Corrigendum to "Counting adolescents in: the development of an adolescent health indicator framework for population-based settings"

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The authors were recently made aware of an oversight such that parts of the text in the Introduction and Methods sections, which describe shortcomings in the existing literature and the methods in this work to identify frameworks and indicators, were missing attribution to published work cited elsewhere in the manuscript.

To clarify, we adjust the relevant sections to fully attribute the prior work in three areas, as described below. Underlined text is additional to the original:

While both school- and community-based modalities can provide nationally representative data among eligible adolescents, several shortcomings in adolescent health measurement in LMICs were noted by the GAMA Advisory Group (Reference 13 as in the original paper). First, these measurements do not equally cover all adolescent subgroups, with evidence gaps being largest for males, younger adolescents aged 10–14 years, adolescents of diverse genders, ethnicities, and religions, as well as those out of school and migrants. Second, age-disaggregated data are often lacking—due in part to incomplete age coverage—limiting their use for program planning. Third, several aspects of adolescent health are inadequately covered including mental health, substance use, injury, sexual and reproductive health among unmarried adolescents, and positive aspects of adolescent health and well-being. Fourth, the definitions and assessment methods used across adolescent health indicator frameworks are inconsistent. For example, adolescent overweight and obesity—a major cause of non-communicable diseases and a public health risk for future and intergeneration health—is inconsistently captured across indicator frameworks and strikingly absent from the SDGs (Reference 13 as in the original paper). Additional shortcomings include, current adolescent health data systems often lack intersectoral coordination beyond health (e.g., with education, water and sanitation, and social protection systems) and suffer from irregularities in coverage and timing (Reference 6 as in the original paper).

Broadly, these indicator frameworks and strategy documents captured disease burden, health risks, and prominent social determinants of health during adolescence. To be congruent with the existing global recommendations and

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guidelines (References 3–7 as in the original paper) and global measurement efforts (References 10 and 16 as in the original paper), the indicator framework documents had to meet three inclusion criteria, as laid out by the GAMA Advisory Group (Reference 14 as in the original paper): (1) provide recommendations about the measurement of adolescents' health and well-being; (2) include indicators for "adolescents" covering the adolescent age range (10–19 years) in the whole or part; and (3) be global or regional in scope.

Using the GAMA's approach (Reference 13 as in the original paper), the recommendations of Lancet Adolescent Health Commission (Reference 6 as in the original paper), and several other guidelines (References 7, 9, 12, 17–19 as in the original paper), we selected adolescent health and well-being domains based on four key aspects of adolescents in LMICs: a) population trends; b) disease burden; c) drivers of health inequality; and d) opportunity for interventions.