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Disclaimer

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**List of acronyms**

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<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ASP</td>
<td>Adolescent Suicide Prevention</td>
</tr>
<tr>
<td>CBT</td>
<td>Cognitive Behavioural Therapy</td>
</tr>
<tr>
<td>CDC</td>
<td>Centre for Disease Control and Prevention</td>
</tr>
<tr>
<td>CEE</td>
<td>Central and Eastern Europe</td>
</tr>
<tr>
<td>CIS</td>
<td>Commonwealth of Independent States</td>
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<tr>
<td>DAC</td>
<td>Development Assistance Committee</td>
</tr>
<tr>
<td>EVT</td>
<td>Evaluation Team</td>
</tr>
<tr>
<td>FGD</td>
<td>Focus Group Discussion</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>HR</td>
<td>Human Resources</td>
</tr>
<tr>
<td>HRH</td>
<td>Human Resources for Health</td>
</tr>
<tr>
<td>HSP</td>
<td>Health Service Provider</td>
</tr>
<tr>
<td>IEC</td>
<td>Information, Education and Communication</td>
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<tr>
<td>KEQ</td>
<td>Key Evaluation Question</td>
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<tr>
<td>KII</td>
<td>Key Informant Interview</td>
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<tr>
<td>LTFU</td>
<td>Lost to Follow-up</td>
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<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
</tr>
<tr>
<td>MHC</td>
<td>Mental Health Centre</td>
</tr>
<tr>
<td>MoES</td>
<td>Ministry of Education and Sciences</td>
</tr>
<tr>
<td>MoH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>NCMH</td>
<td>National Centre for Mental Health</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-governmental Organisation</td>
</tr>
<tr>
<td>OECD</td>
<td>Organisation for Economic Co-operation and Development</td>
</tr>
<tr>
<td>PHC</td>
<td>Primary Health Centre</td>
</tr>
<tr>
<td>QALY</td>
<td>Quality-adjusted Life Years</td>
</tr>
<tr>
<td>RFP</td>
<td>Request for Proposal</td>
</tr>
<tr>
<td>SB</td>
<td>Suicidal Behaviour</td>
</tr>
<tr>
<td>SDV</td>
<td>Self-directed Violence</td>
</tr>
<tr>
<td>SI</td>
<td>Suicidal Ideation</td>
</tr>
<tr>
<td>SIB</td>
<td>Suicidal Ideation and Behaviour</td>
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<tr>
<td>ToC</td>
<td>Theory of Change</td>
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<tr>
<td>ToR</td>
<td>Terms of Reference</td>
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<tr>
<td>UFE</td>
<td>Utilisation-focused Evaluation</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
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<tr>
<td>YHC</td>
<td>Youth Health Centre</td>
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A challenge in suicidology and suicide prevention work has long been finding consensus around accurate and appropriate terminology to clearly define different types of thoughts and behaviours. Standardised language has been attempted by numerous agencies including the World Health Organization (WHO) and the Centers for Disease Control and Prevention (CDC) (WHO, 2014). This report intentionally uses the CDC’s recommended language around Self-directed Violence (SDV). We use this term throughout the report, and where ever possible use language that does not stigmatise suicide (Crosby, Ortega and Melanson, 2011). For instance, the term ‘to commit’ suicide is a relic from times when suicide was an illegal act, and as such, in this report we refer to suicide, death by suicide, or he/she/they suicided. A fuller explanation on language is presented in Annex 7.

Secondly, during the initial stages of the programme under evaluation, it was named ‘The Adolescent Suicide Prevention’ project, though it had wider aims to also improve adolescent mental health and well-being. At later stages, the programme named changed to reflect this wider remit to ‘The Programme on the Promotion of Adolescent Mental Health and Suicide Prevention’. Throughout this report, we refer to the ‘Adolescent Suicide Prevention’ programme, its acronym (the ASP), or simply as ‘the programme’.
Executive Summary

This evaluation reports on the findings from the pilot of the ‘The Programme on the Promotion of Adolescent Mental Health and Suicide Prevention’ in Kazakhstan. The pilot used schools-based training and awareness-raising to identify, refer and treat adolescents with mental health problems and at risk of suicide. The evaluation found that there was robust evidence that the pilot was successful in achieving its aims, with some important lessons learned to incorporate in future rounds of the programme.

Introduction

UNICEF in Kazakhstan has developed, piloted and is bringing to national scale an innovative project which seeks to reduce the risk of adolescent suicide and improve their mental health and well-being. Kazakhstan has been identified by the World Health Organization (WHO) as having some of the world’s highest suicide rates for young adults, adolescents and younger children. The issue is highly sensitive and stigmatized, which has acted as a barrier to raising the profile of the issue and implementing potential solutions.

UNICEF Kazakhstan firstly commissioned a study on prevalence, risk and protective factors of suicide in Kazakhstan in 2012-2013, followed by additional research on the Kzylorda and East Kazakhstan regions. UNICEF then developed a comprehensive pilot programme (the ‘Adolescent Suicide Prevention Project’) which ran from 2015-2017. This report presents the results from the evaluation of the pilot, but with a view to generating insights that could inform the future development of the programme as it is brought to scale across Kazakhstan, responding to the urgent public health need in Kazakhstan.

The evaluation found that there was good evidence that the ASP had made a strong contribution to a viable model to better identify and refer adolescents at risk of self-directed violence, as well as which improved indicators of mental health and well-being (such as anxiety and depression).

This evaluation is summative in nature: it was conducted once the programme ended and evaluates the programme’s changes at impact, outcome and output levels. Our recommendations are forward-looking, informing the future development of the ASP programme (which is currently being rolled out at national level), and are structured around: (i) capturing learning from the ASP pilot on UNICEF’s role and future programme implementation; (ii) how the components of the programme could be improved; and (iii) issues to consider in the scale-up and replication of the model.

Evaluation Purpose and Scope

The evaluation purpose was to (a) assess ‘the pilot’s viability as a cost-effective intervention for adolescents’ suicide prevention and mental health promotion’, and (b) ‘document the Kazakhstan experience in customizing methodologies and approaches with possible use by other countries confronting similar issues in respect to adolescents’ mortality and mental health’.

Evaluation objectives

Specific objectives of the evaluation, as presented in the ToR were to:

1. To identify the extent to which the ASP programme in Kzylorda Oblast has achieved its objectives, and the results that have been achieved to date, including any unintended results from the pilot, as well as their particularity at
outputs at the individual, household and community levels.

2. To identify the opportunities and constraints the programme has faced and draw lessons and good practices from them.

3. To assess the cost benefit of the pilot (final costing methodology depends on availability of data).

4. To identify the extent to which cross-cutting strategies such as a human-rights-based approach, results-based management and gender equity have been mainstreamed in the design and implementation of the programme.

Evaluation Methodology

The overall approach to this evaluation revolves around a theory-based design, which involved reconstructing a Theory of Change (ToC) of the programme, and developing an evaluation framework and Key Evaluation Questions (KEQs). This approach was further complemented by a mix of quantitative and qualitative methods which included: key document reviews, quantitative data analysis, qualitative data collection and analysis through: Key Informant Interviews (KIs); Focus Group Discussions (FGDs), with 120 respondents interviewed across 15 sites in Kyzylorda Oblast, excluding interviews at the central level; and a cost analysis of the ASP pilot.

Limitations

The main limitation of this evaluation is the lack of consistent and reliable data made available to the evaluation team. The strongest evidence presented in the report mostly relies on the primary qualitative data collected by the evaluation team during a country visit and is complemented by the outcome data which tracks changes in adolescents across the pilot period.

Key Findings

There is considerable and robust evidence that the pilot achieved the majority of its aims and has had a positive impact, supported by both qualitative data and the quantitative outcome data.

The reconstructed ToC presented in this report, and its accompanying narrative, have served as a useful mechanism to map the programme’s components and describe how the ASP pilot was set up and how it was meant to operate. Five key components were identified: (1) Awareness-raising materials about mental health are disseminated to adolescents, (2) Adolescents are screened for potential mental health problems, (3) Gatekeepers and health providers participate in mental health awareness-raising training, (4) A referral system is in place to provide adequate mental health services, and (5) Evidence and monitoring data is being collected and analysed.

These components were underpinned by an effective multi-sectoral collaboration, which is one of the key strengths and key successes of the programme.

The ASP pilot also contributed to increasing awareness of mental health issues among adolescents (and their parents), decision makers, gatekeepers, and health providers. The overall decrease in suicidal ideation (36.1%), depression (56.1%), anxiety (80.6%) and stress (65%) amongst all students, further suggests that the ASP pilot has also contributed to improving the mental health well-being of adolescents at risk. This is also demonstrated by 50% of students at risk reporting improved psychological well-being.

Furthermore, the programme has also clearly strengthened the skills of adolescents to cope with mental health problems and provide them with knowledge of where and how to
seek care. In this regard, the ASP pilot has been a success, however given the brief timeframe of the pilot and complexity of influencing factors, the extent to which the ASP project has contributed to reductions in adolescent suicides cannot be concluded.

Other key achievements of the programme include the strengthening of the health and education sector to address mental health needs, and the implementation of a referral mechanism for primary and mental health care. However, both of these achievements have been against a backdrop of challenges: in particular, not all gatekeepers and health providers felt that they had sufficient skills and confidence to carry out their roles, while the paucity of human resources limited the effectiveness of the referral pathway. Gaps in Human Resources (HR) also limit the effectiveness of the referral pathway.

Interestingly, the ASP pilot has also generated unexpected effects that highlighted the sociocultural and contextual factors contributing to poor mental health in adolescents. For example, household and family factors which may have contributed to poor mental health has highlighted the need for parents to be more engaged in the programme.

**Cost analysis**

UNICEF was able to leverage government resources at both federal level, for funding the pilots, and local level, in the implementation of the programme. Despite the local government costs not being included in this cost analysis, the ability of the programme to leverage these funds demonstrates good value for money and bodes well for buy-in and sustainability.

Furthermore, although there are no direct benchmark comparisons for the cost-efficiency analysis, the unit costs calculated appear to be reasonable. The total expenditure for the ASP programme was $337,287 (and targeted over 50,000 adolescents), of which, the unit cost for training master trainers was $1,148, the unit cost for reaching students with mental health awareness activities was $1.20, and the unit cost per health worker trained was approximately $333.50. If they are tracked over time, a decrease in these unit costs, demonstrating efficiency, could be used during scale-up and used for advocacy and allocation purposes. Once data on the longer-term effectiveness of the intervention becomes available, combining this with the costing data would make an even stronger case for investment.

**Recommendations**

Our recommendations are focused around three core areas that respond to the evaluation’s objectives: i) capturing learning, ii) improving programme components and iii) scaling and replication.

The evaluation found that overall, there was good evidence that the programme had resulted in identification of adolescents at risk, with referral into services and marked improvements in their mental health, as well as overall improvements in indicators of mental health and well-being (such as a reduction in anxiety and stress) among general adolescents. The recommendations below are forward looking and present issues for UNICEF to consider as the programme develops.
Capturing Learning

Recommendation One: UNICEF should strengthen evidence generation for piloting of innovative approaches, particularly in health systems, and to test what works

The EVT found that while the project had good evidence on outcomes from surveys, there was a lack of an M&E framework. As a pilot programme, more consideration of the types of evidence needed (using a careful planning approach for evidence uptake) would have been beneficial ahead of scaling. In future, UNICEF and government partners could test different types of intervention models, ahead of scaling to other areas.

Addressed to: UNICEF Kazakhstan

Recommendation Two: The programme’s core aims and objectives should be well articulated and clearly and consistently presented to all stakeholders

There was some variation in how the ASP pilot was understood and interpreted, particularly between national and local levels. This reflects the programme’s development, finding ways of framing the issue in acceptable ways. At this stage, a strong common messaging on the programme’s aims would facilitate working with and getting endorsement from stakeholder and beneficiary groups.

Addressed to: Local and central Government (MoH, MoES, DoH, DoES)

Improving Programme Components

Recommendation Three: minimise unnecessary referral to psychiatric services

While there was some evidence that the ASP has over-come GPs resistance to addressing adolescent mental health problems, it was still current practice to refer to psychiatry in almost all cases, despite the chronic shortage of psychiatrists (and their concomitant high workload) and psychiatrists’ common assessment that most adolescents did not need psychiatric intervention. This ‘erring on the side of caution’ was partly attributed to GPs’ lack of confidence in their care decision making and should be addressed through ongoing training and mentoring.

Addressed to: Health care providers, and specifically GPs

Recommendation Four: Improving treatment options for those with complex needs

The experience from the ASP found that treatment options for high risk adolescents remained limited. This includes evidence-based options, such as psychotherapy, as well as working with families with complex needs. Adolescents at risk often come from families which themselves have complex needs, and addressing a history of family suicide and/or recent childhood trauma necessitates services and competencies which are not widely available. Specialist services need to be available at local level.

Addressed to: Department of Health at Oblast level; Ministry of Health at national level

Recommendation Five: Improve access to pharmacological treatment

The ASP learnt that access to pharmacological treatment needs to be in place ahead of efforts to increase demand. Training with GPs and others is needed to over-come any resistance to prescribing, and it is vital that the local Department of Health is also prepared to ensure that there is a good
drug procurement plan in place. Future programmes should consider how these can be adequately resourced, including through national scholarship programmes. This would strengthen the availability of qualified professionals on the supply side, and help meet the demand for mental health services in the country.

Addressed to: Local and central Government (MoH, MoES, DoH, DoES)

Recommendation Six: Provide a mechanism for debriefing to carers of those at risk of suicide, so that they can receive professional support

This evaluation revealed that gatekeepers and health providers working with adolescents at risk are privy to sensitive and sometimes distressing information and often feel a heightened sense of responsibility for these adolescents. As a result, emotional burnout and anxiety over care decisions were expressed. Options such as peer support groups and one-to-one debriefs with a senior mental health professional such as a master trainer could be explored, emphasising the importance of non-judgemental disclosure of difficulties and confidentiality. Bereavement support to the care provider following the loss of an adolescent is particularly important. It is possible that support mechanisms for school psychologists, GPs, etc. may decrease the likelihood of turnover and improve confidence among practitioners.

Addressed to: Local and central Government (MoH, MoES, DoH, DoES)

Recommendation Seven: Providers and primary health care practitioners in particular should attend the training in full, to build confidence with working with those at risk

Primary evidence suggests that a number of practitioners, most commonly GPs, were unable to fully attend training days. Supporting gatekeepers and primary and mental health workers to be granted protected days/times to attend the dedicated project training sessions would reduce the risk of participants being split across duties and support their ability to gain more comprehensive knowledge and skills.

Addressed to: Health care providers, and specifically GPs

Scaling and Replication
UNICEF has already started to implement the ASP in Mangistau Oblast. The recommendations below should be considered as discussion points, for further integration into the programme. Our recommendations for scaling are structured around addressing gender and equity, ensuring systems readiness, and future models of care.

Addressing gender and equity

Recommendation Eight: Improve understanding of the gender-based norms which affect incidence of self-directed violence, and further develop a gender differentiated approach

It was commonly reported in this evaluation that gender and equity concerns were addressed through using a screening approach, which provided services equally to all groups. Patterns and drivers of suicide however are strongly gendered, including those which may prevent young men from seeking services. Ignoring gender-based norms risks ignoring important drivers of mental ill health, such as norms which stigmatize young men from seeking services, or providing services which are not sensitive to the differing needs of young men and women. Future iterations of the programme
could consider using an approach which focuses on specific drivers such as harmful gender-based norms. The M&E framework should be developed to ensure better monitoring of outcomes disaggregated by sex.

**Addressed to:** UNICEF, local and central Government (MoH, MoES, DoH, DoES)

### Ensuring systems readiness

**Recommendation Nine: Develop more differentiated screening models which can identify complex needs**

In Kazakhstan, correlates of poor mental health in adolescents operate at the individual, sociocultural and situational levels and screening measures should include items to assess risks across these. Risk factors to be included in comprehensive screening should continuously be monitored and modified based on local evidence. Current known factors include personal and family history of mental disorders and/or SIB, lack of social and peer support, recent stressful life events and/or loss, particular personality traits such as aggression and impulsivity (beyond the normal bounds of adolescence), and substance abuse in the individual or in the family.

Given the strong links between mental health and abuse, future scaling of the programme should consider, test and develop intervention models which can improve screening for risk factors, such as experiences of violence or childhood trauma.

**Addressed to:** UNICEF, local and central Government (MoH, MoES, DoH, DoES)

**Recommendation Ten: Enhance the curriculum for pre- and in-service training for educational psychologists**

School psychologists play an essential role in the implementation of the ASP model in schools and colleges. However, in the initial stage of the ASP pilot, it was observed that school psychologists’ knowledge of mental health issues and how to address them was very limited, and gaps in their university training identified. The ASP pilot component which delivered short capacity building activities to school psychologists to improve their skills and knowledge on how to deal with adolescents at risk and their families, has significantly empowered school psychologists. Nevertheless, enhancing the pre and in-service training of educational psychologists using more concrete case studies, practical approaches and improving their communication skills would strengthen the ASP approach.

**Addressed to:** Local and central Government (MoES, DoES)

**Recommendation Eleven: strengthen engagement with policy-makers and decision-makers to ensure that the mental and primary health care systems are adequately resourced to meet demand**

UNICEF’s approach was careful to work with national stakeholders and in alignment with national goals on improving mental health. However, in their role as technical specialists and advocate for child rights, UNICEF needs to work with government partners to ensure that education and health providers are resourced to meet demands and that strategic planning considers these needs ahead of increasing demand.

