in civil society structures for advocacy, and the systems for inter-sectoral action.”¹⁵⁴ The results of the operational research should inform adjustments to the strategies and policy and program plans to better reach adolescent girls and young women.

In addition, the Task Force recommends a \$15-million-per-year investment in data and metrics. These resources should be used to ensure that the United States and its partners adopt common metrics that ultimately demonstrate programmatic impact. Key will be cataloging existing indicators that measure adolescent health outputs and outcomes, creating standard disaggregated indicators, and adopting and integrating the metrics into the local Health Management Information System (HMIS). Mapping of interventions down to the sub-national unit level, as PEPFAR has done, will be essential to



STEVE DAVIS

“America leads the world when it comes to innovation, yet—as a nation—we haven’t sufficiently leveraged innovation to advance development. Better utilization of new data, approaches, and technologies will allow us to have far greater impact. We also need partners with a variety of complementary capabilities, including the private sector, helping design and deliver solutions to improve the lives of women and families around the world.”

drive program planning and evaluation, aided by a dashboard that includes demographic output and outcome and quality measures tied to the HMIS. As a prerequisite for understanding current resource allocations and pursuing greater integration, a shared database should be developed that can be used to facilitate decisions about where to make integrated investments, assess alignment between investments and need, and track progress over time.

Invest in Innovation, Research, and Development

The administration should invest in new technologies and promising approaches to the delivery of health care that can meet the specific needs of adolescent girls and young women.^{155, 156} The secretary of state's designated deputy should address barriers to innovation by strengthening alignment and priority-setting across government, streamlining innovation funding mechanisms, and fostering innovation capacity in the target countries.

In the initiative's first year, the secretary of state should launch a high-level, independent panel of experts from both the public and private sectors to advise the initiative's leadership on priority technological opportunities and outline key steps to enhance partnerships with the private sector, improve contracting mechanisms, strengthen coordination across U.S. agencies, and better align with other donors and funders.

The administration should also create a dedicated mechanism at USAID that can support, through \$25 million in annual finance and technical expertise, emerging innovators in the target countries to incentivize domestic financing from both public and private sectors, and encourage tailored innovations.

APPENDIX

Country Selection Criteria and Key Data

Table 1**COUNTRY SELECTION CRITERIA¹⁵⁷**

Country	MCH + FP priority country	Nutrition Focus Country	PEPFAR COP Country	FTF Country	PMI Country	Other Relevant U.S. Initiatives	U.S. Global Health Assistance 2016
Bangladesh	Yes	Yes	No	Yes	No	N/A	72.9
Ghana	Yes	Yes	Yes	Yes	Yes	Let Girls Learn	71.71
Kenya	Yes	Yes	Yes	Yes	Yes	DREAMS	542.04
Liberia	Yes	Yes	No	Yes	Yes	N/A	35.57
Malawi	Yes	Yes	Yes	Yes	Yes	DREAMS + Let Girls Learn Challenge Fund	163.64
Mozambique	Yes	Yes	Yes	Yes	Yes	DREAMS + Let Girls Learn + PRRR	367.57
Nepal	Yes	Yes	No	Yes	No	Let Girls Learn Challenge Fund	38.78
Nigeria	Yes	Yes	Yes	No	Yes	SMGL	532.31
Rwanda	Yes	Yes	Yes	Yes	Yes	Let Girls Learn	117.56
Senegal	Yes	Yes	No	Yes	Yes	Ouagadougou Partnership	56.33
Tanzania	Yes	Yes	Yes	Yes	Yes	DREAMS + Let Girls Learn Challenge Fund + PRRR	494.91
Uganda	Yes	Yes	Yes	Yes	Yes	DREAMS + SMGL + Let Girls Learn	418.38
Zambia	Yes	Yes	Yes	Yes	Yes	DREAMS + SMGL + PRRR	393.04
Summary	All	All	9 of 13	12 of 13	11 of 13		Total \$3.3 billion

Country	GNI Per Capita (Atlas)	Gavi-Eligible	Gavi Priority	Total Gavi Commitments (2000–2016)	Global Fund Country	GFF Country
Bangladesh	1,190	Yes	Yes	508.215	Yes	Yes
Ghana	1,480	Yes (Accelerated Transition)	Yes	267.979	Yes	No
Kenya	1,340	Yes	Yes	442.316	Yes	Yes (Frontrunner)
Liberia	380	Yes	Yes	35.47	Yes	Yes
Malawi	350	Yes	Yes	191.337	Yes	No
Mozambique	580	Yes	No	199.514	Yes	Yes
Nepal	730	Yes	Yes	144.294	Yes	No
Nigeria	2,820	Yes (Accelerated Transition)	Yes	681.367	Yes	Yes
Rwanda	700	Yes	No	146.399	Yes	No
Senegal	1,000	Yes	Yes	105.91	Yes	Yes
Tanzania	910	Yes	Yes	342.846	Yes	Yes (Frontrunner)
Uganda	670	Yes	No	343.72	Yes	Yes (Frontrunner)
Zambia	1,500	Yes	No	143.2	Yes	No
Summary	Average \$1,050	All	9 of 13	\$3.6 billion	All	8 of 13

These 13 countries were chosen based on a number of criteria, including the presence of U.S. bilateral and multilateral investments. Together, they represent over \$3 billion in U.S. foreign assistance for health in 2016. All 13 countries are USAID priority countries for maternal and child health and family planning, and all are USAID nutrition focus countries.

Consideration was also paid to countries with PEPFAR, PMI, Feed the Future, and other relevant programs focusing on adolescent girls or women's health, including DREAMS, Saving Mothers Giving Life, Pink Ribbon Red Ribbon, and Let Girls Learn. In terms of multilateral investments, all of the countries are home to substantial Gavi and Global Fund commitments, and all are eligible for the Global Financing Facility, with many already frontrunner or second-wave countries.