**Addressed to:** UNICEF, local and central Government (MoH, DoH, and national mental health agencies).

### Future Models of Care

**Recommendation Twelve: UNICEF’s role should shift from implementer to lead technical assistant, capturing what is working for adolescent mental health and well-being as the ASP goes to scale in Kazakhstan**
The issues of adolescent mental health and suicide are critically sensitive in Kazakhstan and UNICEF acted well as a catalyst for the programme set up. In future, we would recommend that UNICEF take on an advocacy and technical assistance role. This is partly due to the perception that local actors may be more appropriate and more cost-effective in providing services, but also because UNICEF now has learning and expertise which could be more appropriately used in technically assisting scaling up interventions which work for adolescent mental health. 

**Addressed to:** UNICEF Kazakhstan

**Recommendation Thirteen: continue to use local organisations as advocates and implementers of the ASP**

In Kyzylorda, the Bilim Foundation has taken over the implementation of the model since the end of the ASP pilot in 2017. This is a promising model of working with local actors to over-come stigma in accessing care, which should be further explored. The Bilim Foundation has introduced several innovations which both address wider adolescent mental health and well-being needs, such as monitoring of outcomes and electronic patient records, and life skills training for adolescents in the programme. 

**Addressed to:** UNICEF, local and national governments, local NGOs

**Recommendation Fourteen: continue to improve the use of evidence and data, particularly through a strengthened monitoring and evaluation framework**

Interventions to strengthen the use of routine monitoring data are needed at national level, and are needed so that UNICEF and the GoK can deliver an equitable approach. The development of a comprehensive M&E framework would result in a greater accountability of the health sector for results (for instance, focusing on access to follow-up care). It also presents an opportunity to build the skills of national and local champions on adolescent mental health (e.g. the National Mental Health Centre, MOES and others) to track the ASP’s effectiveness in reaching it's goals, benchmark local areas against national standards, and could be used to build ownership of delivery at oblast level. 

**Addressed to:** the Ministry of Health, the Ministry of Education, National Centre for Mental Health, Child Rights Committee at MOES.
1. Introduction

1.1 Background – Kazakhstan’s Modern Development and Health Status
Kazakhstan has achieved impressive gains in health indicators in recent years, recovering losses that it sustained during a transitional phase from Soviet rule which ended in 1990. Between 1990 and 2015, there were significant decreases in the neo-natal and under five mortality rates (from 11.1 and 21.5 per 100,000 in 2010 to 6.5 and 12.6 respectively in 2015). Trends in the age standardised mortality rate (shown in Table 1 below) show a more complex picture, with gains reversed in the last 1990s, but followed by a recovery which has nearly reached the levels experienced in 1987. This pattern is also seen in other Central Asian states.

While Kazakhstan has made a strong recovery, a number of areas still remain of concern. In an analysis in changes in the leading causes of death (in 2005 and in 2016), alcohol-related deaths (cirrhosis of the liver) increased by 28%. In 2016, alcohol related disorders were the leading cause of disability, with depressive and anxiety disorders increasing by 11.1% and 10.3% respectively since 2005. Interestingly, while overall levels of investment in the financing for healthcare in Kazakhstan has increased, the overall gap in access to quality health care has increased. The ‘Health care and Quality Access’ index measures the difference between the current access to health care and the ‘best possible scenario’. Figure 1 shows that this gap appears to be widening, which raises concerns for poor and marginal populations.

![Graph showing Healthcare Access and Quality Index, 2015]

<table>
<thead>
<tr>
<th>Year</th>
<th>Women</th>
<th>Men</th>
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<tr>
<td>1987</td>
<td>101.16</td>
<td>276.53</td>
</tr>
<tr>
<td>1997</td>
<td>178</td>
<td>421.16</td>
</tr>
<tr>
<td>2014</td>
<td>121.99</td>
<td>300.48</td>
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*Institute for Health Metrics and Evaluation (www.healthdata.org/kazakhstan)
The Government of Kazakhstan (GoK) has recognised the importance of the well-being of its population, including through ensuring the rights of women and children. It has introduced a number of reforms and policy drivers which together are intended to modernize Kazakhstan’s economy, social policy and protections, and strengthen the health system. These include the ‘Strategy Kazakhstan 2050’ and the ‘Development of Health Care - Densaulyk - for 2016-2019’. Both of these reflect the GoK’s commitment to reforming and strengthening the health and social protection systems in Kazakhstan and especially to targeting vulnerable groups. Key health systems weaknesses are noted in the Densaulyk plan, including:

- Primary health care centres are not sufficiently available or providing services
- Services (including in PHCs) are not offering quality integrated care, a reflection of previous vertical programming
- Health staff in the health system are not well distributed, with an over-staffing at higher levels and under-staffing at PHC level

Major areas for improvement include strengthening people-centred care at the PHC level, plus strengthening preventative measures (such as increasing the identification and referral of at risk populations). The ‘Strategy Kazakhstan 2050’ makes a special note of the importance of protecting women and children from violence, ensuring minimum social standards, and targeting services at ‘ill children’.

1.2 UNICEF’s Country Programme

UNICEF’s country programme has been predominantly focused at supporting the GoK to implement its ambitious reform agenda. The overall goal of UNICEF’s country office programme (2016-2020) is to support the efforts to progress towards the sustained realization of children’s rights, with particular attention to the rights of the most vulnerable children and their families. The country programme is predominantly focused at three areas:

- **Equity and inclusion for adults, children and families**: it promotes the inter-sectoral collaboration in social protection, education and health services in order to better address the needs of socially vulnerable groups
- **Promotion of child-friendly environment**: it works to prevent all forms of violence, abuse and neglect against children (and their families) including through reforming the national child care systems; supporting children’s referral to appropriate services in cases of exposure to violence, abuse and neglect among other things.
- **Innovative partnerships for children’s rights**: UNICEF’s work focuses on promoting children’s rights domestically, but also on facilitating regional and global exchange of knowledge, experience and lessons learned so that Kazakhstan can both learn from its own experience, and promote successful approaches in other countries. This workstream includes fostering a strategic cooperation with Parliament to engage the public in open discourse around children’s rights.

Box 1. *Sine qua non* checklist for quality assurance of pilot interventions

The design of a pilot should include the following elements:

1. **A Theory of Change** (ToC)
2. An equity-based **hypothesis (H)** to describe the pathways from Model to above ToC
3. Expected equity-based **Overall Results** formulated as **Child Rights Realisation**
4. **Baseline**, including equity-increasing impact indicators
5. **Sustainability/Exit Strategy** and **Termination** date agreed with partners
6. **Monitoring mechanisms**, including for process indicators, adequately funded
7. **Impact Equity Based Evaluation** clearly scheduled, budgeted for, partner-led.
8. **CBA/BIA** and estimated **Resource** for scaling up
9. **Dates and budget to document the practice**
10. Strategies and budget to **disseminate results**
11. **Total Budget** for the model.
A recent country level assessment of the UNICEF Kazakhstan office’s programme in health systems strengthening found that a strength of this office was their strategic cooperation with government actors to mainstream successful interventions and approaches. UNICEF’s role is to identify and jointly prioritize areas of public health need with the government, pilot innovative approaches that can meet those needs, and to generate insights, evidence and learning that can support the uptake of successful models. As such, the country office has a quality check-list for piloting innovations to promote wider replication.

1.3 Suicide and Mental Health in Kazakhstan

Globally, adolescent suicide and self-harm has continued to climb the agenda of governments and development organisations (McKinnon et al., 2016). Suicide is the second and fifth leading cause of death for females and males aged 10–19 years respectively, with roughly 67,000 adolescent suicides each year (WHO, 2017a). Between 1990 and 2009, the World Health Organization (WHO) had identified the Republic of Kazakhstan as having some of the world’s highest suicide rates for young adults, adolescents and younger children (WHO, 2014). Kazakhstan continued to demonstrate especially high levels of suicide mortality in 2017, though slight declines have been observed over the past two years since 2015. According to WHO, Kazakhstan’s suicide rate (at 27.5 suicides per 100,000 population) ranks second in the region and sixth globally, and far exceeds the European regional average of 14.1 deaths by suicide per 100,000.

The age-standardised suicide rate disaggregated by sex is striking, as Kazakh men/boys suicide at a rate of 48.1 per 100,000 while the female rate sits at a significantly lower 9.6 (WHO, 2017b). Evidence from 1990–2009 showed that Kazakhstan had the world’s highest suicide rate among boys aged 10–14 years and ranked fourth highest for girls of the same age. Additionally, Kazakhstan observed a marked increase in suicides in this age group for both sexes over this period (Kolves and De Leo, 2014). While the largest contributing age group to suicides in Kazakhstan is young adults between 18 and 29 years, accounting for 80% of all suicide mortality, adolescents and younger children contribute to the remaining 20% (Wasserman et al., 2014). The ‘Plan of Actions for the implementation of Development of Health Care - Densaulyk - for 2016-2019’ identifies targets for reducing suicide rates among those aged 15-17 years, aiming to achieve a rate of 16.7 per 100,000 by 2019.

Kyzylorda Oblast, the setting for the ASP pilot, witnessed a sharp increase in the number of suicides among minors prior to the pilot with six deaths in 2013 and 18 deaths in 2014 (Department of Education and Sciences (DoES), Kyzylorda Oblast, 2017). All evidence pointed towards an urgent need for comprehensive and evidence-informed interventions for the prevention of suicide (WHO, 2014). Evidence from before the ASP pilot from Kyzylorda and East

### Adolescent Mental Health and Suicide Ideation in Kazakhstan

The initial assessment of adolescent mental health in Kazakhstan, funded by UNICEF, found alarmingly high rates of mental ill-health and risk factors for suicide. The study found that:

- 26.5% of adolescents were considered at risk
- 3.3% were considered at high risk of suicide
- 4.4% had moderate or severe depression
- Access to health services was low – only 15.4% of cases in a psychological autopsy had had contact with a general practitioner

**Source:** Wasserman et al 2014
Kazakhstan Oblasts specifically highlighted the need to increase mental health literacy as well as identification of and access to treatment for at-risk individuals, including adolescents.

The international evidence on the drivers of suicide is complex: some suggest that the strongest risk factors for suicide and attempted suicide are psychopathology and adverse childhood events, such as resulting from violence in the household (Beautrais, 2000, & Dube et al, 2001). There is thus controversy about adequate responses to the prevention of suicide, with some favouring an identification, referral and treatment model, and others supporting a comprehensive social protection approach.

Both high levels of psycho-pathology and childhood trauma were said by key stakeholders to be contributory factors to adolescent suicide in Kyrgyz Oblast, and combined with the limited economic opportunities for young people in the region. Furthermore, it is important to note that prior to the ASP pilot, strong barriers existed in the region (and in Kazakhstan generally) to access mental health services. These included: the lack of a systematic mechanism for identifying adolescents at risk of suicide, the lack of a systematic and structured referral pathway for treating mental health issues, and the lack of mental health awareness among the general population which lead to strong stigma being associated with mental health issues and services. Several key informants have described the mechanisms in place to address mental health issues prior to the pilot in Kyzyrorda as being close to non-existent and was metaphorically compared to “a desert”.

1.4 UNICEF Kazakhstan’s Country Programme and Response

UNICEF’s response to the high incidence of adolescent suicide and mood disorders was launched in collaboration with the GoK, with a view to piloting approaches which could be mainstreamed into government services and scaled up to a national scale. The response was in line with both UNICEF’s and GoK’s commitment to Child Rights and increased prioritisation of adolescent mental health and well-being. This joint approach is primarily focused on using a child rights’ approach to addressing disparities and inequalities in the realisation of those rights in Kazakhstan, through better formulation and implementation of social policy. UNICEF Kazakhstan’s 2015 country office report notes that while some progress has been made, “Important social policy decisions are not always accompanied by adequate resource allocations to implement them effectively, especially at oblast and rayon level”.

The ‘Adolescent Suicide Project’ is in line with this aim of addressing inequalities in awareness of and access to effective preventative services for adolescent mental health and well-being. Very little was documented or understood about the drivers of suicide in the Kazakhstani context. The project started with the commissioning of an assessment of suicide preventive activities in Kazakhstan, particularly in the Kyzyrlda and East Kazakhstan regions (Wasserman et al., 2014). This assessment further highlighted the state of emergency for adolescent suicide in the country and the lack of an existing coordinated approach to address the issue, poor access to any services, and high levels of stigma surrounding access to treatment, compounding the severe lack of access to treatment.

UNICEF Kazakhstan and its partners developed a pilot programme to promote mental health and prevent adolescent suicide in the Kyzyrlda region that was implemented between May 2015 and
May 2017. In close collaboration with the National Centre for Mental Health of the Ministry of Health (MoH), Ministry of Education and Science and local government of Kyzylorda Oblast¹, UNICEF provided technical support and co-funding (at a cost of USD337,287) for a comprehensive school-based mental health promotion and suicide prevention programme that included the following components:

a) Identification of adolescents at risk for suicide and mental health problems with referral to health and mental health workers;
b) Gatekeeper training for school staff²;
c) Awareness-raising intervention for adolescents;
d) Building capacity of health and mental health services for management of adolescents at risk for suicide and mental health problems.

UNICEF Kazakhstan has commissioned an independent evaluation of its pilot programme on the Promotion of Adolescent Mental Health and Suicide Prevention (or Adolescent Suicide Prevention – ASP) in the Kyzylorda region to reflect back on the programme’s contribution over the pilot period. The independent evaluation, in line with the evaluators principles of independence, abides to the concepts of impartiality, accountability, credibility and confirms it has no conflict of interest in producing this evaluation. This report presents the final findings of this evaluation.

This evaluation report is presented in six parts:
• Section 1: presents the evaluation scope
• Section 2: articulates the evaluation methodology
• Section 3: presents the reconstructed Theory of Change (ToC) for UNICEF’s ASP pilot, which provides an understanding of how the pilot programme was set up and operated
• Section 4: details the key findings of this evaluation
• Section 5 and 6: provide our overall conclusions and recommendations for the UNICEF and its partners.

¹ Oblast’ is loosely translated as ‘region’ or ‘area’, and is an administrative area in Kazakhstan.
² ‘Gate-keeper’ followed the WHO definition, being a ‘person who is in a position to identify whether someone may be contemplating suicide’. This includes health providers, teachers and other school staff among others.
2. Evaluation Purpose

The main purpose of the evaluation is to assess the extent to which the pilot on ASP in Kyzylorda Oblast has contributed to promoting the mental health and reducing Suicidal Behaviour (SB) among adolescents.

This is a summative evaluation that includes considerations of possible impact of the pilot, and aims to provide UNICEF and its partners with recommendations for their further involvement in adolescent suicide prevention and mental health promotion. As per the Terms of Reference (ToR), the findings and recommendations of the evaluation assess (a) ‘the pilot’s viability as a cost-effective intervention for adolescents’ suicide prevention and mental health promotion’, and (b) ‘document the Kazakhstani experience in customizing methodologies and approaches with possible use by other countries confronting similar issues in respect to adolescents’ mortality and mental health’.

Evaluation objectives
Specific objectives of the evaluation, as presented in the ToR are:

1. To identify the extent to which the ASP programme in Kyzylorda Oblast has achieved its objectives, and the results that have been achieved to date, including any unintended results from the pilot, as well as their particularity at outputs at the individual, household and community levels.
2. To identify the opportunities and constraints the programme has faced and draw lessons and good practices from them.
3. To assess the cost benefit of the pilot (final costing methodology depends on availability of data).
4. To identify the extent to which cross-cutting strategies such as a human-rights-based approach, results-based management and gender equity have been mainstreamed in the design and implementation of the programme.

Evaluation scope

Programmatic focus:
The ToR specify that the evaluation should focus on the five criteria for evaluation stipulated by Development Assistance Committee (DAC) of the Organisation for Economic Co-operation and Development (OECD), which are:

1. Relevance;
2. Efficiency;
3. Effectiveness;
4. Impact; and
5. Sustainability.
For each criterion, the evaluation has refined and adapted Key Evaluation Questions (KEQs) and used a mix of methods to collect and analyse data, and answer the evaluation questions.

**Temporal scope:**
The evaluation covers the period during which the ASP pilot project was implemented, between May 2015 and May 2017. Nevertheless, considerations are given to the way that the pilot project has been scaled by local partners beyond May 2017, as this will generate insights into our overall evaluation question b), on documenting the Kazakhstani experiences in conducting this pilot programme.

**Geographical scope:**
In accordance with the ToR, the evaluation looks at UNICEF’s response to adolescent suicide in the Kyzylorda Oblast. This has also included meetings and data collection at central level in Astana.

**Identification and definition of the target group:**
The ASP pilot directly targeted 50,580 adolescents in the Kyzylorda region across 283 schools and 29 colleges from May 2015 to May 2017. While there are no universally accepted definitions of adolescence and youth, the United Nations understands adolescents to include persons aged 10-19 years. In the context of the ASP pilot, the adolescents who benefited from the pilot were students in the 8th, 9th and 10th form and 1st year of college, which is typically boys and girls aged 12 to 16. In addition, the evaluators recognise that secondary (and tertiary) beneficiaries of the ASP pilot include: the targeted adolescents’ parents (and to some extent their siblings), school psychologists, teachers, and health care providers.

**Implementing partners of the ASP pilot:**
The ASP pilot was initiated and implemented by UNICEF Kazakhstan with strong support from the Ministry of Health (and particularly its National Centre for Mental Health), and the Ministry of Education and Science, with contributions from the Ministry of Internal Affairs at the central level and their relevant counterpart at Regional level (i.e. the Departments of Health, Education and Internal Affairs of Kyzylorda Oblast). UNICEF took the leadership in designing, financing and implementing the pilot project in collaboration with the various Ministries who also acted as enablers to deliver this pilot. The role of UNICEF as advocates for mental health awareness and wellbeing can also not be underestimated. It is important to note that the success of this project would not have been feasible with the strong participation and collaboration of school psychologists, teachers, health care providers and to some extent students’ parents.