We took the considerable U.S. health investments in these countries to represent both a platform on which to build services focused on adolescent girls and young women, as well as established political interest and engagement on the part of the U.S. and country government.¹⁵⁸

Table 2:

KEY DATA BY COUNTRY¹⁵⁹

Country	Population of Girls 10–24	Primary School Completion	Secondary School Completion	Median Age at First Marriage	Cervical Cancer Incidence	HPV Program (all supported by Gavi unless noted)
Bangladesh	23.4	85	26	16.1	19.2	HPV demo 2015–2016
Ghana	4.1	68	35	20.7	35.4	HPV demo 2013–2014
Kenya	7.3	82	38	20.2	40.1	HPV demo 2013–2014 + 2016–2017
Liberia	0.71	33	9	18.8	30.1	HPV demo 2014–2015
Malawi	2.9	51	9	17.8	75.9	HPV demo 2013–2014
Mozambique	4.6	37	4		65	HPV demo 2014–2015
Nepal	4.7	75	21	17.5	19	HPV demo 2015–2016
Nigeria	27.9	65	42	18.1	29	HPV demo approved
Rwanda	1.9	41	9	21.9	41.8	National Program + Gavi support
Senegal	2.4	50	5		41.4	HPV demo 2014–2015
Tanzania	8.6	72	2	18.8	54	HPV demo 2014–2016
Uganda	6.6	41	13	17.9	44.4	HPV support 2015–2016
Zambia	2.7	75	23	18.4	58	HPV demo 2013–2016 (PRRR + Merck)
Summary	Total: 97.8 million girls	60% of girls complete primary	18% of girls complete secondary	Average girl is married before 19	43 cases per 100,000 population	12 of 13 with demos or national program

Country	Unmet Need FP Unmarried 15–24	Unmet Need FP Married 15–24	Median Age First Intercourse	Under-5 Stunting	Anemia Prevalence Women 15–49
Bangladesh	Unavailable	15.9	16.2	41	43.5
Ghana	48.7	45.7	18.4	28	56.4
Kenya	47.1	30.2	18	35	25
Liberia	58.1	41.8	16.2	42	49.3
Malawi	46.2	26.2	17.2	47	28.8
Mozambique	47.2	23.1	Unavailable	43	44.2
Nepal	Unavailable	39.3	17.7	41	36.1
Nigeria	33.2	19.8	17.6	41	48.5
Rwanda	54.4	16	21.8	44	17.4
Senegal	69.5	30.5	Unavailable	27	57.5
Tanzania	33.1	22.7	17.4	42	39.6
Uganda	49.8	34.3	16.8	33	26.7
Zambia	44.6	24.3	17.3	45	29.2
Summary	48% unmet need for FP	28% unmet need for FP	Average girl has sex before 18	39% of children stunted	39% women anemic

Country	Maternal Mortality Ratio 15-49	Newborn Mortality Ratio	Median Age at First Birth	Adolescent mothers or pregnant	Adolescent Fertility Rate
Bangladesh	176	23	18	31	83
Ghana	319	28	21.4	14	68
Kenya	510	22	20.3	18	92
Liberia	725	24	18.9	31	111
Malawi	634	22	18.9	29	137
Mozambique	489	27	Unavailable	Unavailable	143
Nepal	258	22	20.2	17	43
Nigeria	814	34	20.2	23	112
Rwanda	290	19	22.7	7	27
Senegal	315	21	Unavailable	Unavailable	80
Tanzania	398	19	19.5	23	119
Uganda	343	19	18.9	24	115
Zambia	224	21	19.1	29	93
Summary	423 deaths per 100,000 live births	23 deaths per 1,000 live births	Average girl gives birth before 20	22% pregnant/ mothers by 19	94 births per 1,000 girls age 15–19

In addition to representing priority countries for U.S. investments in health, these 13 countries are home to nearly 100 million adolescent girls and young women ages 10–24.

A number of key indicators show a substantial unmet need for family planning, low rates of secondary school completion, early pregnancy and childbirth, and high rates of anemia among women in their reproductive years.

Together, the data demonstrate that adolescent girls continue to fall through the cracks and need to be reached with essential health services and education.

Notes

1. United Nations Department of Economic and Social Affairs, Population Division, "Population Facts," No. 2015/1, May 2015, http://www.un.org/en/development/desa/population/publications/pdf/popfacts/PopFacts_2015-1.pdf.
2. National Intelligence Council, "Global Trends 2015: A Dialogue About the Future with Nongovernment Experts," December 2000, https://www.dni.gov/files/documents/Global%20Trends_2015%20Report.pdf.
3. George C. Patton et al., "Our Future: A *Lancet* Commission on Adolescent Health and Wellbeing," *The Lancet* 387, issue 10036 (June 2016): 2423–78.
4. Ibid.
5. Ana Revenga and Sudhir Shetty, "Empowering Women Is Smart Economics," *Finance & Development* 49, no 1 (March 2012), <http://www.imf.org/external/pubs/ft/fandd/2012/03/revenga.htm>.
6. Jonathan Woetzel et al., "How advancing women's equality can add \$12 trillion to global growth," McKinsey, September 2015, <http://www.McKinsey.com/global-themes/employment-and-growth/how-advancing-womens-equality-can-add-12-trillion-to-global-growth>.
7. Saving Mothers Giving Life, "2015 Mid-Initiative Report," Washington DC, Saving Mothers Giving Life, 2015.
8. Pink Ribbon Red Ribbon, "Results," <http://pinkribbonredribbon.org/results/>.
9. Certain countries that met the selection criteria were not included in this proposal due to ongoing political turbulence. Countries such as Ethiopia and Haiti might warrant inclusion in this initiative at a later date.
10. World Health Organization, "Standards for Improving Quality of Maternal and Newborn Care in Health Facilities," Geneva, WHO, 2016; and World Health Organization, "Global Standards for Quality Healthcare for Adolescents: A Guide to Implement a Standards-Driven Approach to Improve the Quality of Health-Care Services for Adolescents," Geneva, WHO, 2015.
11. Ellen Starbird et al., "Investing in Family Planning: Key to Achieving the Sustainable Development Goals," *Global Health: Science and Practice* 4, issue 2 (June 2016): 191–210.
12. World Health Organization, "Options for Linking Health Interventions for Adolescents with HPV Vaccination," Geneva, WHO, 2014.
13. Melinda Gates, "Advancing the Adolescent Health Agenda," *The Lancet* 387, issue 10036 (May 2016): 2358–59.
14. PATH, "Harnessing the power of innovation to save mothers and children: How 11 emerging innovations could save more than 6 million lives," September 2016, http://www.path.org/publications/files/APP_epcmd_modeling_br2.pdf.
15. USAID's Center for Accelerating Innovation and Impact has piloted innovative financing tools that crowd in resources from the private sector. See USAID, "Financing Framework to End Preventable Child and Maternal Deaths," Summer 2015, <https://www.usaid.gov/sites/default/files/documents/1864/Financing-Framework-for-EPCMD-508.pdf>.
16. Companies have responded with higher investments when presented with similar legislated matching opportunities created for PEPFAR, the Millennium Challenge Corporation, and Power Africa. See Jeffrey L. Sturchio and Maria Schneider, "Strengthening Partnerships with the Private Sector," CSIS, January 2017, http://vision2017.csis.org/wp-content/uploads/2017/02/cross_sectional_studies_privatesector.pdf.
17. PEPFAR, "Working Together for an AIDS-free Future for Girls and Women," <https://www.pepfar.gov/partnerships/ppp/dreams/>.
18. As of 2017, Ghana and Nigeria are classified as accelerated transition countries, meaning that they will reach the end of Gavi support and fully finance the purchase of vaccines by 2022. Gavi, the Vaccine Alliance, "Country Hub," <http://www.gavi.org/country/>.
19. Kaiser Family Foundation, "The U.S. & Gavi, the Vaccine Alliance," March 2016, <http://kff.org/global-health-policy/fact-sheet/the-u-s-and-the-gavi-alliance/>.
20. Global Financing Facility, "Introduction," <http://www.globalfinancingfacility.org/introduction>.
21. Given the size of the population in Bangladesh and Nigeria, these goals are based on estimates for reaching 20 percent of the population of 15- to 24-year-olds.
22. Abortion services are not included in maternal health care, since they are prohibited by U.S. laws on foreign assistance.
23. World Health Organization, "Adolescent Pregnancy," http://www.who.int/maternal_child_adolescent/topics/maternal/adolescent_pregnancy/en/.
24. UNFPA, "Motherhood in Childhood: Facing the Challenge of Adolescent Pregnancy," New York, UNFPA, 2013.
25. World Bank and International Center for Research on Women, "The Economic Impacts of Child Marriage," Power-Point presentation, December 2016.
26. World Health Organization, "Adolescent Pregnancy," http://www.who.int/maternal_child_adolescent/topics/maternal/adolescent_pregnancy/en/.