**Primary and secondary users of these results:**
The intended primary users of the results of this evaluation are:

- UNICEF Kazakhstan country office, as a knowledge product in contribution to international exchange and in support of UNICEF country offices in the Central and Eastern Europe (CEE)/Commonwealth of Independent States (CIS) region (given that the region is the most affected by adolescent suicide and mental health problems); and
- The National Centre for Mental Health (NCMH);
• Akimat (local government office), department of education and department of health of Kyzylorda Oblast;
• NGO Bilim Foundation;
• Direct project stakeholders, such as adolescents in the project areas, gatekeepers such as teachers, health providers and parents;
• The main GoK stakeholders for the ASP project, who include:
  o The MoH;
  o The Ministry of Education and Science (MoES);
  o Local government offices, departments of education and health of the other 15 regions of Kazakhstan (excluding Kyzylorda Oblast);
  o The Ministry of Internal Affairs (they are part of the Joint Order on the ASP nationwide implementation).

The intended secondary users of the results of this evaluation are:
• The Ministry of Foreign Affairs (to apply the experience for KazAid for overseas assistance to neighbouring countries interested in addressing suicide in adolescent and youth, and mental health promotion, like Tajikistan, Kyrgyzstan, Uzbekistan, and Belarus)
• Non-governmental Organisations (NGOs) involved in mental health promotion and suicide prevention;
• Universities in Kazakhstan involved in pre- and in-service training of psychologists, health and mental health workers;
• Academia and research entities involved in mental health/suicide related research;
• The international suicide prevention and research community, given the importance of this topic and its increasing effect on adolescents and youth throughout the world.

This includes providing insights to NGOs and NCMH, who are the main developers and implementers of the adolescent suicide prevention programme at the national level (in other regions of the country), and to UNICEF, which in 2016 started a second pilot on adolescent mental health promotion and suicide prevention in Mangystau Oblast.

2.1 Key Evaluation Questions
Table 2 presents a summary of the KEQs, signals which section of the report addresses each KEQ and assesses the evaluability of the KEQs. The table also presents the evaluation team’s assessment of the strength of evidence for each KEQ, in line with a theory-based approach. The team found that the project did not have a comprehensive Monitoring, evaluation, research and learning framework and as such, chose to develop ‘progress markers’ rather than specific indicators against each evaluation question, to indicate the types of evidence that would be considered in evaluating each question.

The evaluation also assessed the strength of evidence against the Theory of Change (ToC, see Section 3), for this evaluation.
Table 2: Evaluability assessment and strength of the evidence

<table>
<thead>
<tr>
<th>KEQs (and relevant DAC-OECD criteria)</th>
<th>Relevant sections of this report</th>
<th>Data collection methods</th>
<th>Strength of the evidence</th>
<th>Comment</th>
<th>Progress marker/Evaluation indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>How well do these outputs and outcomes contribute to preventing adolescent suicide (model of prevention)? (Relevance, effectiveness, efficiency and impact)</td>
<td>Section 4.1 Section 4.2</td>
<td>• Document review and data analysis</td>
<td>Medium</td>
<td>Lack of documented data</td>
<td>1. Key stakeholder perceptions that the ASP contributed to better mental health outcomes for adolescents 2. Trends in outcomes (number of pupils at risk identified and referred, trends in depression, anxiety and suicide ideation) 3. Perceptions of project beneficiaries that the project has contributed to better mental health outcomes 4. Evidence and data is used within the programme to improve coordination and strengthen programming 5. Key stakeholder and project beneficiary perceptions of programme benefits</td>
</tr>
<tr>
<td>What factors affected the achievement of the outputs and outcomes (in terms of implementation, partnership working, use of evidence and data?) (Efficiency and impact)</td>
<td>Section 4.1 Section 4.2</td>
<td>• Document review and data analysis</td>
<td>Medium</td>
<td>Lack of documented data</td>
<td>1. Key stakeholders and providers perceive that resourcing is sufficient to meet ASP goals 2. Evidence and data is used within the programme to improve coordination and strengthen programming 3. The programme model captures unintended effects: there is evidence of the programme model adapting to take these into account</td>
</tr>
<tr>
<td>What is the strength of evidence for each outcome? (Efficiency and effectiveness)</td>
<td>Section 4.1 Section 4.2</td>
<td>• Document review and data analysis</td>
<td>Medium</td>
<td>Lack of disaggregated data</td>
<td>1. Triangulated evidence supports the EVT’s conclusions on contribution of outputs to outcomes 2. Trends in outcomes (number of pupils at risk identified and referred, trends in depression, anxiety and suicide ideation) 3. Key stakeholder and project beneficiary perceptions of programme benefits</td>
</tr>
<tr>
<td>KEQs (and relevant DAC-OECD criteria)</td>
<td>Relevant sections of this report</td>
<td>Data collection methods</td>
<td>Strength of the evidence</td>
<td>Comment collection</td>
<td>Progress marker/Evaluation indicators</td>
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<tr>
<td>How efficiently did the ASP allocate resources for the implementation of the programme? (Efficiency and sustainability)</td>
<td>Section 4.3</td>
<td>• Document review and data analysis</td>
<td>Medium</td>
<td>Lack of documented data</td>
<td>1. Costing analysis by project component 2. Key stakeholder perceptions of level of resourcing according to their role in the project</td>
</tr>
<tr>
<td>How well has the pilot contributed to the implementation of a child rights framework (outlined in ‘general comments no.20’ and those made by the Child Rights Committee to Kazakhstan)? (Relevance)</td>
<td>Section 4.2.7</td>
<td>• Document review and data analysis  • KIs and FGD</td>
<td>Low  High</td>
<td>No documented evidence  Based on primary data collection</td>
<td>1. Gender, equity and rights of children in relation to adolescent mental health and suicide are well evidenced and understood 2. There is evidence that considerations of gender and equity has been included in the programme intervention model 3. There is an articulated gender, equity and rights strategy, in line with UNICEF’s goals</td>
</tr>
<tr>
<td>What do key stakeholders (adolescents (at risk and general), service providers, teachers, health decision-makers and others) perceive the ASP pilot’s benefits as being? (Relevance and sustainability)</td>
<td>Section 4.2</td>
<td>• KIs and FGD</td>
<td>High</td>
<td>Based on primary data collection</td>
<td>1. Key stakeholder perceptions that the ASP contributed to better mental health outcomes for adolescents 2. Perceptions of project beneficiaries that the project has contributed to better mental health outcomes 3. Key stakeholder and project beneficiary perceptions of programme benefits</td>
</tr>
<tr>
<td>KEQs (and relevant DAC-OECD criteria)</td>
<td>Relevant sections of this report</td>
<td>Data collection methods</td>
<td>Strength of the evidence</td>
<td>Comment</td>
<td>Progress marker/Evaluation indicators</td>
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</tr>
<tr>
<td>What are the cost components of the pilot which should be considered for replication? (Efficiency and sustainability)</td>
<td>Section 4.3</td>
<td>• KIIs and FGD</td>
<td>High</td>
<td>Based on primary data collection</td>
<td>1. Costing analysis by project component 2. Key stakeholder perceptions of level of resourcing according to their role in the project 3. Key stakeholders perceive the programme as being relevant and effective to national goals to address adolescent mental health 4. Key stakeholders and providers are able to implement the programme model (resources are sufficient and available; technical competence is available) 5. Key stakeholders and providers are willing to implement the ASP, as part of a local response 6. The programme has successful over-come barriers to implementation</td>
</tr>
<tr>
<td>What other factors should be considered for replication? (Relevance and sustainability)</td>
<td>Section 4.3, Section 5</td>
<td>• KIIs and FGD</td>
<td>High</td>
<td>Based on primary data collection</td>
<td>1. Costing analysis by project component 2. Key stakeholder perceptions of level of resourcing according to their role in the project 3. Key stakeholder and project beneficiary perceptions of programme benefits</td>
</tr>
</tbody>
</table>
Section Three: Evaluation Methodology

This section presents the methodology applied to this evaluation and includes: the overall approach to this evaluation (2.1), our evaluation framework and KEQ (2.2), the data collection process (2.3), the structure of the data analysis (2.4), and the limitations to this evaluation (2.5).

### 3. Overall approach to this evaluation

The overall approach to this evaluation focuses on a theory-based evaluation with a utilisation focus. A Utilisation-focused Evaluation (UFE) approach seeks to increase the uptake of evaluation findings by ensuring that the needs of the evaluation’s intended users drive the design and conduct of the evaluation. This requires: identifying the intended users early through stakeholder analysis; involving them in determining the purpose, objectives and scope; and involving them and relevant stakeholders systematically throughout the process. While this approach requires additional effort, it ensures a value-adding process and high-quality findings, conclusions and recommendations. Our evaluation approach was inspired by contribution analysis, in assessing the strength of claims against the outputs, outcomes and impacts identified for the ASP.

Given the sensitivity of suicide in Kazakhstan, and the need for evaluation findings to feed into the development of a scalable pilot, it was felt that a UFE was the most appropriate approach to deliver an insightful evaluation.

#### 3.1 Theory-based evaluation

The purpose of a theory-based design is to: (i) help the evaluation team gain a better understanding of how the programme was intending to effect change; (ii) map out the various components of the programme and its causal pathways (testing the underlying causal pathways); and (iii) inform the refinement of KEQs, data collection tools and protocols, and the evaluation process in order to test the ToC.

More specifically, key questions that a theory-based design can help answer are:

- Has the programme made a difference?
- How and why has the programme made a difference?
- What other factors needed to be present alongside the programme to produce the observed outcomes?
- Has the programme resulted in any unintended results, and if so, how?
- What factors does the programme need to consider if it is to be replicated elsewhere?
- To what extent did the programme contribute to an impact? To what extent can it be attributed to an impact?
- What was the net change caused by the intervention?
- What was the value for money of the intervention?
A UFE works with the intended users to align the KEQs to the intended audiences. It works well within a theory-based approach. Our UFE approach included mapping key stakeholders for the ASP, including them in several ToC workshops (at national and regional levels), and refining the KEQs in line with identified needs.

3.2 Assessing contribution and attribution

A theory-based design that is inspired by contribution analysis aims to increase confidence that the intervention contributed to the outcome, rather than establishing attribution and definitive proof. This method is especially useful where there is no counterfactual, and in evaluating complex programmes. It demonstrates the probability that the programme has contributed to the desired outcomes by building a well-evidenced case, and is an iterative process of collecting and analysing additional evidence over time to strengthen the contribution story. A summary of contribution analysis is provided in Annex II.

The evaluation used a range of data sources, including primary data collection, to assess the strength of contribution and attribution against each component of the ToC. For the ASP pilot programme, a baseline was conducted with a control group in Aktobe Oblast, but was found to have large differences in the sociodemographic data received and thus could not perform as a valid counterfactual. This means that the observed outcomes of the intervention cannot be thoroughly attributed to the ASP pilot programme, and require a theory-based design to measure the plausible contribution of the pilot to its desired objectives.

Another important distinction between attribution and contribution relates to the numerous factors or conditions relating to the perceived change that can be observed in this context. Attribution refers to the extent to which a programme has directly caused an outcome. However, in many cases, a programme is only one of a number of causes contributing to change, and programmes may have unintended consequences that are not captured. A theory-based design inspired by contribution analysis is a way of dealing with the attribution problem, when it is not possible to use experimental or quasi-experimental techniques to quantitatively measure the extent to which a change can be attributed to an intervention (Mayne 2008). It is therefore relevant to use a theory-based design in the context of this evaluation as the lack of a counterfactual makes the strength of attributing the observed outcomes to the ASP pilot programme weak.

3.3 Evaluation framework and KEQ

The evaluation framework has been presented in the progress report (December 2017) and is repeated in Annex 4 for information. The framework is inferred from the reconstructed ToC, which is presented in Section 3 of this report, and presents the final KEQs answered in this report, their relevance to the DAC OECD evaluation criteria (relevance, efficiency, effectiveness, impact and sustainability) as prescribed by the evaluation ToR, and data sources that have been used to answer the KEQs.

3.4 Evaluation Methods

The evaluation team conducted a rapid ‘evaluability assessment’, evaluating the availability of data
in principle (asking whether the KEQs are evaluable) and in practice (whether the data was available and in a usable format). This highlighted that while there was good baseline and endline data and a determinants analysis conducted (see Section 2.8 below on limitations), there was a lack of monitoring data. The evaluation was also a theory-based evaluation and as such, used the programme’s theory of change as the basis for mapping the causal pathways under-lying the intervention, and assessing the strength of the evidence against these.

The evaluation design focused on a mixed methods approach, supplementing primary data collection where evidence was less strong. Multiple sources of data have been gathered or newly generated and then analysed by the evaluation team. The processes of the analyses are presented separately by type of data in Table 3 for clarity.

Table 3: Types of data included in the evaluation by source

<table>
<thead>
<tr>
<th>Type of data</th>
<th>Data source</th>
<th>Contribution to the evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theory of Change workshop</td>
<td>ToC workshops with key stakeholders in Almaty and Kyzylorda</td>
<td>Mapping the causal pathways for the project, key stakeholders’ perceptions of how the project achieved change</td>
</tr>
<tr>
<td>Structured document review</td>
<td>UNICEF ASP programme documents, relevant national policy documents, previous evaluation reports and case studies</td>
<td>The structured document review fed into the programme mapping but did not include a comprehensive programme description</td>
</tr>
<tr>
<td>Survey data from the ASP programme</td>
<td>Baseline and end-line surveys on outcomes (mental health problems and disorders)</td>
<td>The survey was a pre/post design and contributed to the evaluation’s assessment of contribution to outcomes</td>
</tr>
<tr>
<td>Costing data</td>
<td>Cost data was extracted from the UNICEF financial system</td>
<td>A cost analysis provided benchmarked costs for future implementation</td>
</tr>
<tr>
<td>Qualitative interview data</td>
<td>Primary data collection with programme stakeholders in the implementation site and with key stakeholders at national level</td>
<td>Strengthening evidence of causal pathways in the ToC</td>
</tr>
</tbody>
</table>

Structured document review
We began data analysis by conducting a thorough review of documents provided by UNICEF and related sources, such as those provided by programme partners. This exercise took place throughout the lifespan of the evaluation, beginning with a desk-based assessment of the availability of data during the inception phase. We systematically mapped which data sources were readily available at the inception and ToC workshop phases, and which additional forms of data needed to be gathered or generated during field visits to complement existing evidence.

Documents reviewed by type

<table>
<thead>
<tr>
<th>Document type</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASP programme documents</td>
<td>19</td>
</tr>
<tr>
<td>Outcome evaluation data (baseline/endline)</td>
<td>2</td>
</tr>
<tr>
<td>Additional research with ASP stakeholders</td>
<td>1</td>
</tr>
<tr>
<td>Kazakhstan strategic documents</td>
<td>2</td>
</tr>
</tbody>
</table>
The team compiled a wide range of programmatic and strategic documents and extracted evidence against the KEQs and the elements of the newly constructed ToC. Materials reviewed included: global-level and regional-level documentation, such as strategic plans (including UNICEF’s strategic plans for the period of interest) and progress reports; policy, guidance, and advocacy documents; financial data; knowledge products; UNICEF staffing and reporting mechanisms; and other relevant documentation made available by UNICEF and, later, by stakeholders in the field.

**Secondary analysis of quantitative outcome data**
Baseline and follow-up survey data generated through the use of the long-version screening tool in 54 schools in Kyzylorda Oblast in 2015 and 2016, and conclusions of analyses run on these data, were provided to the evaluation team at the inception phase. These two waves of data, comprising a single dataset, are henceforth referred to as the outcome data. The evaluation team took a three-step approach to quantitative analysis of the outcome data, all of which was supported by the use of SPSS v21 (IBM). Firstly, we embarked on missing value analysis on both waves of the outcome data and attempted missing value analysis on those students who were Lost to Follow-up (LTFU) between the two waves. Secondly, descriptive statistics were produced to provide spot-checking of background characteristics, and prevalence data on outcomes such as: Suicidal Ideation (SI); suicide attempts; risk categories for depression, stress, anxiety and other mental ill-health indicators; engagement in risk behaviours; frequency of positive identification; referral; and perceived effectiveness of received treatment. Bivariate analysis and multivariate logistic regression were not employed given the nature of data and scope of this evaluation. Thirdly, and finally, findings from our independent analysis were compared to the findings produced by the international pilot academic partners of the project.

Furthermore, the EVT was also provided with the results of the “routine screening” outcome data collected in all other schools (n=283) and colleges (n=29) during Year 1 and 2 of the ASP pilot, and the resulting impact (as well as the baseline and endline data) is assessed in section 4.2.6 of this report.

**Cost analysis**
The cost analysis exercise used a bottom-up costing approach and considered only direct programme-related costs. Other costs, for example the overhead cost, have not been included in the analysis. In discussion with UNICEF, it was agreed that focusing on the direct programme costs was most relevant for answering questions around costing allocations for scale-up of the interventions.

Programme-related expenditure data was obtained from reports from the UNICEF financial system (SAP). This data was used to complete a template developed by the review team. The template was completed by the ASP programme officer. The expenditure was disaggregated under broad categories of labour and non-labour costs and presented year by year. From this data analysis, the total cost (labour and non-labour cost) per component was obtained. The output result for each of components one to four was also obtained. This was used to estimate the cost per output produced and presented in Section 4.3.2.