27. World Health Organization, "Early marriage, adolescent, and young pregnancies: Report by the Secretariat," December 2011, http://apps.who.int/gb/ebwha/pdf_files/EB130/B130_12-en.pdf.
28. Recent studies have attempted to assess the health and social risks faced by young mothers in low-income countries by focusing on young women between the ages of 15 and 19. See, for example, Andrea Nove et al., "Maternal mortality in adolescents compared with women of other ages: evidence from 144 countries," *The Lancet Global Health* 2, issue 3 (March 2014): e155–e164; Ann Blanc et al., "New Findings for Maternal Mortality Age Patterns: Aggregated Results for 38 Countries," *PLOS One* 8, issue 4 (April 2016); Togoobaatar Ganchimeg et al., on behalf of the WHO Multicountry Survey on Maternal Newborn Health Research Network, "Pregnancy and childbirth outcomes among adolescent mothers: A World Health Organization multicountry study," *British Journal of Obstetrics and Gynaecology* 121, issue s1 (March 2014): 40–48.
29. Astha Ramaiya et al., "A systematic review of risk factors for neonatal mortality in Adolescent Mothers in Sub-Saharan Africa," *BMC Research Notes* 7, issue 750 (October 2014).
30. Margaret E. Kruk at CSIS event, "The Lancet Maternal Health Series and Implications for U.S. Policy," October 20, 2016, <https://www.csis.org/events/Lancet-maternal-health-series-and-implications-us-policy>.
31. World Health Organization, "Calcium supplementation during pregnancy for the prevention of pre-eclampsia," http://www.who.int/elena/titles/calcium_pregnancy/en/.
32. Patton, "Our future: A Lancet commission on adolescent health and wellbeing."
33. World Health Organization, "Early marriage, adolescent, and young pregnancies: Report by the Secretariat," December 2011, http://apps.who.int/gb/ebwha/pdf_files/EB130/B130_12-en.pdf.
34. Together for Girls, "Issue," <http://www.togetherforgirls.org/issue/>.
35. Deborah Birx, "DREAMS Update," PPT slides, August 2, 2016. The countries were: Kenya, Malawi, Nigeria, Tanzania, Zambia, Haiti, Swaziland.
36. Patton, "Our future: A Lancet commission on adolescent health and wellbeing," 2434.
37. Jad Chaaban and Wendy Cunningham, "Measuring the Economic Gains of Investing in Girls: The Girl Effect Dividend," Policy Research Working Papers, World Bank, Washington DC, August 2011.
38. The United States is the largest donor to maternal and child health globally, providing \$7.5 billion between FY 2010 and FY 2016, 35 percent of which was for global immunization efforts. See Henry J. Kaiser Family Foundation, "U.S. Funding for International Maternal & Child Health," <http://kff.org/global-health-policy/issue-brief/u-s-funding-for-international-maternal-child-health/>. In addition, in 2012, the United States, in cooperation with the governments of Uganda, Zambia, and Norway, as well as Merck for Mothers, Every Mother Counts, and the American College of Obstetricians and Gynecologists, launched the five-year Saving Mothers Giving Life (SMGL) partnership, focused on improving maternal and neonatal health outcomes during the critical labor and delivery window. SMGL was designed with the ambitious goal of reducing maternal mortality by 50 percent in one year in selected districts of Zambia and Uganda. Now nearing the end of its five-year program, SMGL has achieved measurable success, contributing to a 53 percent reduction in institutional maternal mortality in its original target areas in Zambia, and 45 percent in Uganda. SMGL has recently expanded to Nigeria, which accounts for 14 percent of maternal deaths and 25 percent of newborn deaths globally, and will focus on strengthening maternal health services in Cross River State over the next 2.5 years.
39. USAID, "Acting on the Call, Ending Preventable Child and Maternal Deaths," Washington, DC, USAID, 2014.
40. Ibid.
41. This can be measured through service provision assessments through DHS.
42. Women and girls with an unmet need for family planning are those who want to avoid or delay pregnancy but are not using a modern contraceptive method. Given the size of the population in Bangladesh and Nigeria, this estimate is based on meeting unmet need for 20 percent of the population of 15- to 24-year-olds in those two countries, based on the most recent survey estimates of unmet need.
43. Modern methods of family planning are short-acting, long-acting, and permanent methods, such as the pill, injectables, IUDs, implants, female and male condoms, and other barrier methods, and some also include standard days method (cycle beads). Natural family planning methods, also referred to as fertility-based awareness methods, include standard days method (cycle beads) and lactational amenorrhea method. Traditional methods include withdrawal and periodic abstinence. See WHO, "Adolescent Contraceptive Use," <http://apps.who.int/iris/bitstream/10665/252536/1/WHO-RHR-16.72-eng.pdf?ua=1>; and Victoria Jennings, The Mother & Child Project, "New Ideas, New Opinions," Grand Rapids, Zondervan, 2015.
44. According to Avenir Health, the final cost savings includes the same types of costs that were estimated to reduce unmet need. This includes direct costs, such as contraceptives and related supplies, and health workers' salaries; and indirect costs, such as program and systems costs.
45. This assumes other resources to maintain baseline contraceptive prevalence relating to increase in numbers of young women in this age cohort.
46. The Helms amendment (1973) prohibits the use of U.S. foreign assistance to pay for abortion as a method of family planning or to motivate or coerce any person to seek abortion. The Kemp-Kasten amendment (1995) prohibits funding to any organization that supports or participates in coercive abortion or involuntary sterilization. The Ti-