**Primary qualitative data**

**Sampling – Key Stakeholders, and project beneficiaries**
The evaluation team chose to purposive sampling of key informants (KIs) identified for having played key roles in the conceptualisation and implementation of the pilot. The KI list was developed in collaboration with the UNICEF programme lead and local consultant. The EVT aimed to capture a broad range of sectoral perspectives from education, health, research, governmental and non-governmental bodies at both national and sub-national levels. Inclusion criteria requires that selected KIs were professionally and directly involved in the establishment, roll-out and/or monitoring of the ASP project. Project beneficiaries included adolescents in the project area, and their parents/guardians. Teachers, school/college staff, school/college psychologists and regional level health care providers of both primary and mental health services who received gatekeeper and/or crisis management training were also interviewed. The EVT used a purposive sampling strategy but aimed to ensure representation of the region’s urban, semi-urban and rural populations, balancing the timeframe within which the evaluation team has with geographic coverage and accessibility. Finally, a random sample of gatekeepers, health providers, students, and parents who participated in the programme will be invited to participate in IDIs or FGDs from within the selected institution. In most schools, there will be only one school psychologist and/or school director, rendering this purposive selection. Additionally, adolescents deemed ‘at risk’ and who received referrals through the project will be purposively sampled based on recommendations of school/college psychologists.

3.5 Data collection process

The in-country data collection process was conducted by the Itad team between 20 November and 1 December 2017 in Astana and Kyzylorda Oblast (multiple sites). This was the opportunity to conduct two ToC reconstruction workshops, at central (Astana) and regional levels (Kyzylorda Oblast), to pilot the data collection tools and surveys, and to conduct Key Informant interviews (KIs) and Focus Group Discussions (FGDs). The process for data collection, which was presented in the progress report (December 2017) and is replicated in Annex 4, resulted in a wealth of information gathered from 120 respondents in the form of KIs and FGDs (Table 4) across 15 different sites (Table 5) in the Kyzylorda region. The process also included interviews at the central level and data collection for the cost analysis.

Table 4: Type of interviews during the data collection process

<table>
<thead>
<tr>
<th>Type of interview</th>
<th># of discussions</th>
<th># of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>FGD</td>
<td>16</td>
<td>106</td>
</tr>
<tr>
<td>Individual interviews</td>
<td>14</td>
<td>14</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>120</strong></td>
<td></td>
</tr>
</tbody>
</table>

Table 5: Sites visited in Kyzylorda Oblast during data collection

<table>
<thead>
<tr>
<th>Sites sampled</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kyzylorda Region</td>
<td>Schools</td>
</tr>
<tr>
<td></td>
<td>College</td>
</tr>
<tr>
<td></td>
<td>Primary Health Centres</td>
</tr>
<tr>
<td></td>
<td>Mental Health Centre</td>
</tr>
<tr>
<td></td>
<td>Youth Health Centre</td>
</tr>
<tr>
<td></td>
<td>DoH</td>
</tr>
</tbody>
</table>
### Sites sampled

<table>
<thead>
<tr>
<th>Category</th>
<th>Sites sampled</th>
</tr>
</thead>
<tbody>
<tr>
<td>DoES</td>
<td>1</td>
</tr>
<tr>
<td>TOTAL</td>
<td>15</td>
</tr>
</tbody>
</table>

#### 3.6 Data analysis

**Synthesis of data analysis**

Systematic analyses of qualitative data are critical to ensure transparency and that the evaluation team’s interpretations of the data are based in participants’ views. This evaluation applied a form of thematic analysis developed by Attride-Stirling (2001), which involved six steps (summarised in Annex 6) to go from the spoken text of participants (i.e. the data) to our interpretation. Basic themes – those at the lowest level, which were often derived from participants’ direct language – were organised into mid-level categories, or organising themes. Relationships between these organising themes were identified in order to finally group them into global themes, which summarised all of the issues being explored by the participants.

Qualitative analysis began concurrently with data collection in order for the evaluation team to consider the early themes emerging from interviews and FGDs and to be able to modify future interviews to probe more deeply, and to clarify, confirm and explore participants’ various views. As saturation began to set in during primary data collection, in which issues were being repeated across participants, the evaluation team was confident that a comprehensive set of themes had been gathered, data collection could stop, and post-data collection analysis could begin. Many of the interviews and FGDs were recorded, with verbatim transcripts produced, with the exception of ‘high level interviews’, such as government officials, where recording was not appropriate. Transcripts and field notes were analysed in NVivo 11 (QSR International), using a coding framework developed by the team based on a first thematic review of narrative data. As many discussions were bi- or trilingual (i.e. English with Russian and/or Kazakh), English translations of field notes and transcripts were also validated by Kazakh evaluation team members before data analysis progressed. On several occasions, member checking, or the process of re-contacting participants to request clarification or additional information, was used to confirm understanding.

The last phase of data analysis involved synthesising the evidence from across the different data sources to develop key findings and conclusions for each of the KEQs and evaluation criteria. We carefully drew together findings from the document review, the ToC workshops, the KII and FGDs, and the review of quantitative outcome data. The evaluation team examined the evidence collected to assess whether the theory operated as assumed and contributed to the desired intermediate outcomes. In order to reinforce the credibility and validity of the findings, we triangulated preliminary findings using each subset of data to identify where consensus and disagreement were observed, ultimately arriving at the conclusions of the evaluation.
3.7 Gender and Equity Analysis

Our approach to evaluating the effectiveness of ASP as a rights-based and gender-focused was based on UNICEF’s own ‘Seven Principles of a Child Rights’ Approach’. The evaluation also assessed the ASP’s inclusion of gender, and assessment of how the project’s results contribute to gender equality, and seeks to achieve transformational change. The UN’s own guidance on ‘Integrating Gender and Equity in Evaluations’ recommends assessing how the project achieves empowerment in four domains: legal, political, social and economic, but as a schools-based programme focusing on adolescents, these domains are not always relevant (with the exception of ‘social empowerment’).

Box 2 shows how Itad assesses projects and to what extent their project results have led to gender transformative change. The evaluation considered gender and equity in the following key focus areas:

1. Gender, equity and rights of children in relation to adolescent mental health and suicide are well evidenced and understood
2. There is evidence that considerations of gender and equity has been included in the programme intervention model
3. There is an articulated gender, equity and rights strategy, in line with UNICEF’s goals
4. Key stakeholder and project beneficiary perceptions of programme benefits include addressing

Gender and equity considerations were included in our methodology in the following ways:

**Evaluation design:** the evaluation team included gender and equity in the design of our methods and tools, and worked to ensure that these would capture how the project results could be assessed as empowering, and how to capture unintended and intended gender and equity consequences

**Evaluation methods:** gender and equity was included in i) the structured document review (evidence of the gender and equity drivers of suicide, and that the programme was taking these into consideration), ii) theory of change workshop (how stakeholders perceive the ASP project as addressing gender/equity), iii) outcomes analysis (reports showing the data disaggregated with determinants analysis of socio-demographic differences in outcomes), iv) primary data collection (both key stakeholder and project beneficiary interviews included questions on how the project had or had not addressed gender/equity considerations). Our analysis strategy triangulated these data streams against our gender and equity thematic framework (Box 2 above).

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3 This is available from: https://www.unicef.org.uk/child-friendly-cities/child-rights-based-approach/, accessed 15.01.18
3.8 Ethical considerations

The evaluation was conducted in strict adherence with the United Nations Evaluation Group’s (UNEG) ‘Norms and Standards for Evaluation (2016)’, as well as the ‘UNICEF procedures for Ethical Research involving Children (2013)’ which includes:

- Respect for the right of participants to provide information in confidence
- Ensuring that sensitive data is protected
- Ensuring informed consent
- Following a ‘do no harm’ principle
- Ensuring that the research benefits children
- Ensuring that the research creates space for reflection

The evaluation methodology and tools were reviewed against Itad ethical standards, however, were not submitted to Ethical Review Board approval. Itad has a statement of ethical principles and adheres to these in all the evaluations that it conducts. Following clear ethical principles, which consider and reduce the potential harm to participants from taking part in the evaluation, is particularly true in the context of this evaluation, which addresses a sensitive topic (suicide) in Kazakhstan. To do so, Itad has taken ethical measures and considerations in every step of the evaluation process. These include:

- The ethical review and validation of the data collection tools and protocols;
- Internal ethical review for the data collection process prior to piloting the data collection tools;
- The development of informed consent forms (in both Russian and Kazakh), presented to and signed by respondents, which explicitly state that respondents, should they wish to participate, are providing information of their own free will, and that all information collected through interviews will be kept anonymous; and
- Ensuring confidentiality at all stages of the process (including data and document reviews).

In the context of this evaluation, all respondents agreed to take part in the interviews and signed an informed consent form.

Furthermore, in order to ensure the anonymity of students at risk, all interviews with students at risk were conducted off the school grounds and in the Kyzylorda Youth Health Centre (YHC) on appointment. This allowed students at risk to remain anonymous in regards to their peers and to access the YHC’s mental health services before and/or after the interviews if they desired to do so. Although students at risk were interviewed individually, their parent(s) or care takers were also present at the time of the appointment and gave their written informed consent to the evaluation team before interviews were conducted with their child.

3.9 Limitations

The Request for Proposal (RFP) identified several limitations to this evaluation, which are summarised below with (when appropriate and feasible) the evaluation team’s mitigation measures.
The evaluation team has also identified further limitations, based on the information and data made available for this evaluation, and based on the logistical and timing constraints of the data collection process.

**Lack of a counterfactual and the complexity of the programme:** As explained in Section 2.1.2, the ASP pilot programme’s control group, surveyed at baseline, was deemed inappropriate. This means that an experimental or quasi-experimental design, which may have strengthened the programme’s attribution to impact, could not be performed for this evaluation. Taking this into account, the evaluation team has developed a theory-based design to measure the *contribution* of the pilot to its desired objectives.

**Availability of key documents:** Some of the key documents that would have constituted the basis for this evaluation appear not to have been produced at the time of planning and implementing the ASP pilot. These include, for example, a comprehensive Monitoring and Evaluation (M&E) framework of the intervention, and a budgeted planning document describing the set-up and process of the intervention.

**Survey data:** The survey data was not made available to the EVT in a format which allowed a determinants analysis, or evaluation of outcomes. As such, the survey data was checked for consistency with reported findings only. Survey data at baseline and follow-up offers both cross-sectional and longitudinal findings on adolescent mental health outcomes, risk and help-seeking behaviours. However, based on the data made available to the evaluation team, the ability to perform missing data analyses, specifically on those adolescents LTFU, is limited. Without this, the evaluation team is unable to conduct a determinants analysis, disaggregate the data to explore socio-demographic differences in outcomes, such as gender-based differences. A request was made to the project’s academic partners for disaggregated data for sex, age and rural/urban location. Finally, as the available survey data is on an intervention group only, and there is no control with which to make comparisons, data is limited to reporting correlation rather than causation.

**Costing data:** The analysis was unable to fully assess the pilot’s viability as a cost-effective intervention for adolescents’ suicide prevention and mental health promotion owing to the lack of comparative benchmarks for efficiency measures and unavailability of effectiveness or impact data for the intervention. Although cost data was collected, this was done retrospectively and relied on the programme management to categorise cost data to facilitate analysis. This required some assumptions to be made and therefore the data may be less robust than if cost data had been captured in sufficient detail during implementation.

**Timing of the ToC workshops:** Despite there not being one way of conducting contribution analysis, best practice would have recommended that the ToC workshops and the reconstruction of an evaluation ToC be conducted and validated prior to data collection. However, given the relatively short timeframe and the resources available for this evaluation, it was not possible to do so. Data collection was thus held immediately after the two workshops.
**Qualitative data:** Qualitative primary data gathered over the course of the country visit has provided rich insights into the perceived benefits, challenges and future possibilities of the programme. Sampling strategies have been employed to support a diverse range of insights; however, this qualitative data is not generalisable to the population of stakeholders reached by the programme in Kyzylorda or at national level.
4. The Theory of Change: Introduction

The evaluation began with a re-construction of the programme’s ‘theory of change’, which determined the evaluation framework. The ASP project had two previous theories of change, but these were not found fit for purpose for this evaluation.

The purpose of this section is to present the reconstructed ToC, based on the two ToC workshops, document reviews and KII and FGDs held in country, and describes how the ASP pilot was set up and how it was meant to operate. This is particularly useful, as the design and set-up of the programme were not systematically documented from the outset. Section 3.4 presents a visual representation of the reconstructed ToC, and Section 3.1.2 gives a description of each of the components.

4.1 Suicide Prevention and Mental Health Well-being in Kyzylorda

The Kyzylorda pilot’s school-based screening process to detect adolescents at risk of suicide identified 997, 684, and 366 youths in 2015, 2016 and 2017 respectively, over 90% of whom visited specialists for additional support following screening. At the Oblast level, ten, nine, and five known adolescent suicides occurred in the years 2015, 2016 and 2017. Across the pilot period, the number of parental refusals for child participation plummeted, and during the course of the pilot 48,754 teens participated in the screening programme in the region across 283 schools and 29 colleges. At school level, 424 psychologists were trained under the pilot, as well as 29 college psychologists (DoES, Kyzylorda Oblast, 2017). Figure 1 presents a visual timeline of the ASP pilot programme.

As nearly 40% of Kazakhstan’s population is under 25 years of age (CIA, 2017), youth-focused suicide prevention interventions are recognised by the Government of Kazakhstan as critical for addressing
the ongoing public health crisis of youth suicide. This evaluation of Kyzylorda Oblast’s ASP pilot endeavours to reflect on the successes and challenges of the pilot programme, which may help to inform future design and decision making around youth suicide prevention in Kazakhstan.

4.2 Reconstructed ToC

The purpose of reconstructing a ToC is to map out the different components of the intervention, the way they interacted to provide the desired outcomes, the assumptions that effect the outcomes of the programme and the external factors that have had an effect or might be affected by the programme (including the broader policy context and unexpected results). Figure 2 gives a visual representation of the reconstructed ToC based on in-country primary data collection.

Figure 2: Reconstructed Theory of Change

4.2.1 Goal of the ASP pilot programme

The process of reconstructing the ToC was based on two ToC workshops at central and regional levels, as well as on the responses collected during KIIs and FGDs. The result is a description of what the main objective of the project and its key components were perceived to be by stakeholders, partners and beneficiaries. Indeed, based on KII, it appeared that there was a lack of consensus on the overall goal of the project: some respondents claimed the final objective of the project was to prevent suicide in adolescents while others believed the project had a broader scope of addressing
the mental health well-being of adolescents. The analysis of data collected during the field visit shows that the majority of respondents considered the overall purpose of the programme to be:

“To achieve improved mental health among adolescents (who are then better able to self-manage their health and recognise distress in peers)”

Some respondents believed that additional goals were equally as important as improving overall mental health, while others did not mention overall mental health at all and instead offered different perceptions of the pilot’s primary purpose. Some of these additional goals included:

- to improve the mental health literacy of adolescents (and general population);
- to decrease the number of adolescent suicides; and
- to provide early prevention of suicide and early identification of risk.

In addition to being asked about their perceptions of the pilot’s purpose, respondents were also asked to describe the core components of the programme (presented as outputs in Figure 2). Of the respondent input analysed for this report, only two national-level key informants named all four components presented in the ToC. The reason for this is likely to be that respondents described components with which they were directly involved: depending on their role (as adolescent, teacher, General Practitioner (GP), etc.) they would have been reached by differing materials and techniques. However, the overall consensus across this subset of data describes four perceived components for the pilot as a whole:

1. An educational/awareness-raising component for adolescents on mental health, Suicidal Ideation and Behaviour (SIB);
2. Screening and identification of students at risk of mental ill-health and/or SIB;
3. Gatekeeper training, i.e. an educational component for psychologists at school level, teachers and other school staff, GPs and mental health providers in standalone mental health services; and
4. Referral and management of at-risk youth.

A fifth component/output has been added to the reconstructed ToC and appeared to be of particular importance for key informants at the central level, and is also believed to be a crucial aspect of the ASP pilot by the evaluation team. This fifth output relates to the use of evidence and data generated by the ASP pilot and how that is used to evaluate the ASP model and to inform the broader policy dialogues on appropriate ways to address adolescent mental health in Kazakhstan.

4.2.2 Theory of Change – narrative

Output 1: Awareness-raising materials about mental health are disseminated to adolescents

Disseminating awareness-raising materials about mental health to adolescents constitutes the premise of the ASP pilot and has set the scene for the programme to be understood and accepted. Over 50,500 students were reached by the awareness-raising component which took the form of awareness-raising sessions, led by school/college psychologists, the distribution of leaflets and the dissemination of posters to be exhibited in schools and colleges.
**Assumption**: The awareness-raising materials and sessions are appropriate, relevant and acceptable.

**Contribution to Outcomes 1 and 2**: The awareness-raising component contributed to producing a more knowledgeable and more acceptable environment for the programme to be implemented.

**Output 2: Adolescents are screened for potential mental health problems**

The screening component of the ASP pilot is a key part of the approach and is also its most controversial component. Indeed, without a systematic mechanism for identifying adolescents at risk of SIB the programme would not have been able to address the needs of those at risk. This has been achieved by the programme through the implementation of a questionnaire, which was given to students in the 8th, 9th and 10th form and 1st year college students at the beginning of the school year in all schools of Kyzylorda Oblast for both years of the pilot programme. A subset of students targeted by the questionnaire were given a long version of the questionnaire (eight pages), while the majority of students were given a shorter version (four pages). The results of the questionnaire were then analysed by school psychologists, who administered the questionnaires, and who also used a scale to assess the level of risk of each student based on their responses. If a student was assessed to be at risk, the school psychologists invited the student and his/her parents to discuss the results and to suggest a referral to a GP for a further mental health evaluation and to monitor the mental health well-being of the student.

**Assumptions**: The success of the screening process relies on two key assumptions: (i) the screening tool (questionnaire) is sensitive enough to truly identify students at risk; and (ii) stakeholders, and particularly parents, accept the screening tool to be administered to the students and understand this may lead to a referral.