- ahrt amendment (1998) prohibits the use of targets, quotas, or financial incentives in family planning projects. See Kaiser Family Foundation, "The U.S. Government and International Family Planning & Reproductive Health: Statutory Requirements and Policies," <http://kff.org/global-health-policy/fact-sheet/the-u-s-government-and-international-family-planning-reproductive-health-statutory-requirements-and-policies/>.
47. See Kaiser Family Foundation, "The U.S. Government and International Family Planning & Reproductive Health Efforts," June 20, 2016, <http://kff.org/global-health-policy/fact-sheet/the-u-s-government-and-international-family-planning-and-reproductive-health/>.
48. Jacqueline E. Darroch et al., "Adding It Up: Costs and Benefits of Meeting the Contraceptive Needs of Adolescents," New York, Guttmacher Institute, 2016.
49. U.S. support for international family planning is based on the principles of voluntarism and informed choice, and is guided by legislative and policy restrictions regarding abortion. See USAID, "USAID'S Family Planning Guiding Principles and U.S. Legislative and Policy Requirements," <https://www.usaid.gov/what-we-do/global-health/family-planning/usaid-family-planning-guiding-principles-and-us-0>.
50. World Health Organization, "Family Planning/Contraception," fact sheet, May 2015, <http://who.int/mediacentre/factsheets/fs351/en/>; and World Health Organization, "Adolescent Pregnancy," fact sheet, September 2014, <http://www.who.int/mediacentre/factsheets/fs364/en/>.
51. Darroch, "Adding It Up: Costs and Benefits of Meeting the Contraceptive Needs of Adolescents."
52. WHO, "Adolescent Pregnancy"; and Relief Web, "Pregnancy complications, child birth, leading cause of death among 15-19-year-old girls—UNFPA chief," <http://reliefweb.int/report/world/pregnancy-complications-child-birth-leading-cause-death-among-15-19-year-old-girls>.
53. The maternal mortality rate in the United States rose to 28 per 100,000 in 2013, up from 23 in 2005, in part related to health care availability, access, and utilization by underserved communities. See Sabrina Tavernese, "Maternal Mortality Rate in U.S. Rises, Defying Global Trend, Study Finds," *New York Times*, September 21, 2016, <https://www.nytimes.com/2016/09/22/health/maternal-mortality.html>.
54. United Nations Department of Economic and Social Affairs, Population Division, "World Population Prospects, the 2015 Revision," <https://esa.un.org/unpd/wpp/Download/Standard/Population/>.
55. Saifuddin Ahmed et al., "Maternal deaths averted by contraceptive use: an analysis of 172 countries," *The Lancet* 380, issue 9837 (July 2012): 111–125; and Adrienne Kols, "Reducing Unmet Need for Family Planning: Evidence-based Strategies and Approaches," *PATH Outlook* 25, issue 1 (November 2008).
56. John Cleland et al., "Contraception and health," *The Lancet* 380, issue 9837 (July 2012): 149–156.
57. PEPFAR, "DREAMS Partnership: Fact Sheet 2017," <https://www.pepfar.gov/documents/organization/252380.pdf>.
58. PEPFAR, "Technical Considerations: Provided by PEPFAR Technical Working Groups for 2015 COPS and ROPS," 306–14, <https://www.pepfar.gov/documents/organization/237687.pdf>.
59. Patton, "Our future: A *Lancet* commission on adolescent health and wellbeing," 2427.
60. Kaiser Family Foundation, "The U.S. Government and Family Planning & Reproductive Health Efforts," June 20, 2016, <http://kff.org/global-health-policy/fact-sheet/the-u-s-government-and-international-family-planning-and-reproductive-health/>.
61. U.S. State Department, "United States Global Strategy to Empower Adolescent Girls," Washington DC, State Department, 2016.
62. USAID, "DREAMS: Partnership to Address HIV/Aids in adolescent girls and young women," <https://www.usaid.gov/what-we-do/global-health/hiv-and-aids/technical-areas/dreams>.
63. The "Mexico City Policy" prohibits U.S. funds from going to any foreign nongovernmental organization that uses its own funds to provide any service related to abortion, including counseling, referral, or advocacy. The policy was first imposed by President Ronald Reagan in 1984; rescinded by President Bill Clinton in 1993; reinstated by President George W. Bush in 2001; and rescinded by President Barack Obama in 2009. On January 23, 2017, President Donald J. Trump both reinstated and expanded the Mexico City policy. See Kaiser Family Foundation, "Mexico City: An Explainer," <http://kff.org/global-health-policy/fact-sheet/mexico-city-policy-explainer/>.
64. The vaginal ring is a female-controlled contraceptive that contains the same birth control hormones found in birth control pills. See U.S. Department of Health and Human Services, "Vaginal Ring," <https://www.hhs.gov/opa/pregnancy-prevention/hormonal-methods/vaginal-ring/index.html>.
65. Sayana Press is an easy-to-use injectable contraceptive that requires minimal training, making it suitable for community-based distribution and ultimately for women to self-inject. PATH is introducing it in four African countries. See PATH, "Sayana Press (DMPA-SC in Uniject) Product and Project Summary," http://sites.path.org/rh/files/2017/02/PATH_SayanaPress_proj_summary_2017.pdf.
66. We are grateful to the input of many experts, and would like to especially acknowledge the assistance from Priya Emmart and Michelle Weinberger of Avenir Health and Scott Radloff, senior scientist at the Johns Hopkins Bloomberg School of Public Health.
67. The DHS measures knowledge of contraceptive methods, current use of family planning, source of modern method, use of social marketing brands, informed choice, discontinuation rates and reasons for discontinuation, need and

demand for family planning, future use, reasons for not intending to use family planning, exposure to family planning messages, contact of nonusers with family planning providers, and partner's knowledge of family planning.