**Contribution to Outcomes 1 and 2**: Screening adolescents for potential mental health problems contributes to identifying adolescents at risk, who can then be referred to access appropriate mental health services (Outcome 1), and has provided school psychologists with a systematic tool to identify students at risk, therefore strengthening the education system to address mental health problems (Outcome 2).

**Output 3: Gatekeepers and health providers participate in mental health awareness-raising training**

Training gatekeepers and health providers on mental health awareness is a crucial component of the ASP pilot. For the pilot to achieve its objectives, it is essential to have a workforce that is empowered with the skills, the tools and the confidence to address mental health problems among adolescents. Prior to the ASP pilot, very few gatekeepers and health providers felt that they had the resources and knowledge to address these problems. The training sessions were conducted at the beginning of the pilot and took the approach of a training of trainers model. Indeed, master trainers were identified, based on their competence, to receive training by international experts which they further disseminated to their peers.
Since the beginning of the pilot, there have been several refresher training courses to either complement the knowledge of gatekeepers and health providers already trained or to take into account staff turnover, with newcomers needing to be trained.

**Assumptions:** For the training to be effective, the training materials and methods need to be relevant and appropriate. It is also important that all gatekeepers and health providers involved in the programme are trained (taking into account staff turnover and refresher trainings).

**Contribution to Outcomes 1 and 2:** Training gatekeepers and health providers on mental health provides them with the right set of skills and tools to deliver appropriate mental health services to adolescents at risk (Outcome 1), and therefore contributes to strengthening the health and education systems to address mental health problems (Outcome 2).

**Output 4: A referral system is in place to provide adequate mental health services**

Raising awareness of mental health problems, screening for adolescents at risk of SIB, and training gatekeepers and health providers on mental health would not be effective without a referral system in place to provide adequate services. There are three main levels to the referral system implemented by the ASP pilot, these are:

1. First level: Based on the results of the screening process, school psychologists invite students identified as at risk and their parents to a consultation and may suggest (depending on the level of severity) to refer the student to a GP.

2. Second level: GPs are trained on how to administer and use a scale to assess the level of risk of a referred adolescent. The risk levels vary from low, to medium, to high. Students identified at low or medium risk will be monitored on a monthly basis (an approximately 20-minute consultation) by GPs for a period of 6 to 12 months. During this period, if the adolescent’s risk status improves, GPs may conclude the monthly consultations. If an adolescent’s risk status deteriorates, GPs may prescribe mental health medication or refer to a psychiatrist. All students referred to a GP and who are then assessed to be at high risk will be referred to a psychiatrist.

3. Third level: Adolescents who are assessed at a high risk by GPs (or students at low and medium risk whose status deteriorates) are referred to a psychiatrist and school psychologist. Psychiatrists will then apply corrective measures and/or prescribe psychopharmacological medication.

**Assumptions:** The effectiveness of the referral system relies on three main assumptions: (i) adolescents at risk are effectively identified; (ii) gatekeepers and health providers have the skills, the tools and the confidence to address adolescents’ mental health problems; and (iii) there are sufficient Human Resources (HR) in place throughout the referral pathway to ensure that adolescents at risk receive appropriate and timely services.

**Contribution to Outcome 2:** Having a referral system in place to provide adequate mental health services contributes to strengthening the health and education systems to address mental health problems (Outcome 2).
Output 5: Evidence and monitoring data is being collected and analysed

Collecting and analysing evidence and data from the pilot is essential to track the progress of the project, to inform its future and to inform similar interventions. Nevertheless, this appears to be the weakest component of the ASP pilot. Indeed, owing to the lack of a systematic budgeted plan and M&E framework at set-up and during the course of the project, and despite having a baseline and endline assessment, there was very little evidence of how the project had been monitored and thus factors which affected its implementation and effectiveness.

Assumption: The evidence and monitoring data collected is reliable and accurate, and is being systematically analysed and reported on.

Contribution to Outcome 3: Systematically collecting and analysing evidence and monitoring data could have contributed to supporting a model for scale-up and replication (Outcome 3).

Precondition: There is strong political will and leadership for inter-sectoral collaboration

The great majority of respondents reported that inter-sectoral collaboration was not only one of the key strengths of the ASP pilot but also one of its key achievements. Indeed, by examining the way the programme was set up (Figure 3) with three Ministries working in collaboration with UNICEF and working with gatekeepers, health providers, adolescents etc. the programme truly built momentum. Many of these groups had previously never worked together and by combining their efforts to achieve a common goal, inter-sectoral collaboration has not only put mental health on the minds of decision makers and the population of Kazakhstan, but has also demonstrated that a collaborative approach involving various sectors can be an effective way of achieving good results. It has been noted by a senior Government official that the vertical nature of Kazakhstan’s Government structure has contributed to building the political will and leadership to implement inter-sectoral collaboration.
4.2.3 Policy context

**Primary Health Care (PHC) reform:** PHC reform can play an important role in the future of the ASP pilot. The reform was officially launched in August 2017, and has formally introduced mental health services at the PHC level. Although the ASP pilot does not seem to have directly benefited from this reform, which started to be implemented after the course of the pilot, it may assist other regions of the country to emphasise the need to appropriately train PHC health staff in mental health, and can establish and strengthen the links of the referral pathway (from schools to GPs to psychiatrists). In addition, although there is little evidence apart from KIs to support this claim, the ASP pilot may have influenced PHC reform and could have been a catalyst in introducing mental health services at the primary care level. Furthermore, the results-based financing component of the PHC reform can also play a role in motivating health staff and making them more accountable for mental health services.

**Mental health reform:** The ASP pilot can also be perceived as a catalyst for ongoing mental health reform in Kazakhstan. Indeed, the mental health reform led by the National Centre for Mental Health very much relies on the experience from and the evidence generated by the programme. There is a clear opportunity for the ASP pilot to feed into the development and implementation of mental health reform, although this relies on having strong and reliable data from the pilot to justify and inform future developments.
Section Five: Evaluation Findings

5. Evaluation Findings: Over-view

This section of the report presents findings that synthesise the main evaluation workstreams to report the extent to which outcomes and their respective outputs have been achieved, and to answer the KEQs. This involves consideration for the reliability and quality of data, the strength of evidence to support the contribution story, and testing the validity of assumptions. The findings of this evaluation are structured along the evaluation criteria and assess: (i) the relevance of the ASP pilot; (ii) the effectiveness and impact of the project; and (iii) the efficiency and sustainability of the model.

Overarching KEQs:

- How well do these outputs and outcomes contribute to preventing adolescent suicide (model of prevention)?
- What factors affected the achievement of the outputs and outcomes (in terms of implementation, partnership working, use of evidence and data)?
- What is the strength of evidence for each outcome?
- How efficiently did the ASP pilot allocate resources for the implementation of the programme?
- How well has the pilot contributed to the implementation of a child rights framework (outlined in ‘general comments no.20’ and those made by the Child Rights Committee to Kazakhstan)?
- What do key stakeholders (adolescents (at-risk and general), service providers, teachers, health decision makers and others) perceive the ASP pilot’s benefits as being?
- How well does the evidence support these perceptions?
- What are the cost components of the pilot that should be considered for replication?
- What other factors should be considered for replication?

It is important to note that the findings described in Section 4 for some outputs and outcomes of interest are heavily informed by the primary qualitative data generated during the evaluation, as it emerged as the most robust evidence available to the evaluation team for many indicators. To the best extent possible, multiple sources of evidence were triangulated to form evaluation conclusions.

5.1 UNICEF Leadership and relevance of the ASP pilot to national goals

Key Findings

- The ASP pilot was particularly relevant to the context it in which it was implemented.
- The project invested in overcoming barriers to implementation, which were mostly related to stigma associated with suicide.
5.1.1 Relevance to the national context

The ASP pilot was particularly relevant to the context of Kazakhstan and intervened at a time and place where it was clearly needed. Indeed, evidence gathered prior to the set-up of the ASP model (Wasserman et al. 2014) demonstrated an urgent need to address the mental health well-being and to prevent suicide among adolescents in the Kyzylorda region. Furthermore, as mentioned in the previous section of this report, the ASP pilot has been reported by key informants to have acted as a catalyst to promote discussion on how to address mental health in the country, particularly as part of on-going mental health reform in the country. The project was therefore very relevant to its context.

5.1.2 Relevance of the awareness-raising materials (Output 1)

The awareness-raising materials developed for and used by the ASP pilot, comprised of brochures, leaflets and poster sets, were both appropriate and relevant to the intervention and the population’s needs. This conclusion is strongly supported by global standards of best practice in suicide prevention work and by participants themselves. In line with global recommendations, the ASP pilot grounds its suicide prevention within a broader context of mental health promotion among adolescents (Robinson et al., 2013). As with other demonstrably effective interventions such as the Signs of Suicide programme (Aseltine et al., 2007; Aseltine and DeMartino, 2004), the ASP pilot incorporates a complementary approach of both screening and education in its materials. In total, 68,067 brochures, 60,596 leaflets, and 27,156 sets of six posters were distributed to adolescents across 283 schools and 29 colleges during the pilot period.

There is a recommendation from global reviews of school-based interventions to measure potential distress in young people before and after the implementation of suicide-related awareness-raising components as, unlike with screening, the evidence base on the potential negative effects of education interventions on suicide is non-existent (Robinson et al., 2013). The ASP pilot did not explicitly do this. However, qualitative evidence from adolescents who participated in the pilot suggests there were no negative effects from participating in this component of the pilot, and that materials were explained to students by school psychologists.

5.1.3 Relevance of screening adolescents for potential mental health problems (Output 2)

Supported by global evidence on screening in targeted populations and the majority view of respondents involved in the intervention, there is reasonable evidence that the approach to screening used in the pilot was appropriate and largely acceptable. Global evidence on school-based screening also supports the ASP pilot’s choice to screen for a broader range of mental health as opposed to solely checking for suicide risk (Nemeroff et al., 2008). The ASP pilot also appropriately incorporated both necessary steps in the screening process, which included not only

- There is no evidence to suggest that awareness-raising materials incited distress.
- Screening adolescents for potential mental health problems was appropriate and acceptable for adolescents but was met with resistance from stakeholders and parents.
- Training materials were largely deemed appropriate; however, the format of training was reported to be a challenge by a large number of GPs.
the initial questionnaire populated by adolescents, but also the subsequent follow-up (one-on-one) assessment of young people identified as meeting a particular threshold of risk.

Attitudes towards screening received considerable attention from all respondents and generally fell into one of three categories:

1. Acceptance/indifference to screening;
2. Positive attitudes towards screening;
3. Negative attitudes towards screening.

The great majority of students interviewed by the evaluation team either accepted the screening tool or felt indifferent to it. Only one adolescent who had been identified as being at risk and needing further support had a negative attitude towards screening. Nevertheless, negative attitudes toward screening were widely reported by pilot stakeholders and parents when asked about their first impressions of the ASP pilot. Indeed, negative attitudes towards screening from pilot stakeholders initially resulted in delays and anxieties, particularly around the employment of direct questioning of students regarding their experiences of SIB. Following receipt of additional information from programme partners or through self-learning, all respondents had evolved to agree that the best way to identify these risks was to directly and clearly ask about them (the effectiveness of how the resistance was addressed by the pilot is examined in Section 4.2). On the whole, it appeared that confidentiality of data resulting from screening of adolescents and the anonymity of students were maintained across most schools we visited. Female students remarked on their preference for this anonymised screening, which facilitated honest responses, over previous tools used by school psychologists. Only one breach of confidentiality of screening data was reported to us, which occurred at the very start of the pilot.

5.1.4 Relevance of the training materials (Output 3)

There is strong qualitative evidence that training was viewed overwhelmingly as a positive experience for participants, who focused on the benefits of the format, content and impacts of the training they received. Indeed, respondents praised the interactive and collaborative nature of the ASP pilot training format, noting that materials were understandable and comprehensive, and tailored to particular roles and duties. Gatekeeper training provided by the ASP pilot included didactic learning, case vignettes, group discussions and practising active listening skills. Between 2015 and 2017, 48,315 school-based staff were trained as gatekeepers for the pilot programme. In addition, 900 school psychologist manuals were distributed across the Oblast. We are unable to confirm precise figures of GPs, psychiatrists and other Health Service Providers (HSPs) who participated in the pilot programme trainings as records were unavailable from UNICEF.

Nevertheless, many GPs reported that the format and length of the trainings posed a challenge for them to continue carrying out their duties as health care providers. According to GPs, training lasted for three days and was delivered at selected PHCs for each district. During those three days, GPs who had to travel to the selected PHCs were not able to carry out their duties, while GPs already affiliated to the selected PHCs were regularly interrupted in order to attend urgent client needs.
5.2 Effectiveness and impact of the ASP pilot

The model of intervention, being based on international best practice of implementing a school-based approach to prevent adolescent suicide, has effectively contributed to achieving the outcomes of the intervention. Some of the key factors that have affected the achievement of the desired results have been the strong political will, ownership, collaboration and leadership of the Government of Kazakhstan in implementing this pilot in the Kyzylorda region (see Section 4.1).

5.2.1 Effectiveness of the ASP pilot to address resistance

There is significant evidence that the various strategies employed by UNICEF, pilot partners, and those delivered through grassroots-level sensitisation, contributed to substantial reductions in resistance across the pilot period. Success of the pilot programme heavily rested on the acceptability and navigation of resistance encountered through the early stages of the pilot, which have almost wholly been overcome in the region to date. All respondents were asked to reflect on their first impressions and first reactions to the prospect of being involved in the pilot, and the unprompted responses all fell into one of the following categories:

1. Fear
2. Worry/nervousness
3. Shock
4. Stressed by the prospect

Key Findings

- There is considerable and robust primary evidence that the pilot achieved the majority of its aims and has had a positive impact.
- Resistance against the programme decreased significantly through the pilot period as a result of both top-down and grassroots-level sensitisation efforts.
- The screening tool effectively identified adolescents at risk but still has further areas for development.
- Gatekeeper training was overwhelmingly deemed effective in providing practical skills and confidence in addressing the mental health needs of adolescents. However, four areas for improving the training sessions have been identified.
- The majority of adolescents identified at risk were effectively referred to higher levels of care; however, the timeliness and adequacy of referrals were not consistent, and the referral system is confronted with gaps in human resources.
- The M&E component of the ASP pilot did not seem effective and is one of the weakest links of the project.
- Furthermore, the ASP pilot has also had an impact by producing additional effects, some of which were unexpected.
- Quantitative outcome data demonstrates the pilot is likely to have had an impact on reducing the number of adolescents at risk.
- However, the ASP pilot failed to demonstrate the implementation of a child rights framework, particularly with regards to gender and equity.
5. Scepticism
6. Anticipated difficulties
7. Non-specific negativity
8. Acceptance or no strong feelings.

Fear and worry received the most endorsements. Critically, however, adolescents and adults interviewed in the evaluation responded in distinctly different ways to the initial introduction of the pilot, as adolescents fell into the category of acceptance or holding no particularly strong feelings for or against the forthcoming programme in their schools, whereas adults endorsed the negative previous seven categories above. This strongly suggests that adolescents did not harbour the stigma and anxieties around discussing and exploring mental health that adults clearly held.

Attitudinal changes were brought about, according to participants, through four primary mechanisms:

1. Information
2. Training
3. Experience
4. Use of modified (softened/less sensitive) language.

While nearly all instances of refusal or resistance by parents were temporary and able to be reversed with tenacity and patience on the part of school psychologists, GPs, psychiatrists, etc. some parents could not be convinced to allow their children to take part in the programme, and on several occasions this resulted in adolescents becoming distressed. All respondents emphasised the key role of evidence-based information, tailored to different audiences, as critical for encouraging participation of stakeholders. Parents reported that had there been a greater number of awareness-raising sessions between schools and parents, and had they been held earlier in the process, it would have helped them to understand the programme even better and reduce resistance. Furthermore, they expressed that if the full package of the intervention could not be delivered in future, the awareness-raising component for parents could support improvements in parent-child discussions of mental health in the home. Overall levels of parental refusal for adolescent participation in the programme declined sharply across the two-year pilot, and as reported by an ASP pilot coordinator: ‘5% of parents refused in the first year and now they have only 1% of parents who refused’. This decline has been corroborated in project documentation.

The pilot programme was perceived by a large number of respondents to have produced strong leadership in younger professionals, particularly among school psychologists, and to have developed ‘champions’ of the programme and the wider cause of adolescent mental health. These champions hold potential for sensitising new regions early on in the intervention process to encourage buy-in of stakeholder groups, including parents, providers and gatekeepers. Avoiding long delays between being informed about the programme and forthcoming training and receiving those materials, or being signposted to initial relevant, evidence-based, albeit non-pilot, materials, could further reduce
early anxieties⁴. Early engagement with parents was proposed by mothers of participating adolescents.

5.2.2 Effectiveness of the screening tool (Output 2)

With regard to sensitivity and specificity of the tool, the majority of respondents reported confidence in the tool to effectively and accurately identify true cases of adolescents in need of extra support as a first step in assessing adolescent mental health. Indeed, 48,754 adolescents were screened through the programme across 283 schools and 29 colleges in Kyzylorda. This resulted in the identification of 997, 682, and 366 adolescents at risk of suicide in 2015, 2016 and 2017 respectively. Of those, over 90% visited specialists for additional support following screening. Screening instruments’ sensitivity and specificity to identify the ‘right’ youth are, in part, affected by what threshold of risk school personnel wish to identify. The threshold used to identify adolescents at risk changed between Waves 1 and 2, as project gatekeepers’ competencies increased. In Wave 1, adolescents were identified using a small subset of items, while in Wave 2, a broader range of survey items including use of the Strengths and Difficulties Questionnaire responses were considered. This resulted in more young people being identified at Wave 2 as a proportion of all students screened than during Wave 1 (4.5% vs. 3% respectively). Evidence shows that when the goal is to identify mental health problems more broadly and not specifically suicide risk, this lower threshold is indeed most appropriate (Scott et al., 2010). The pilot instrument also importantly included measurements at Wave 2 of screening to assess self-reported student-level health and social outcomes, measures for students who received help from gatekeepers, help-seeking and referral uptake. This is an asset of the ASP pilot’s screening as it addresses a global evidence gap on the effectiveness of gatekeeper interventions and longer-term health-related outcomes of young people picked up through the screening process (Robinson et al., 2013).