68. This is based on the assumption that baseline contraceptive prevalence in this age group will be maintained.
69. The target for Bangladesh and Nigeria is 20 percent of adolescent girls and young women.
70. Scaling Up Nutrition, "The SUN Movement Strategy and Roadmap," <http://scalingupnutrition.org/about-sun/the-sun-movement-strategy/>.
71. Andrew M. Prentice et al., "Critical windows for nutritional interventions against stunting," *American Journal of Clinical Nutrition* 97, no. 5 (May 2013): 911–918.
72. George C. Patton, "Why Focus on Adolescent Health and Wellbeing? Our future: A *Lancet* Commission on adolescent health and wellbeing" (PowerPoint presented at SPRING Webinar: Improving the Diet and Eating Practices of Adolescent Girls, September 7, 2016).
73. Parul Christian, "Investing in Adolescent Girls' Nutrition: A Second Window of Opportunity" (PowerPoint presented at SPRING Webinar: Improving the Diet and Eating Practices of Adolescent Girls, September 7, 2016).
74. Shan Soe-Lin et al., "Renewing U.S. Leadership to End Stunting: Opportunities for the Next Administration," CSIS 2016, http://vision2017.csis.org/wp-content/uploads/2016/11/sectoral_studies_nutrition.pdf.
75. Written commentary from George Patton: "The other reason is that perhaps the most important epigenetic changes happen in the first 10 weeks after conception, that is before pregnancy is often recognized and certainly before the first antenatal visit."
76. International Food Policy Research Institute, "Global Nutrition Report 2016: From Promise to Impact: Ending Malnutrition by 2030," Washington, DC, IFPRI, 2016.
77. Meera Shedkar et al., "An Investment Framework for Nutrition; Reaching the Global Targets for Stunting, Anemia, Breastfeeding, and Wasting," Washington, DC, World Bank, 2016.
78. International Food Policy Research Institute, "Global Nutrition Report 2016."
79. The majority of nutrition interventions have focused on improving maternal health, the first 1,000 days (from conception to two years of age), and child survival for those under 5 years old. Adolescent girls are virtually absent from the nutritional landscape except when pregnant. In fact, there have been very few large-scale nutrition programs targeting adolescent girls. As a result, relatively little is known about the nutritional issues affecting adolescent girls in various settings, which nutrition interventions are most efficacious, and how these interventions should be implemented.
80. Laura E. Caulfield et al., *Nutrition of Adolescent Girls and Women of Reproductive Age in Low- and Middle-Income Countries: Current Context and Scientific Basis for Moving Forward* (Arlington, VA, Strengthening Partnerships, Results, and Innovations in Nutrition Globally [SPRING], 2015), https://www.spring-nutrition.org/sites/default/files/publications/reports/spring_current_context_scientific_basis.pdf.
81. Ibid.
82. World Health Organization, "Metrics: Disability-Adjusted Life Year (DALY)," http://www.who.int/healthinfo/global_burden_disease/metrics_daly/en/. "One DALY can be thought of as one lost year of 'healthy' life. The sum of these DALYs across the population, or the burden of disease, can be thought of as a measurement of the gap between current health status and an ideal health situation where the entire population lives to an advanced age, free of disease and disability."
83. Patton, "Our future: A *Lancet* commission on adolescent health and wellbeing."
84. Ibid.
85. World Health Organization, "Anaemia," <http://www.who.int/topics/anaemia/en/>. Anemia means there is an insufficient number of oxygen-carrying capacity of red blood cells to meet physiological needs. Causes of anemia also include vitamin B12 deficiency, vitamin A deficiency, chronic inflammation, parasitic infections, and inherited disorders.
86. World Health Organization, "Global Nutrition Targets 2025 Anaemia Policy Brief," Geneva, WHO, 2014.
87. International Food Policy Research Institute, "Global Nutrition Report 2016."
88. K. Srinath Reddy, "Global Burden of Disease Study 2015 provides GPS for global health 2030," *The Lancet*, 388, issue 10053 (October 2016): 1448–49.
89. World Health Organization, "Global Nutrition Targets 2025 Anaemia Policy Brief."
90. World Health Organization, "General Assembly proclaims the Decade of Action on Nutrition," April 2016, http://www.who.int/nutrition/GA_decade_action/en/.
91. World Health Organization, "Global Nutrition Targets 2025 Anaemia Policy Brief."
92. International Food Policy Research Institute, "Global Nutrition Report 2016."
93. Ibid.
94. Meera Shekar et al., "Investing in Nutrition: The Foundation for Development," Washington, DC, World Bank, 2016.
95. Shekar, "An Investment Framework for Nutrition."
96. Ibid.

97. The World Bank included four primary interventions in their costing of this goal: iron and folic acid supplementation in women 15–59 years of age; antenatal micronutrient supplementation; intermittent presumptive treatment of malaria in pregnancy in malaria-endemic regions; and staple food fortification. While this initiative focuses on iron supplementation in adolescents, scaling up these high-impact, proven interventions in other countries and demographics likewise has the potential to deliver transformational results. Shekar, “An Investment Framework for Nutrition.”
98. Shekar, “An Investment Framework for Nutrition.”
99. Preetu Mishra and Jee Hyun Rah, “Closing the Nutrient Gap During Adolescent Pregnancies,” *Sight and Life* 30, issue 2 (2016): 93–98.
100. Scaling Up Nutrition, “The SUN Movement Strategy and Roadmap.”
101. Shekar, “An Investment Framework for Nutrition.”
102. Ibid.
103. Ibid.
104. In malaria endemic areas, intermittent preventive treatment for malaria in pregnancy (for stunting reduction as well) by providing two doses of sulfadoxine-pyrimethamine for pregnant women should be delivered as part of antenatal care.
105. World Health Organization, “Guideline: Daily Iron Supplementation in Adult Women and Adolescent Girls,” Geneva, WHO, 2016.
106. Shekar, “An Investment Framework for Nutrition.”
107. Anemia prevalence in women of reproductive age (15–49). IFPRI, “Global Nutrition Report 2016.”
108. United Nations Department of Economic and Social Affairs, Population Division, “World Population Prospects, the 2015 Revision.”
109. UNICEF, Data and Analytics, “Survey Data on Secondary Net Attendance Rate,” October 2015, <http://data.unicef.org/topic/education/overview/>.
110. Shekar, “An Investment Framework for Nutrition.”
111. Ibid.
112. Ibid.
113. Given the population size of Bangladesh and Nigeria, the goal is to achieve 50–75 percent coverage of the HPV vaccine among 20 percent of adolescent girls and young women.
114. The most recent global estimate of annual maternal deaths is 303,000, which represents a 44 percent decrease between 1990 and 2015. See “Trends in maternal mortality: 1990 to 2015: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division” (Geneva: World Health Organization, 2015), http://apps.who.int/iris/bitstream/10665/194254/1/9789241565141_eng.pdf; Katherine Peck, “The Global Experience in Addressing Cervical Cancer: CSIS Conference Summary,” June 2015, https://csis-prod.s3.amazonaws.com/s3fs-public/legacy_files/files/publication/150629_Peck_CervicalCancer_Web.pdf.
115. World Health Organization, “Options for Linking Health Interventions for Adolescents with HPV Vaccination,” Geneva, WHO, 2014.
116. Kaiser Family Foundation, “The U.S. & Gavi, the Vaccine Alliance,” March 2016, <http://kff.org/global-health-policy/fact-sheet/the-u-s-and-the-gavi-alliance/>.
117. USAID Maternal and Child Survival Project, “New Vaccine Introduction,” www.mcsprogram.org/our-work/immunization/new-vaccine-introduction/.
118. In total, Gavi has supported 23 demonstration projects, and two national introductions of the HPV vaccine. See Seth Berkley, “CEO Board update,” PowerPoint presented at Gavi Board meeting, Côte d’Ivoire, December 2016.
119. PATH, UNFPA, IARC, the Cervical Cancer Action coalition, Alliance for Cervical Cancer Prevention, vaccine manufacturers, and academe have also played critical roles as collaborating partners. For more information, see Gavi, “Human Papillomavirus Vaccine Support,” <http://www.gavi.org/support/nvs/human-papillomavirus/>.
120. Gavi’s current policy requires that countries cofinance the cost of the vaccine based on their current income level, and provides a Vaccine Introduction Grant to cover 80 percent of the start-up costs of vaccine introduction with countries covering recurrent program costs. For more information, see Celina Hanson et al., “Gavi HPV Programs: Application to Implementation,” *Vaccines* 3, no. 2 (2015): 408–19, <http://www.mdpi.com/2076-393X/3/2/408>.
121. Nine- to 13-year-old girls are the WHO-recommended primary target population for the HPV vaccine. WHO, “Human papillomavirus,” www.who.int/immunization/diseases/hpv/en/.
122. Gavi, “Human Papillomavirus Vaccine Support,” <http://www.gavi.org/support/nvs/human-papillomavirus/>; and Kaiser Family Foundation, “The HPV Vaccine: Access and Use in the U.S.,” September 2015, <http://kff.org/womens-health-policy/fact-sheet/the-hpv-vaccine-access-and-use-in/>.
123. Seth Berkley, “CEO Board Update” (PowerPoint presentation, Côte d’Ivoire, December 7, 2016).
124. National Cancer Institute, “HIV Infection and Cancer Risk,” May 2011, <https://www.cancer.gov/about-cancer/causes-prevention/risk/infectious-agents/hiv-fact-sheet#q1>.

125. Gavi, "Girl Effect and Gavi join forces with US \$10 million commitment to fight cervical cancer in developing world," October 2016, www.gavi.org/library/news/press-releases/2016/girl-effect-and-gavi-join-forces-with-usd-10-million-commitment-to-fight-cervical-cancer-in-developing-world/.
126. Laia Bruni et al., "Global estimates of human papillomavirus vaccination coverage by region and income level: a pooled analysis," *The Lancet Global Health* 4, issue 7 (July 2016).
127. Andrew Pollard, "Schedules and strategies for HPV immunization: Conclusions and proposed recommendations for SAGE" (PowerPoint presented at SAGE Meeting, Geneva, October 2016).
128. Anagha Loharikar et al., "Status of New Vaccine Introduction—Worldwide, September 2016," *Morbidity and Mortality Weekly Report* 65, issue 41 (October 2016): 1136–40.
129. Joël Ladner et al., "Performance of 21 HPV vaccination programs implemented in low and middle-income countries, 2009–2013," *BMC Public Health* 14, issue 670 (June 2014), <http://bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-14-670>; Joël Ladner et al., "Assessment of eight HPV vaccination programs implemented in lowest income countries," *BMC Public Health* 12, issue 370 (May 2012), <http://bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-12-370>.
130. PATH and London School of Hygiene and Tropical Medicine, "HPV Vaccine Lessons Learnt Project Overview," September 2016, <http://www.rho.org/HPVlessons/>.
131. It should be noted that Gavi has approved support for a HPV demonstration project in Nigeria. As of 2017, Ghana and Nigeria are classified as accelerated transition countries, meaning that they will reach the end of Gavi support and fully finance the purchase of vaccines by 2022.
132. UNICEF Supply Division, "Human Papillomavirus Vaccine Supply & Demand Update," New York, UNICEF, 2015.
133. The Bill & Melinda Gates Foundation is currently supporting efforts in India and China to produce a cheaper, second-generation vaccine, and along with the National Cancer Institute is supporting trials to demonstrate the relative efficacy of a single dose of the HPV vaccine. Both of these would work dramatically to reduce the cost of the vaccine itself, and associated delivery costs.
134. National Cancer Institute, "Benefit of fewer than three doses of HPV vaccine reported," June 2015, <https://www.cancer.gov/news-events/press-releases/2015/fewer-doses-hpv-vaccine>.
135. There are a few notable challenges that this initiative would not directly address, but are necessary to mention. First is the cost of the vaccine for non-Gavi-eligible countries. Few non-Gavi middle-income countries have implemented HPV vaccination at scale; especially for these middle-income countries, the price of the vaccine remains a barrier to introduction, but the cost savings in terms of later cancer care are tremendous. Even countries in the process of transitioning away from Gavi support are wary of introducing a new, expensive vaccine. Additionally, while Gavi may decide to expand its efforts to vaccinate multiple cohorts of girls concurrently, there are other girls in need of the vaccine who either won't qualify for the vaccine under Gavi or will require a more targeted approach, including HIV positive girls who are sexually inactive, and sexually active girls who are HPV negative. Finally, while we acknowledge that the HPV vaccine represents a valuable and underutilized tool for cervical cancer prevention, other activities such as screening remain important methods of prevention.
136. It has been recommended that country-wide introductions be phased only when the vaccine is not affordable or operational. In a review of countries that have implemented girls-only HPV vaccination programs, coverage over 50 percent has seen significant decreases in HPV 16/18 infections (68 percent). See Marc Brisson et al., "Modelling estimates of the incremental effectiveness & cost-effectiveness of HPV vaccination" (report presented at SAGE meeting, Geneva, October 2016).
137. Gavi requires DTP3 coverage of at least 70 percent, and "demonstrated ability to deliver a multi-dose vaccine to at least 50 percent of a target population of 9-13-year-old girls in an average size district." For more information, see Hanson, "Gavi HPV Programs," <http://www.mdpi.com/2076-393X/3/2/408>. A review of HPV demonstration projects (which covered 10 of our 13 target countries) recorded 50 projects able to achieve coverage of 70 percent or greater. See PATH and London School of Hygiene and Tropical Medicine, "HPV Vaccine Lessons Learnt Project Overview."
138. This represents an evolution from previous policies and demonstration projects that focused on reaching a single cohort of adolescent girls. See World Health Organization, "SAGE Meeting of October 2016," <http://www.who.int/immunization/sage/meetings/2016/october/en/>.
139. According to a recent review of Gavi-supported demonstration projects, estimated introduction costs for the HPV vaccine in low-income countries range from \$3.13 to \$5.15 for introduction costs and \$4.23 to \$5.81 for operational costs per fully immunized girl. For more information, see Hanson, "Gavi HPV Programs."
140. Gavi has indicated additional funding of \$2.40 per girl to support a number of vital introduction activities including social mobilization and technical assistance, and \$0.65 per girl to support operational costs for campaigns. See Gavi, "Vaccine introduction grants and operational support for campaigns policy," <http://www.gavi.org/about/governance/programme-policies/vaccine-introduction-grants-and-operational-support-for-campaigns/>.
141. U.S. departments, agencies, and offices expected to be engaged: State (Office of the Global AIDS Coordinator and Health Diplomacy; Office of International Women's Issues; Under Secretary for Public Diplomacy and Public Affairs; Bureau of Education and Cultural Affairs; Bureau of Population, Refugees, and Migration; Bureau of Democracy, Human Rights, and Labor; and regional bureaus); USAID (Bureau for Global Health; Bureau for Economic Growth, Education, and Environment; Youth Power; Bureau for Food Security; Senior Coordinator for Gender Equality and