Nevertheless, the screening tool has two main areas for improvement. Two forms of the screening tool were developed; an eight-page form used in the embedded study, which captured outcome data from 54 schools, and a four-page form applied across all other participating schools in the Oblast. The study version is lengthy – some respondents believed overly so – and is comprised of a series of recognised scales for assessing depression, non-suicidal self-injurious behaviour, SIB and self-efficacy in adolescents. A recent systematic review of tools used to investigate SIB reports great diversity in available global instruments (n = 15 for SI alone) and suggests there is no ‘gold standard’ which can be applied across all populations and settings (Ghasemi et al., 2015). However, the screening tool, in either its short or long form, has two limitations. The subscales selected were piloted in East Kazakhstan in 2012 in Russian and Kazakh, and again subject to modification following piloting among adolescents in 2015 from other regions to ensure linguistic equivalence of the tool in translating the original English-language subscales into local languages. However, they were not formally validated (i.e. they did not undergo a process of screening followed by clinical diagnoses of participating adolescents in order to assess the specificity and sensitivity of each subscale). The subscales were not piloted in Kyzylorda Oblast and piloting from elsewhere in Kazakhstan was deemed sufficient to apply it in untested populations. This is not unusual, particularly in LMIC, given the resource intensity of validation research. While local trends in self-directed violence (SDV) from

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⁴ Teachers and school psychologists noted that between being told about the programme and starting training, an entire summer passed, which allowed their anxieties to grow unnecessarily.
East Kazakhstan informed selection of behavioural items included in the subscale on non-suicidal self-injurious behaviour, it is not comprehensive to capture all forms of self-harming behaviours in adolescents. Method shifting is not uncommon and trends change, sometimes rapidly, in subpopulations, particularly as adolescents have increased exposure to the internet. Method substitution may also occur – sometimes in a short space of time – particularly where interventions to restrict or discourage particular methods are trialled. Without the inclusion of any items on self-harm that explore non-tissue-damaging injury (e.g. a single item on ingestion of harmful substances of substances in harmful amounts), the tool risks under identifying adolescents at risk and misses an opportunity to track trends in methods, even those currently deemed uncommon.

5.2.3 Effectiveness of the training sessions (Output 3)

There is ample primary evidence to suggest that training – including screening of adolescents – was viewed as sufficient and fairly comprehensive. Between 2015 and 2017, 48,315 school-based staff were trained as gatekeepers for the pilot programme. In addition, 900 school psychologist manuals were distributed across the Oblast. School psychologists provided explanations for how they made decisions about triaging adolescents, and what protocols and decision-making tools they had been given or developed in order to arrive at a referral outcome. Many referred to a particular subset of items from the screening tool as markers of ‘instant referral’ and this ‘algorithm’ was provided by the pilot programme materials delivered through training and the psychologists’ manual. Psychologists were largely reliant on these materials to reach care decisions, at least until experience accumulated to reinforce their learning from training.

There is strong qualitative evidence that training was viewed overwhelmingly as a positive and effective experience for participants, who focused on the benefits of the format, content and impacts of the training they received. Gatekeeper training included didactic learning, case vignettes, group discussions and practising active listening skills. These techniques have been effective in increasing mental health and suicide literacy in GPs, mental health workers and school-based personnel. As a result of training, respondents expressed improved understanding of the importance of the intervention and increased self-efficacy and confidence to undertake their pilot responsibilities. However, as further training on how to respond to distressed students and robust referral mechanisms are critical for training to translate into practical and tangible impacts on adolescent suicide and mental health outcomes (Surgenor et al., 2016), respondents’ recommended areas for further development are presented below:

1. Receiving electronic training materials may be beneficial for two primary reasons: a) because in an increasingly technology-based age, eBooks may be deemed more accessible to busy professionals on the go, particularly in rural areas, and b) because if materials were to be sent in advance of the three-day training, they might reduce some of the anxieties experienced by certain respondents in the period between being informed of the programme and their first training. We would add that electronic training materials might complement how people learn, as some people thrive when able to familiarise themselves with topics before trainings or through enhancing and refreshing their training on their own afterwards. The new phase of the ASP project, under Bilim Foundation, will explore this.
2. Communication skills were highlighted as essential for the effectiveness of people’s roles. Additional trainings and/or time during the sessions focusing on how to communicate with students, other gatekeepers or HSPs, were requested. While the original training package and some refresher sessions offered this, participants demonstrated a thirst for even more opportunities to enhance their communication skills.

3. Participants requested that additional methodological inputs be made available during training, i.e. what tools and processes to actually use to identify and/or support at-risk adolescents in the programme, including alternatives or additions to the ones provided through the training package. This remark is based on some respondents feeling that they still lacked practical skills and confidence to support adolescents identified as being at risk.

4. Finally, rather than reflecting on the training received, some participants voiced concerns about the sustainability of training, and more specifically were concerned that the training they had received may become redundant or ‘out of date’. This was reinforced by the lack of guarantee that they will receive follow-up or further training in the future.

Training on how to address a suicide was not provided through the ASP pilot and could also strengthen the ASP model. Schools in Kyzylorda Oblast did still experience suicides during the pilot period, and as responding to a suicide had not been addressed in their training, they did not have additional guidance as to how to address the death of a student effectively and sensitively with the rest of the student body and school-based personnel. This is a final area for consideration for further training packages.

5.2.4 Effectiveness of the referral system (Output 4)

Primary data suggests that most adolescents identified as ‘at risk’ received referral and treatment within the parameters of the intended pilot system; however, the timeliness and adequacy of accessing care varied across the course of the pilot and by local area. Further, outcome data shows that nearly a quarter of adolescents referred never accessed care; however, most adolescents who did not comply with treatment regimens could not articulate why and further exploration of barriers to treatment uptake may improve access and compliance in future. Participants with relevant roles spoke at length about the referral systems in place and to what extent they felt they were working. All local referral systems involved three progressive roles, from Step 1) school psychologists, to Step 2) GPs, to Step 3) Psychiatrists, as core stakeholders for providing treatment, while adolescents were the core beneficiary. Most respondents perceived parents as integral stakeholders, largely in that they were heavily influential in whether referrals were accepted and actioned. This was acknowledged as one of the vulnerabilities of the referral system, as parental resistance (influenced by stigma), sometimes led to outright refusal to treat. School psychologists especially emphasised the slow and persistent work required to overturn parents’ decisions to forego treatment, and we learned of only a few instances where they were unsuccessful. This resistance, resulting in a treatment gap, was seemingly concentrated in the first year of the pilot, and reportedly much less common in Year 2, as both school psychologists and parents were more familiar and comfortable with the programme.

Different models of care were experimented with across the local areas, with many respondents arriving at a model of co-attendance for appointments to ensure that adolescents did not slip
through the cracks or ‘escape’, as one GP put it. Traditional onward referral had resulted in adolescents queuing for appointments to access the GP, only to give up in frustration, or failing to attend psychiatric appointments at Mental Health Centres (MHCs) as a result of stigma (largely from parents). Local pilot teams proactively addressed these gaps in the referral process by:

- Directly phoning GPs and psychiatrists to book appointments;
- Co-attending appointments with adolescents and their parents at the PHC or MHC;
- Arranging for psychiatrists to come to them to provide care.

Outcome data revealed a different picture from that described by respondents, as only 5.5% of those adolescents who received a referral reported being offered more than a one-off session. Nearly 70% of at-risk adolescents reported receiving some form of help only once, which conflicts with the suggestion from health providers and school psychologists that ongoing care and/or co-attendance at further appointments was ‘normal’. Furthermore, the overwhelming majority of respondents reported that use of medication for adolescents was rare and indeed largely unnecessary; however, outcome data showed that nearly 40% of adolescents received medication as part of their treatment package. These different recollections are possibly due, however, to adjustments made to the project in 2016 and thus reflect practices occurring at different time points in the pilot period rather than two different accounts of the same period. For example, as early referral practices revealed under-referral to psychiatry (substantiated by outcome data), recommendations were introduced by UNICEF and NCMH to refer all adolescents at risk to psychiatrists for initial assessment. This standard process to refer all adolescents at risk to psychiatry would then be adjusted as the competencies of GPs to accurately identify and triage adolescents at the PHC level improved.

Timeliness of referrals (from referral to first visit) varied significantly: some psychologists made appointments for adolescents within one to two days of reviewing them, others took up to one month. There was no articulated ‘standard turnaround’ or target for how soon referrals should be put through; however, if students indicated a history of SIB, ‘immediate referral’ was encouraged. What ‘immediate’ meant in real time, though, could vary greatly, based on the availability of GPs and psychiatrists. Psychologists, GPs and psychiatrists modified the model of care, as above, in order to offset observed delays in the early stages of the pilot.

There is substantial primary evidence, confirmed by national and regional health and education sector leadership, that HR were the weakest aspect of resourcing during the pilot programme and had an impact on the referral system. This was outside the control of UNICEF and the pilot and speaks to broader health and education system needs. Turnover was a recurrent theme with respondents, as GPs in particular were known to leave posts quickly. Rural areas also reportedly struggled to retain staff that worked, at least part of the time, on the pilot, as they preferred to become more specialised, migrate to urban areas and achieve higher salaries. Rural areas are disproportionately affected by suicides in Kyrgyzstan, which makes the reduced access to services and insufficient human resourcing ever more critical. School psychologists frequently left posts, according to the DoES, because of poor salaries. There was an overall accepted position that health sector staff were insufficient, particularly mental health specialists. There is a lack of psychiatrists
across the whole of the country, including Kyzylorda, and this was felt to impact the pilot because of the limited access to psychiatrists in the region.

There is sufficient primary evidence from core stakeholders involved in the referral and treatment of at-risk adolescents to suggest that additional training is required for GPs. Psychologists and GPs were asked when, and how often, they felt adolescents needed to be referred to the third step of the referral chain, i.e. to be seen by psychiatrists. Although there was agreement among many respondents that most adolescents could be managed at school level, it was clear that almost all GPs were referring on to psychiatry as a matter of course, sometimes leading to over-referral and excessive burdening of psychiatrists. As previously discussed, this standard practice of onward referral was in part due to recommendations based on outcome data, which showed that GPs early in the project were not referring adolescents at risk enough to ensure appropriate intervention and treatment. UNICEF and NCMH encouraged onward referral from 2016 onwards while GPs’ capacities were still being built to manage lower risk adolescents at PHC level. GPs themselves explained that this was also an exercise for them in erring on the side of caution, and appeared to partly stem from a fear of ‘getting it wrong’ and wanting a second opinion. However, it also reflected a view among several GPs that they were not trained properly to administer mental health support and were being inappropriately asked to do so, resulting in onward referral as they felt ill-equipped to take on the patient.

Beyond a dearth of particular roles, the working conditions emphasised by some respondents – and confirmed by heads of the health and education sector – revealed challenges to building and sustaining motivation during the pilot. As with human resourcing, the lack of time, excessively high overall workloads, poor salaries, and high paperwork burdens, were largely out of the control of the pilot partners and UNICEF. Several psychiatrists in particular described remarkable workloads, with one psychiatrist confirming that in addition to her usual 1000+ patients, the pilot had expanded her cases by 200 adolescents and 31 schools. Use of personal time for the pilot was common across roles. This was partly driven by scheduling challenges when trying to coordinate appointments with adolescents, which simply made after-hours appointments more feasible for all involved, and by feelings of obligation that there was no one else to provide care if they declined to see the adolescent. One GP described taking calls at any time of the day or night from students because, while she may not be the only source of support, she was the preferred source for some adolescents. Pilot duties, having been added to often already stretched workers, sometimes led to neglect of other duties, with psychiatrists reportedly faring the worst. It is worth noting, however, that as these roles were historically the purview of other sectors, some descriptions of excessive workloads may be linked with early hesitation of (particularly mental) health workers to participate in the project, which may have disproportionately overburdened ‘early adopters’ of project duties, and/or were narratives deployed by project workers to mask underlying discomfort with taking on project duties.

5.2.5 Effectiveness of collecting and analysing M&E data (Output 5)

Through assessment of documents, review of outcome data, and the rich primary data gathered during the course of this evaluation, it is evident by both what is available and what is missing that M&E has been the weakest pillar of the ASP pilot. Neither an M&E framework, nor an accurate
budgeted workplan were created at the outset of the pilot programme in design phase. M&E was emphasised to a limited extent among respondents and never raised without specifically being asked to reflect on how they had tracked progress and why particular methods were used. HSPs, school psychologists and teachers already had pre-existing requirements for documenting and tracking adolescents’ health and well-being in their roles, which many of them said they continued to use during the pilot.

However, in terms of specific M&E strategies to monitor the ASP pilot, most initiatives seemed to have emerged from the grassroots level rather than being a project requirement. For example, GPs described a follow-up mechanism put in place to track outcomes in the at-risk adolescents they treated, which was developed at facility level. Even pilot coordinators asserted that their monitoring framework was developed during the pilot through trial and error, and required changes to the usual reporting mechanism followed by schools to the DoES. Methodologists and school psychologists are responsible for data collection and submission to the coordinators on a monthly basis. They confirmed that they asked for and received guidance from UNICEF for selecting indicators, although the extent of this guidance was unclear. They have found the system they developed to be very beneficial in decision making, e.g. for human resourcing around the district, and they seemed to consider it a living system, which they intend to maintain and develop in the future.

This limits the capacity of the project to sufficiently monitor gender-disaggregated data on important outcomes, such as identification, referrals and access to treatment. There were important gender-based differences highlighted in the determinants analysis conducted with the survey data, but the lack of monitoring data limits the project’s and stakeholders’ capacity to adjust and be responsive to these gender-based differences.

There is good evidence that feedback loops from UNICEF, MoES and MoH to school and beneficiary levels did not appear to be systematised in the pilot. Instead, ad hoc feedback was described between different levels, seemingly reliant upon individual preferences and the capacity to develop mechanisms. The mid-way report, from April 2016, was shared by UNICEF with pilot coordinators and a small number of respondents, according to key stakeholders. As with M&E systems, reporting mechanisms to UNICEF evolved as the pilot matured, pilot coordinators explained. Students reported sensitive feedback from school psychologists following the screening component, and that this reassured them of fellow students’ well-being. Only one episode of breached confidentiality on the part of a gatekeeper was reported, and students felt confident that anonymity was maintained in the feedback provided by their psychologists.

5.2.6 Impact of the ASP pilot

There is considerable and robust evidence that the pilot achieved the majority of its aims and has had a positive impact, supported by both qualitative data and the quantitative outcome data. Two types of data sets for the quantitative outcome data were made available to the EVT, the “routine screening” done in all schools of the Kyzylorda region during the course of the pilot, and a more in-depth baseline (Wave 1) and endline (Wave 2) survey administered in a sub-sample of schools. The results of these are presented in the following paragraphs.
Impact demonstrated by the “routine screening” outcome data
In all 283 schools and 29 colleges that participated in the project between 2015 and 2017, a self-administered four-page questionnaire was given to all students who participated in the screening (Table 5). These questionnaires were then assessed by school psychologists to identify adolescents at risk. Following this assessments, school psychologists invited students identified at risk through the self-administered questionnaire to a semi-structured interview which aimed to triage true positives from false positive (i.e. students who were identified at risk through the questionnaire but in fact did not show significant signs of SIB, and those who were identified at risk through the self-administered questionnaire and were indeed showing signs of SIB).

Table 6 presents key figures from outcome data from the 283 schools and 29 colleges that participated in the project between 2015 and 2017.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>School Year 2015–16 (Year 1)</th>
<th>School Year 2016–17 (Year 2)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of students</td>
<td>35,074</td>
<td>15,506</td>
</tr>
<tr>
<td>Number of students who participated in screening (i.e. the self reported questionnaire)</td>
<td>33,677 (100%)</td>
<td>15,077 (100%)</td>
</tr>
<tr>
<td>Number of students identified at risk through the self-reported questionnaire</td>
<td>1128 (3.3%)</td>
<td>799 (5.3%)</td>
</tr>
<tr>
<td>Number of students identified at risk through the self reported questionnaire and who were confirmed to be at risk following a semi-structured interview with a school psychologist</td>
<td>997 (3.0%)</td>
<td>682 (4.5%)</td>
</tr>
<tr>
<td>Number of students identified at risk and referred to a GP</td>
<td>933 (2.8%)</td>
<td>501 (3.3%)</td>
</tr>
<tr>
<td>Number of students identified at risk and referred to a psychiatrist</td>
<td>246 (0.7%)</td>
<td>186 (1.2%)</td>
</tr>
<tr>
<td>Number of students at risk identified with depression</td>
<td>302 (0.9%)</td>
<td>204 (1.4%)</td>
</tr>
<tr>
<td>Number of students at risk identified with SI</td>
<td>456 (1.4%)</td>
<td>102 (0.7%)</td>
</tr>
<tr>
<td>Number of students at risk identified with suicide attempts</td>
<td>239 (0.7%)</td>
<td>91 (0.6%)</td>
</tr>
</tbody>
</table>

Source: UNICEF Kazakhstan, *Overview of adolescent suicide prevention project in Kazakhstan, (PowerPoint Presentation), June 2017 which presented findings and results from the outcome evaluation*

*Note that this data only reports from January to end of April 2017

As can be observed in Table 5, the number of students at risk identified with suicide attempts reduced throughout the course of the project, despite the number of students identified at risk through the questionnaire and those confirmed through the semi-structured interview proportionally increasing. This means that more students were identified at risk but those identified at risk with suicide attempts still reduced. Interestingly, the fact that (proportionally) more students were identified at risk in Year 2 demonstrates two further positive impacts of the project. Firstly, the data seems to suggest that the awareness raising component of the project had a very positive
impact on students who therefore felt more confident in accurately self-reporting danger signs, hence the proportional increase in adolescents identified at risk. Secondly, this improved confidence amongst students to more accurately reply to the questionnaire improved the sensitivity of the screening process. Nevertheless, it would have been useful for the project to have collected disaggregated data (by age, gender and urban/rural for example) for the routine screening process. This may have permitted the ASP pilot to have developed more focussed strategies to address the specific needs of adolescents identified at risk (e.g. a gender-based strategy).

**Impact demonstrated by the baseline and endline outcome data**
The second set of data made available to the EVT is the baseline and endline data collected through a more in-depth (8 pages long) self-administered questionnaire in a sub set of 54 participating schools. The more lengthy questionnaire allowed to measure a greater number of outcomes (such as more socio-demographic data and a disaggregation by gender) and permitted a more thorough analysis, as presented in the Kyzylorda Follow Up Report. This sample survey involved 4,839 students from school grades 8 to 10 at baseline and 3,748 of these completed the endline survey. The difference in number (which equates to 77.45% retention) can be explained by the fact that some students who were part of the baseline sample had graduated by the time the endline survey was conducted and were therefore LTFU. These LTFU were not included in the denominator for the outcome results at endline. From a research perspective, it would have been interesting to have a LTFU analysis to highlight potential differences in outcomes for those students who graduated. Nevertheless, from a programmatic perspective, the baseline/endline outcome data confirms the positive impact the ASP pilot seems to have had on the mental well-being of adolescents. Table 7 presents the disaggregated data for the selected sample of the impact study (baseline/endline).

**Table 7: Disaggregated data for the selected sample of the impact study (ABC Form Analysis, 2017)**

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>Baseline 2015–16</th>
<th>Follow Up 2016–17</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General or demographic data</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total number of schools participating</td>
<td>54</td>
<td>54</td>
</tr>
<tr>
<td>Including rural:</td>
<td>43</td>
<td>43</td>
</tr>
<tr>
<td>Including urban:</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>Total number of students participated in impact assessment of the ASP programme</td>
<td></td>
<td>3,748</td>
</tr>
<tr>
<td>Including males:</td>
<td>1,667 (44.5%)</td>
<td></td>
</tr>
<tr>
<td>Including females:</td>
<td>2,059 (54.9%)</td>
<td></td>
</tr>
<tr>
<td>Including rural:</td>
<td>2,573 (68.6%)</td>
<td></td>
</tr>
<tr>
<td>Including urban:</td>
<td>1,175 (31.4%)</td>
<td></td>
</tr>
</tbody>
</table>

As can be seen in the table above, a larger number of rural versus urban schools, and therefore students, participated in the study. Nevertheless, there were no statistically significant difference in outcomes for students from a rural or urban setting. For clarity and conciseness, the following outcome tables therefore exclude the rural versus urban disaggregation.
Table 8 presents the disaggregated data by gender for students who were identified with depression, anxiety, stress and lifetime suicide attempts. It also presents the decreased levels observed at endline for each of these outcomes.

Table 8: Disaggregated data for all students who participated in the study (ABC form analysis)

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>Baseline 2015–16</th>
<th>Follow Up 2016–17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of students identified with depression (mild, moderate, severe and extremely severe):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Including males:</td>
<td>265 (7.1%)*</td>
<td>205 (5.5%)**</td>
</tr>
<tr>
<td>Including females:</td>
<td>94 (5.6%)</td>
<td>71 (4.3%)</td>
</tr>
<tr>
<td>* one student with missing gender</td>
<td>** two students with missing gender</td>
<td></td>
</tr>
<tr>
<td>Number of students reported on decreased level of depression (out of total reported depression at baseline)</td>
<td>217 (81.9%)*</td>
<td></td>
</tr>
<tr>
<td>Including males:</td>
<td>81 (86.2%)</td>
<td></td>
</tr>
<tr>
<td>Including females:</td>
<td>135 (79.4%)</td>
<td></td>
</tr>
<tr>
<td>* one student with missing gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of students identified with anxiety (mild, moderate, severe and extremely severe):</td>
<td>480 (12.8%)*</td>
<td>320 (8.5%)*</td>
</tr>
<tr>
<td>Including males:</td>
<td>163 (9.8%)</td>
<td>101 (6.1%)</td>
</tr>
<tr>
<td>Including females:</td>
<td>314 (15.3%)</td>
<td>216 (10.5%)</td>
</tr>
<tr>
<td>* three students with missing gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of students reported on decreased level of anxiety (out of total reported anxiety at baseline)</td>
<td>417 (86.9%)</td>
<td></td>
</tr>
<tr>
<td>Including males:</td>
<td>142 (87.1%)</td>
<td></td>
</tr>
<tr>
<td>Including females:</td>
<td>272 (86.6%)</td>
<td></td>
</tr>
<tr>
<td>Number of students identified with stress (mild, moderate, severe and extremely severe):</td>
<td>167 (4.5%)</td>
<td>124 (3.3%)*</td>
</tr>
<tr>
<td>Including males:</td>
<td>46 (2.8%)</td>
<td>34 (2%)</td>
</tr>
<tr>
<td>Including females:</td>
<td>120 (5.8%)</td>
<td>87 (4.2%)</td>
</tr>
<tr>
<td>* three students with missing gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of students reported on decreased level of stress (out of total reported stress at baseline)</td>
<td>146 (87.4%)</td>
<td></td>
</tr>
<tr>
<td>Including males:</td>
<td>43 (93.5%)</td>
<td></td>
</tr>
<tr>
<td>Including females:</td>
<td>103 (85.8%)</td>
<td></td>
</tr>
<tr>
<td>Number of students identified with lifetime suicide attempts:</td>
<td>28 (0.7%)</td>
<td></td>
</tr>
<tr>
<td>Including males:</td>
<td>4 (0.2%)</td>
<td></td>
</tr>
<tr>
<td>Including females:</td>
<td>24 (1.2%)</td>
<td></td>
</tr>
</tbody>
</table>

The table clearly demonstrates relatively high prevalence of depression, anxiety, stress and lifetime suicide attempts among the study sample, and further justifies the need for the ASP intervention. Furthermore, the endline data also demonstrates the positive impact the ASP project appears to have had on the mental well-being of adolescents. Indeed, the number of students who reported decreased levels of depression, anxiety, and stress were 81.9%, 86.9%, and 87.4% respectively at
endline. Overall, it can also be said that the prevalence for these outcomes was observed to have decreased during the endline survey and may be an indication that the ASP project not only contributed to decrease depression, anxiety and stress, but may also have had a protective effect. Nevertheless, it is important to keep in mind that although the 2 year ASP pilot seems to have had a positive effect on the mental well being of adolescents, these outcomes may fluctuate during the lifetime of young people, and efforts to promote mental health awareness and well-being should be maintained, improved and potentially scaled up.

Interestingly, there appears to be a difference in outcomes between young males and females. Indeed, for all the outcomes presented in Table 8, female adolescents reported higher prevalence rates compared to their male counterparts. This may be an indication that young females are more vulnerable and more affected by depression, anxiety and stress. Furthermore, the difference between males and females identified with lifetime suicide attempts appears to be significant, with 1.2% females and 0.2% males reporting an attempt. As these outcomes were self-reported by the students, it would have been interesting to further research the difference in outcome between the two genders. For example, in the context of a strong patriarchal society, such as is the case in Kyzylorda Oblast, it may be that males are less inclined to report a lifetime suicide attempt.

Amongst all students who participated in the impact study, a further 4.8% were identified to be at risk, and Table 9 presents the disaggregated data by gender against outcomes of students at risk. As per the outcomes from the total sample of students, more female students were identified to be at risk compared to males, but with greater decreases in suicidal ideation amongst females.

Table 9: Disaggregated data for students who were identified at risk (ABC Form analysis)

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>Baseline 2015–16</th>
<th>Follow Up 2016–17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of students identified at risk</td>
<td>180 (4.8%)</td>
<td></td>
</tr>
<tr>
<td>Including males:</td>
<td>59 (3.5%)</td>
<td></td>
</tr>
<tr>
<td>Including females:</td>
<td>121 (5.9%)</td>
<td></td>
</tr>
<tr>
<td>Number of adolescents at risk with reported on decreased suicidal ideation (out of total number of adolescents at risk)</td>
<td>65 (36.1%)</td>
<td>14 (23.7%)</td>
</tr>
<tr>
<td>Including males:</td>
<td>14 (23.7%)</td>
<td>51 (42.1%)</td>
</tr>
<tr>
<td>Number of adolescents at risk reported on decreased depression (out of total number of adolescents at risk)</td>
<td>101 (56.1%)</td>
<td>31 (52.5%)</td>
</tr>
<tr>
<td>Including males:</td>
<td>31 (52.5%)</td>
<td>70 (57.9%)</td>
</tr>
<tr>
<td>Number of adolescents at risk reported on decreased anxiety (out of total number of adolescents at risk)</td>
<td>145 (80.6%)</td>
<td>39 (66.1%)</td>
</tr>
<tr>
<td>Including males:</td>
<td>39 (66.1%)</td>
<td>106 (87.6%)</td>
</tr>
<tr>
<td>Number of adolescents at risk reported on decreased stress (out of total number of adolescents at risk)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Including males:</td>
<td></td>
<td>37 (62.7%)</td>
</tr>
<tr>
<td>Including females:</td>
<td></td>
<td>80 (66.1%)</td>
</tr>
</tbody>
</table>

Number of students identified at risk

Including males: 59 (3.5%)
Including females: 121 (5.9%)

Number of adolescents at risk with reported on decreased suicidal ideation (out of total number of adolescents at risk)

Including males: 14 (23.7%)
Including females: 51 (42.1%)

Number of adolescents at risk reported on decreased depression (out of total number of adolescents at risk)

Including males: 31 (52.5%)
Including females: 70 (57.9%)

Number of adolescents at risk reported on decreased anxiety (out of total number of adolescents at risk)

Including males: 39 (66.1%)
Including females: 106 (87.6%)

Number of adolescents at risk reported on decreased stress (out of total number of adolescents at risk)
Nevertheless, the overall decrease in suicidal ideation (36.1%), depression (56.1%), anxiety (80.6%) and stress (65%) amongst all students, further suggests that the ASP pilot has also contributed to improving the mental health well-being of adolescents at risk. This is also demonstrated by 50% of students at risk reporting improved psychological well-being.

What is particularly interesting amongst students identified at risk is the fact that young females systematically reported a proportionally higher decrease in outcomes (and increased psychological well-being) compared to their male counterparts. This observation would suggest that young females are either more resilient and/or that the ASP project has more strongly and more positively affected the well-being of female adolescents than males. The difference in gender for these outcomes is particularly noteworthy for prevalence of anxiety and suicide ideation.

In conclusion, the impact study with disaggregated data has been invaluable in spotting what appears to be systematic differences in outcomes by gender, with females being more affected with negative outcomes but interestingly more resilient for those identified at risk. Further research could have been and should be done to elucidate the nature and cause for these gender differences. More importantly, these results should be taken into account to develop a gender strategy to improve the impact and effectiveness of the ASP intervention.

The evaluation team found that outcome data were appropriately disaggregated and capable of reporting against a number of key outcomes (Tables 6 and 7). For example, the provided dataset allows for identification of gender differences in mental health status and intervention effectiveness, and gauging of changes in mean values for mental disorders, including suicidal behaviour, between the two time points. Equally, the dataset allows for checking adolescents’ beliefs on barriers to mental health support at follow-up and their satisfaction with the programme, reporting behaviours and interactions with teachers/psychologists, reported compliance with referral methods and perceived effectiveness of referrals.

The data was verified through re-running descriptive analyses. Overall, we conclude the original figures are accurate enough within an acceptable margin of error to be used as evidence for the programme’s impact. As such, we present a subset of substantive findings from the latest analysis of outcome data (updated December 2017) to demonstrate project effects.

**Suicidal ideation and behaviour outcomes**

At the core of the ASP pilot, suicidal ideation (SI) and suicidal behaviour (SB) were targeted with hopes of encouraging reductions in both experiences. Outcome data show that SI significantly
reduced in students at follow-up, and this reduction was particularly strong among female students (Table 10). The data below presents differences in psychological states, using different tests.

**Table 10. Differences between baseline and follow-up suicidal ideation among males and females**

<table>
<thead>
<tr>
<th></th>
<th>Male Mean ± SD</th>
<th>Female Mean ± SD</th>
<th>Total Mean ± SD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Baseline</td>
<td>Follow up</td>
<td>Baseline</td>
</tr>
<tr>
<td></td>
<td>0.10±0.75</td>
<td>0.08±0.58</td>
<td>0.26±1.27</td>
</tr>
</tbody>
</table>

*Results of paired samples t-test where *p < 0.001  **p < 0.01  
*Source: ABC Form, Kyzylorda follow-up report (December 2017)*

There is evidence that adolescents reporting a 12-month history of suicide attempts at Wave 1, did not go on to re-attempt by follow-up and that all reported cases of suicide attempts at Wave 2 were first attempts. There was not a statistically significant reduction between Waves 1 and 2 (0.5% and 0.4% incidence respectively), however no new cases at Wave 2 reported requiring medical treatment following their attempt, whereas roughly 17% of cases at Wave 1 were medically serious enough to need medical care. This may indicate reduced lethality of new attempts by follow-up. Several students reporting suicide attempts at Wave 2 were identified as ‘at risk’ at Wave 1 screening, however did not receive timely referral and support.

Confirmed suicides in Kyzylorda Oblast among minors have reduced or remained stable year-on-year since 2009, with the exception of 2013, which, as an outlier, experienced 18 known cases (Kazakhstan Committee of Statistics and General Prosecutor Office, n.d.). During the pilot period, 7 and 6 suicides in minors (15 to 17 years of age) were confirmed in Kyzylorda in 2015 and 2016 respectively, and 2017 saw only one case. Taking these additional data into consideration alongside outcome data demonstrating that suicidal behaviours are rare events in this population at both time points, conclusions from statistical analysis are subject to sparse data bias (Greenland et al., 2016). That is, these behaviours are too rare to identify risk factors common to the adolescents and in the case of outcome data, it is too short a time period to accurately draw conclusions about trends and the role of the ASP in affecting any observed changes. However, the overall picture is one of stability if not slight improvement.

**Related mental health outcomes**

Outcome data explored changes in symptoms of depression, anxiety and stress between Waves 1 and 2, all of which are known correlates to suicidal ideation and behaviour in this population. Table 7 presents results. Positively, both anxiety and stress symptomology decreased significantly for both males and females between the two-time points. Reductions in depressive symptomology were not statistically significant. This may reflect that anxiety and stress can be modified through individually adopted behaviours – some of which were taught through the project – more easily than depressive symptoms, which may require a more complex intervention involving mental health providers, or could indicate a more chronic nature to adolescents’ depressive symptoms compared to anxiety and stress which may be responding more acute and short-lived triggers. Despite the depressive scores not being statistically significant overall, scores for adolescents at risk did show substantively meaningful reductions.
Table 7. Depression, anxiety and stress – Differences between baseline and follow-up among males and females

<table>
<thead>
<tr>
<th></th>
<th>Male Mean ± SD</th>
<th>Female Mean ± SD</th>
<th>Total Mean ± SD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Baseline</td>
<td>Follow up</td>
<td>Baseline</td>
</tr>
<tr>
<td>Depression</td>
<td>2.13±3.55</td>
<td>2.02±3.53</td>
<td>2.70±4.18</td>
</tr>
<tr>
<td>Anxiety</td>
<td>2.08±3.86</td>
<td><strong>1.51±3.17</strong></td>
<td>3.24±5.07</td>
</tr>
<tr>
<td>Stress</td>
<td>2.97±4.33</td>
<td><strong>2.40±4.03</strong></td>
<td>4.51±5.68</td>
</tr>
</tbody>
</table>

* Paired samples t-test, p < 0.001
Source: ABC Form, Kyzylorda follow up report (December 2017)

Assessing outcome data for adolescents at risk specifically, we observe even more marked improvements in their mental health and functioning compared to the overall sample. This suggests elements of the pilot project may have contributed to reductions in risk by the time they were screened at Wave 2. We are not able to isolate the extent to which improvements are attributable to the project overall nor a specific component of the project (e.g. awareness raising, access to a health professional, etc.), however it suggests these adolescents may have benefitted from the project more than the general student population. Table 8 presents Wave 1 and 2 mean scores for six of the survey subscales (males and females combined).