- Women's Empowerment; and Bureau for Democracy, Conflict, and Humanitarian Assistance); Health and Human Services (Centers for Disease Control and Prevention and Substance Abuse and Mental Health Services Administration); Peace Corps; Millennium Challenge Corporation; Let Girls Learn; Defense; Agriculture; and Education.
142. Similar to the PEPFAR country coordinators, this position should be a senior-level, cleared U.S. position (either local eligible family member or offshore hire) able to convene the interagency, mission-wide team and communicate directly with the heads of the U.S. government departments and agencies in the mission and high-ranking representatives of the host government.
143. World Health Organization, "Global Standards for Quality Healthcare for Adolescents: A Guide to Implement a Standards-Driven Approach to Improve the Quality of Health-Care Services for Adolescents," Geneva, WHO, 2015.
144. Patton, "Our future: A *Lancet* commission on adolescent health and wellbeing."
145. According to the IFC, "lower-income women are often the primary consumers and beneficiaries of microfinance around the world." Access to key financial services and resources is key to empowering women in low-resource settings. See International Finance Corporation, "Women and Microenterprise," 2017, http://www.ifc.org/wps/wcm/connect/Topics_Ext_Content/IFC_External_Corporate_Site/Gender+Secretariat/Entrepreneurship/.
146. CSIS Task Force on Women's and Family Health, "Improving the Health of Women, Girls, and Families around the World: Will Greater Integration Get Us There? Considerations for the New Administration and Congress," CSIS, February 2017, http://vision2017.csis.org/wp-content/uploads/2017/02/cross_sectional_studies_multisectoral_integration.pdf.
147. World Health Organization, "Global Standards for Quality Healthcare for Adolescents."
148. GHI PowerPoint deck.
149. CSIS Task Force, "Improving the Health of Women, Girls, and Families."
150. PEPFAR, "DREAMS Innovation Challenge," Washington, DC, PEPFAR, 2016.
151. The Incentive Fund is a \$10 million effort with the goal of fostering innovative, locally established PPPs. For more information, see PEPFAR, "PPP Incentive Fund," <https://www.pepfar.gov/partnerships/ppp/incentivefund/index.htm>.
152. Sturchio and Schneider, "Strengthening Partnerships with the Private Sector."
153. Ibid.
154. Patton, "Our future: A *Lancet* commission on adolescent health and wellbeing," 11.
155. Dean T. Jamison et al., "Global Health 2035: A World Converging Within a Generation," *The Lancet* 382, issue 9908 (December 2013): 1898–1955.
156. Innovation can be defined as an intervention that changes the affordability, accessibility, or effectiveness of practices or tools used for prevention, diagnosis, treatment, and care or as product- or technology-based innovations (e.g., diagnostics, medical devices, vaccines, and medicines) and system-, design-, or process-focused innovations (e.g., community care design or digital health).
157. Foreignassistance.gov, "Map of Foreign Assistance Worldwide," <http://beta.foreignassistance.gov/>; Gavi, the Vaccine Alliance, "Disbursements and commitments," <http://www.gavi.org/results/disbursements/>; World Bank, "GNI per capita, Atlas method (current US\$)," 2016, <http://data.worldbank.org/indicator/NY.GNP.PCAP.CD>.
158. Certain countries that met the selection criteria were not included in this proposal due to ongoing political turbulence. Countries such as Ethiopia and Haiti might warrant inclusion in this initiative at a later date.
159. Agence Nationale de la Statistique et de la Démographie (ANSD/Sénégal) and ICF, *Sénégal: Enquête Démographique et de Santé Continue (EDS-Continue 2015)* (Rockville, MD: ANSD/Senegal and ICF, 2016), <http://www.dhsprogram.com/publications/publication-FR320-DHS-Final-Reports.cfm#sthash.4AiSuS05.dpuf>; Anemia prevalence in women of reproductive age (15–49), IFPRI, "Global Nutrition Report 2016"; Central Statistical Office/Zambia, Ministry of Health/Zambia, and ICF International, *Zambia Demographic and Health Survey 2013–14* (Rockville, MD: Central Statistical Office/Zambia, Ministry of Health/Zambia, and ICF International, 2014), <http://dhsprogram.com/publications/publication-FR304-DHS-Final-Reports.cfm#sthash.aHAaFYsU.dpuf>; Ghana Statistical Service (GSS), Ghana Health Service (GHS), and ICF International, *Ghana Demographic and Health Survey 2014* (Rockville, MD: GSS, GHS, and ICF International, 2015), <http://dhsprogram.com/publications/publication-FR307-DHS-Final-Reports.cfm#sthash.U9ZcS-JGg.dpuf>; International Agency for Research on Cancer, WHO, "Cancer Today," http://gco.iarc.fr/today/online-analysis-map?mode=cancer&mode_population=continents&population=900&sex=0&cancer=29&type=0&statistic=0&prevalence=0&color_palette=default&projection=natural-earth; Kenya National Bureau of Statistics, Ministry of Health/Kenya, National AIDS Control Council/Kenya, Kenya Medical Research Institute, National Council for Population and Development/Kenya, and ICF International, *Kenya Demographic and Health Survey 2014* (Rockville, MD: Kenya National Bureau of Statistics, Ministry of Health/Kenya, National AIDS Control Council/Kenya, Kenya Medical Research Institute, National Council for Population and Development/Kenya, and ICF International, 2015), <http://www.dhsprogram.com/publications/publication-FR308-DHS-Final-Reports.cfm#sthash.1F1LP8zl.dpuf>; Liberia Institute of Statistics and Geo-Information Services (LISGIS), Ministry of Health and Social Welfare/Liberia, National AIDS Control Program/Liberia, and ICF International, *Liberia Demographic and Health Survey 2013* (Monrovia, Liberia: LISGIS and ICF International, 2014), <http://dhsprogram.com/publications/publication-FR291-DHS-Final-Reports.cfm#sthash.AtfglGwa.dpuf>; Kerry MacQuarrie, "Unmet Need for Family Planning among Young Women: Levels and Trends," *DHS Comparative Reports* No. 34 (Rockville, MD: ICF International, 2014); Ministerio da Saude (MISAU/Moçambique), Instituto Nacional de Estatística (INE) Moçambique and ICF International, *Moçambique Inquérito Demográfico e de Saúde 2011* (Calverton, MD: MISAU/Moçambique, INE/Moçambique and ICF International, 2012), <http://dhsprogram.com>.

com/publications/publication-FR266-DHS-Final-Reports.cfm#sthash.z1s5G4Br.dpuf; Ministry of Health and Population (MOHP/Nepal), New ERA/Nepal, and ICF International, *Nepal Demographic and Health Survey 2011* (Kathmandu, Nepal: MOHP/Nepal, New ERA/Nepal, and ICF International, 2012), <http://dhsprogram.com/publications/publication-fr257-dhs-final-reports.cfm#sthash.bE6s43Y7.dpuf>; Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDGEC), Tanzania Mainland, Ministry of Health (MoH/Zanzibar), National Bureau of Statistics (NBS/Tanzania), Office of Chief Government Statistician (OCGS/Zanzibar), and ICF, *Tanzania Demographic and Health Survey and Malaria Indicator Survey* (TDHS-MIS) 2015–16 (Dar es Salaam, Tanzania: MoHCDGEC, MoH, NBS, OCGS, and ICF, 2016), <http://dhsprogram.com/publications/publication-FR321-DHS-Final-Reports.cfm#sthash.hRZYJbx.dpuf>; National Institute of Population Research and Training (NIPORT/Bangladesh), Mitra and Associates, and ICF International, *Bangladesh Demographic and Health Survey 2014* (Dhaka, Bangladesh: NIPORT, Mitra and Associates, and ICF International, 2016), <http://dhsprogram.com/publications/publication-FR311-DHS-Final-Reports.cfm#sthash.tDd38tWF.dpuf>; National Institute of Statistics of Rwanda, Ministry of Finance and Economic Planning/Rwanda, Ministry of Health/Rwanda, and ICF International, *Rwanda Demographic and Health Survey 2014-15* (Kigali, Rwanda: National Institute of Statistics of Rwanda, Ministry of Finance and Economic Planning/Rwanda, Ministry of Health/Rwanda, and ICF International, 2015), <http://dhsprogram.com/publications/publication-FR316-DHS-Final-Reports.cfm#sthash.NYPBhTGx.dpuf>; National Population Commission (NPC/Nigeria) and ICF International, *Nigeria Demographic and Health Survey 2013* (Abuja, Nigeria: NPC/Nigeria and ICF International, 2014), <http://dhsprogram.com/publications/publication-FR293-DHS-Final-Reports.cfm#sthash.aRXYrosv.dpuf>; National Statistical Office (NSO/Malawi) and ICF Macro, *Malawi Demographic and Health Survey 2010* (Zomba, Malawi: NSO/Malawi and ICF Macro, 2011), <http://dhsprogram.com/publications/publication-FR247-DHS-Final-Reports.cfm#sthash.29ydW4m9.dpuf>; Uganda Bureau of Statistics (UBOS) and ICF International, *Uganda Demographic and Health Survey 2011* (Kampala, Uganda: UBOS and ICF International, 2012), <http://dhsprogram.com/publications/publication-FR264-DHS-Final-Reports.cfm#sthash.wehhFOBB.dpuf>; UN Data “Prevalence of stunting (moderate and severe),” 2017, <http://data.un.org/Data.aspx?d=SOWC&f=inID:106#SOWC>; UNICEF, “Data on Primary Education – Completion Rates,” UNICEF Data, <http://data.unicef.org/topic/education/primary-education/>; United Nations Department of Economic and Social Affairs, Population Division, “World Population Prospects, the 2015 Revision,” <https://esa.un.org/unpd/wpp/Download/Standard/Population/>; World Bank, “Adolescent fertility rate (Births per 1,000 women ages 15–19),” <http://data.worldbank.org/indicator/SP.ADO.TFRT>; World Bank, “Maternal mortality ratio (modeled estimate, per 100,000 live births),” <http://data.worldbank.org/indicator/SH.STA.MMRT>.



1616 Rhode Island Avenue NW
Washington, DC 20036
202 887 0200 | www.csis.org

ROWMAN &
LITTLEFIELD

Lanham • Boulder • New York • London

4501 Forbes Boulevard
Lanham, MD 20706
301 459 3366 | www.rowman.com