Table 8. Differences between baseline and follow-up for adolescents at risk across six pathological scales

<table>
<thead>
<tr>
<th>Adolescents at risk Mean ± SD</th>
<th>Baseline</th>
<th>Follow up (in 12 months)</th>
</tr>
</thead>
<tbody>
<tr>
<td>WHO well-being index (WHO-5)</td>
<td>17.55±5.91</td>
<td><strong>19.06±5.27</strong> ***</td>
</tr>
<tr>
<td>Depression Anxiety Stress Scale (DASS-21):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>9.40±7.56</td>
<td><strong>5.08±5.70</strong> *</td>
</tr>
<tr>
<td>Anxiety</td>
<td>15.21±8.37</td>
<td><strong>5.42±6.05</strong> *</td>
</tr>
<tr>
<td>Stress</td>
<td>14.7±8.24</td>
<td><strong>6.89±6.85</strong> *</td>
</tr>
<tr>
<td>Paykel Suicide Scale</td>
<td>2.12±3.92</td>
<td><strong>0.41±1.40</strong> *</td>
</tr>
<tr>
<td>Deliberate Self-Harm Inventory (DSHI)</td>
<td>1.59±2.03</td>
<td><strong>0.39±0.91</strong> *</td>
</tr>
<tr>
<td>Strengths and Difficulties Questionnaire (SDQ):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotional problems</td>
<td>3.68±2.48</td>
<td><strong>1.76±1.94</strong> *</td>
</tr>
<tr>
<td>Conduct problems</td>
<td>2.79±1.73</td>
<td><strong>1.94±1.50</strong> *</td>
</tr>
<tr>
<td>Hyperactivity</td>
<td>3.44±1.99</td>
<td><strong>2.34±1.93</strong> *</td>
</tr>
<tr>
<td>Peer problems</td>
<td>3.26±1.81</td>
<td><strong>2.34±1.69</strong> *</td>
</tr>
<tr>
<td>Prosocial behaviour</td>
<td>6.78±1.53</td>
<td><strong>6.09±1.95</strong> *</td>
</tr>
<tr>
<td>Total difficulties</td>
<td>13.06±5.74</td>
<td><strong>8.34±5.09</strong> *</td>
</tr>
<tr>
<td>CRAFFT</td>
<td>0.19±0.58</td>
<td><strong>0.03±0.21</strong> *</td>
</tr>
</tbody>
</table>

Results of paired samples t-tests where * p < 0.001    ** p < 0.01    *** p < 0.05
Source: ABC Form analysis, Kyzylorda follow up report (December 2017)

In addition to the changes presented above, outcome data also showed that, while rare to begin with, alcohol and drug use were significantly less common at follow-up. This may reflect true reductions or changes in reporting, however as these are particularly important risk factors for SIB among males, and social and general health and wellbeing outcomes for all students, these are promising early findings to be tracked over time.
Outcome data suggest adolescents’ perceptions of barriers to help-seeking were reduced between the two time points, more strongly for adolescents at risk. Of those who accessed care and complied with treatment, 80% reported feeling much better. However, as other sections of this report highlight, there were challenges and delays in referrals and uptake of referrals, particularly at the beginning of the pilot. Outcome data demonstrate very high levels of acceptance for the project’s school-based approach (97.2%), interest in topics presented through the awareness raising component (95.3%), and acceptability of screening as a mechanism for identifying young people at risk of poor mental health outcomes (95.8%).

Impact demonstrated through qualitative evidence
Qualitative data collected during the in-country visit revealed the extent to which respondents felt that anticipated effects – that is, goals they expected the pilot to achieve – actually had been reached, and many of these are supported by the outcome data presented above. This needs further validation in future waves of the ASP. Each of the effects below materialised according to at least two types of respondent, reinforcing one another’s claims that these changes were observed to some extent because of the programme:

1. Prevention of suicides/SB;
2. Prevention of mental disorders, such as anxiety and depression;
3. Improvement of overall mental health;
4. Improvements of children’s physical health;
5. Development/acquisition of coping skills;
6. Providers/gatekeepers increasing understanding of disorder-specific knowledge;
7. Identification of others in need of support;
8. Knowledge of sources of support;
9. Improved relationships between students and school personnel.

The vast majority of respondents emphasised changes in the first four items, and particularly the prevention of suicides in adolescents. Several stories, confirmed by multiple sources, illustrated how school psychologists came to be seen as principal sources of support for adolescents in distress through the pilot programme and ultimately interrupted episodes of SDV. Outcome data also reported significant reductions in SI, although this effect was stronger for females. This suggests that there are gender-based differences in outcomes, particularly for boys, which need further investigation.

Relationships between students and members of the school staff, particularly psychologists, have improved during the pilot, and students understood at least one clear source of support available to them, which they may not have known or utilised previously. Students, gatekeepers and GPs all remarked on how adolescents’ abilities to cope had improved through the course of the pilot period, and this is corroborated by outcome data that suggests improvements in anxiety and stress symptomatology following the pilot (although this finding needs further validation through

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5 This is not surprising as females reportedly experience SI more than males globally. This is the result of a combination of exposure to risk factors, biological differences, and higher likelihood to report mental health issues than men.
longitudinal data). Modifications in behaviour were observed in multiple groups, generally for their benefit, including changes to help-seeking, parenting, and adolescent–parent dynamics in the household. Improvements in help-seeking among adolescents are further evidenced by outcome data showing, for example, increased use of helplines following the pilot. However, outcome data also showed continued barriers to help-seeking that required sustained attention, such as entrenched beliefs that they should self-manage difficulties and scepticism around adults’ abilities to maintain confidentiality. Despite these enduring challenges, all respondents, including beneficiaries, spoke about modified pro-mental health attitudes in parents, students and those within the health and education sectors.

**Perhaps some of the richest evidence from participants themselves revolved around the multiple positive effects perceived by them to be additional or unanticipated.** Some of these, particularly items 1, 2 and 4, were expected by UNICEF and the expert technical advisors who had previous experience in implementing such interventions elsewhere. Elements of items 1, 2 and 4 were incorporated into training and awareness raising materials which sensitised participants to the relationships between mental health and dimensions of adolescents’ school experience. However, for a number of beneficiaries and project staff in Kyzylorda, the following were viewed as bonuses to the core effects they expected to see:

1. Improved sociability/peer relationships;
2. Improved performance in school;
3. Improved coping with aggression;
4. Reductions in bullying;
5. Overall self-development;
6. Support for groups not targeted by the pilot;
7. Support from parents;
8. Use of pilot evidence for planning;
9. Catalyst for changes in other areas of social development;
10. Improved status of school psychologists;
11. Development of strong leadership/champions.

Students talked about how they enjoyed making new friends during the awareness-raising sessions and improved their ability to detect and support friends and schoolmates with problems. Gatekeepers reported some cases of students identified as at risk displaying improvements in their school performance following referral and treatment. A number of participants shared examples of when the tools, skills and referral mechanisms developed for the pilot were applied to children outside the target population of the pilot, including accounts of intervention for those as young as eight years old. One psychiatrist reported improvements in criminal behaviour (i.e. theft) following treatment of a student from the pilot, while two psychologists shared observations of reduced bullying and borderline ‘criminal’ behaviour on the part of older classmates, who were stealing from younger students.

The pilot programme was perceived by a large number of respondents to have produced strong leadership in younger professionals, particularly among school psychologists, and to develop
‘champions’ of the programme and the wider cause. This is perhaps best evidenced by the recent 100 Kazakhs given awards by the President for their service to the country, one of whom was a coordinator of the programme from the education sector and head of a unit in the local in-service training centre. She has been supported to participate in national-level awareness-raising efforts and policy discussions and to attend international conferences on SIB and mental health.

Finally, the pilot programme helped to uncover previously underexplored social and familial issues in the region, such as childhood trauma, sexual and domestic violence, alcoholism etc. as these emerged consistently as common factors in the lives of at-risk adolescents. By forcing a spotlight on these equally challenging circumstances, dialogues between agencies, including the police, have been kick-started in local areas and have provided much needed evidence which may be used to advocate for further investment in these areas in the future.

These ‘bonus effects’ have reinforced commitment and belief in the programme’s effectiveness at regional and local level, and participants expressed their hope to use this additional information to advocate for the programme’s roll-out in other parts of Kazakhstan.

5.2.7 Effectiveness of cross-cutting strategies (gender and equity)

The ASP pilot is very much a schools-based programme, and as such targeted all adolescents regardless of their gender and location. As schools are the most effective means of reaching a large-scale adolescent population, this is a justified approach. The evaluation found that the project had substantially contributed to adolescents’ social empowerment, primarily through making services more accessible, over-coming stigma to access, and making contributions to increasing mental health and well-being, and reducing self-directed violence.

In terms of gender, the project started with a comprehensive assessment of the drivers of suicide among adolescents in Kazakhstan (Wasserman et al, 2014). This found that there were no significant differences in terms of key socio-demographic variables (such as rural/urban location, religion). However, there are strong differences in terms of gender incidence and access to services which we found in the outcomes survey, and as reported by key stakeholders. The ASP project was found to be social empowering and transformative in some ways, since an intervention through schools appears to over-come differences in rural/urban access to services, addressed systems level changes (such as improving the health service’s capacity to treat adolescents) and normative barriers (such as social stigma surrounding the discussion of suicide). However, there was little evidence that the programme had comprehensively considered how gender could or should be integrated into the ASP’s intervention. This may have been because the outcome survey showed better improvements in adolescent girls versus boys (for instance, in access to services, and reductions in mood disorders, such as depression). This however ignores that a gender sensitive approach would recognize how gender affects the under-lying drivers of suicide for both genders, and takes steps to address this in the intervention strategy.

For this reason, the EVT felt that a more differentiated approach, taking into account gender-based norms which may stigmatise access to support services in different ways for adolescent boys and girls, could be achieved in future. This would include understanding in more depth how the under-
lying drivers of suicide, such as childhood traumas, are affected by gender, and how the project can address this more comprehensively. As such, the EVT found that the project is currently taking a ‘do no harm’ rather than gender sensitive approach.

In terms of child rights (outlined UNICEF’s own ‘Seven Principles of a Child Rights’ Approach’). The project was found to have made a strong contribution to some of these principles, including:

- Respect and care for children in all places, including in schools and homes, by making services and treatment more accessible to children and adolescents in the places where they live and study
- Rights to a good standard of living, by increasing mental health and well-being
- Non-discrimination: delivering the programme through the schools system meant that both genders had equal access. There were some interesting findings in terms of equity, with adolescents in rural areas showing higher improvements than those in urban areas, for instance.

As a predominantly schools-based programme, the ASP uses a selective form of prevention (meaning that it is not focused on the population at large, nor is it taking a highly targeted approach). This was justified since the assessment conducted for the suicide prevention project identified that there were no significant differences between high risk and not at high risk pupils in terms of gender, ethnicity and rural/urban residence.

A less differentiated approach, targeting all children and adolescents in school, may be justified in earlier stages of the programme, especially when there are large stigma-related barriers to overcome (including among providers). However, now that these initial barriers have been overcome and the programme is well established, further stages of the programme, whether implemented by UNICEF or other agencies, should consider a more differentiated approach. This should include understanding and responding to gender-based norms which often underlie patterns of mental health and SIB. The wider social determinants which have often been found to underlie suicidal behaviours appear to be poorly understood in the Kazakhstan. The study on prevalence conducted in 2014 indicated several areas where the determinants of suicidality could be addressed in a comprehensive preventative approach for adolescents:

- Alcohol use and abuse
- History of trauma, abuse and violence
- A family history of suicidality
- Inter-personal conflict with peers and social isolation

It is also likely that the needs of marginalised groups, such as out of school adolescents and those with disabilities should be given special consideration. Future rounds of the ASP should be used to ensure that a gender and equity focus is mainstreamed within the programme’s ways of working, for instance, through systematically disaggregating the data by sex, poverty and other socio-demographic variables.

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6 This is available from: https://www.unicef.org.uk/child-friendly-cities/child-rights-based-approach/, accessed 15.01.18
7 WHO (2014) “Preventing Suicide: A Global Imperative”
Based on the available information for this evaluation, we infer that the programme has partially contributed to a child rights framework, but this needs to be further defined against the UNICEF principles of a child rights approach and articulated into a national strategy. This should provide, for instance, a clearer articulation of how gender-based norms which often underlie suicidal patterns have been integrated into the programme approach.

5.3 Sustainability of the ASP pilot

**Key Findings**

- The total expenditure of the Kyzylorda ASP programme was $337,287
- The labour cost accounts for about 71% ($240,542) of the total programme expenditure
- About 41% of the non-labour expenditure was incurred by component 4 which provided capacity-building services for mental health and primary health workers
- The cost per master trainer trained was $1,148
- The cost per student reached with the mental health awareness activities was $1.20
- The cost per health worker trained was about $333.50
- However, there is no benchmark to assess whether the ASP project could have been delivered more efficiently
- Finally, the cost effectiveness of the intervention could not be modelled because of the limited scope/coverage of the pilot programme and non-availability of relevant data required

This section presents the results of the ASP pilot’s efficiency and sustainability by providing a cost analysis undertaken as part of the evaluation. The costing element of the evaluation was initially conceived as a necessary step towards assessing the pilot’s viability as a cost-effective intervention for adolescents’ suicide prevention and mental health promotion. The analysis presented here focuses on a cost analysis of the pilot and cost efficiency analysis. A full cost–benefit analysis could not be conducted at this stage, though recommendations are included for future analysis. Furthermore, as this costing exercise was based on a pilot and included programme set-up costs, it is very likely that the programme is now much more cost-effective. Interviews with current NGO providers, for instance, reported that they deliver the programme for approximately half the cost of the pilot. As such, the costing is not a strong guide for scale-up or sustainability.

Owing to the form in which the costing data was delivered to the evaluation team, the cost analysis section presents each of the components in a slightly different order and with slightly different names from those reconstructed during the ToC workshops and used for the other sections of the report. Table 6 demonstrates how these differently referenced components relate to each other.

<table>
<thead>
<tr>
<th>Components/Outputs as per the reconstructed ToC</th>
<th>Relevant components for the cost analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Output 1: Awareness-raising materials about mental health are disseminated to adolescents</td>
<td>Component 3 – awareness-raising intervention for adolescents</td>
</tr>
</tbody>
</table>
### Components/Outputs as per the reconstructed ToC

<table>
<thead>
<tr>
<th>Output 2: Adolescents are screened for potential mental health problems</th>
<th>Relevant components for the cost analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Component 1 – identification of adolescents at risk for suicide and with mental health problems</td>
</tr>
</tbody>
</table>

| Output 3: Gatekeepers and health providers participate in mental health awareness-raising training | Component 2 – gatekeeper training for school staff  
Component 4 – capacity building of mental health and primary health workers |
|---|---|

<table>
<thead>
<tr>
<th>Output 4: A referral system is in place to provide adequate mental health services</th>
<th>N/A</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Output 5: Evidence and monitoring data is being collected and analysed</th>
<th>Component 5 – assessment of the impact of adolescent suicide prevention programme in Kyzylorda Oblast</th>
</tr>
</thead>
</table>

### 5.3.1 Total planned and actual programme costs

The analysis described the total expenditure of the ASP programme between May 2015 and May 2017. The funding for the programme was provided by the Federal Government of Kazakhstan and UNICEF. The total budget was $500,000 for the implementation of the programme in Kyzylorda and Mangystau Oblasts. The funding for each of the states is about $250,000 each.

The total expenditure of the Kyzylorda ASP programme was $337,287. The programme budget in Kyzylorda was overspent by $87,287 in the inception phase. The reasons for this overspend include the fact that the pilot started in Kyzylorda and there was a huge investment on programme development costs; the second pilot in Mangystau Oblast, however, started afterwards and will have benefited from some of the development work. This includes the cost of development of training materials, Information, Education and Communication (IEC) and awareness materials, data collection tools, implementation manuals etc. These materials were eventually used for both pilots and will be useful for scale-up of the pilot. In addition to this, there was a lot of inertia at the start of the programme, which was mainly associated with stigma attached to suicide prevention intervention. The success in overcoming this inertia and other lessons learned paved the way for successful implementation in other states. This cost analysis captures both the programme development cost and the cost of actual roll-out of the pilot in Kyzylorda Oblast. For the sake of this review and the estimation of unit cost per output, it is assumed that the cost of production of these materials will be borne by the pilot in Kyzylorda; however, from the explanation above, this may not be strictly so.

### 5.3.2 Breakdown of Programme Costs

The labour cost accounts for about 71% ($240,542) of the total programme expenditure. The labour cost includes consultancy fees (75.2%) and salaries of UNICEF staff (24.8%) during programme implementation. The non-labour cost accounted for about 29% ($96,745) of the total programme expenditure. This was also disaggregated into the five components of the ASP programme. About
66% of the total programme expenditure was spent in the first year of implementation while 26% and 9% was spent in years two and three respectively.

Figure 3: Total cost of the ASP programme disaggregated into labour and non-labour cost

As shown in Figure 4, there was a decline in the total programme expenditure from Year 1 to Year 3. The expenditure during the first year of programme implementation was the highest and this was largely driven by the labour cost.

Figure 4: Shows the non-labour cost for the programme disaggregated on year by year basis to show the decrease in the trend of these costs during programme implementation.

The total non-labour cost for the ASP programme was estimated to be $96,745 (29% of total programme costs). The non-labour costs were disaggregated into the five individual components of the programme, cross-cutting costs and administration and management costs. The components of the ASP programme are:

- Component 1 – identification of adolescents at risk for suicide and with mental health problems;
- Component 2 – gatekeeper training for school staff;
- Component 3 – awareness-raising intervention for adolescents;
• Component 4 – capacity building of mental health and primary health workers;
• Component 5 – assessment of the impact of adolescent suicide prevention programme in Kyzylorda Oblast.
About 41% of the non-labour expenditure was incurred by Component 4, which provided capacity-building services for mental health and primary health workers. The third component of the programme, which was designed to raise awareness of the ASP intervention among the adolescent group, accounted for about 30% of the non-labour expenditure. The remaining three components, together with cross-cutting and administration and management costs, accounted for the remaining non-labour cost. Expenditure on the key inputs into various programme components was also estimated. These key inputs included training costs, production and printing of IEC materials, equipment, transportation and other programme costs (see Table 12). The main cost drivers for the inputs were the training and capacity building expenses for Component 4, which accounted for about 86% of the component expenditure, while the production of awareness and IEC materials was the main cost driver for Component 3, accounting for about 85% of the component expenditure.

Table 12: Non-labour expenditure disaggregated by intervention component (with cost drivers for largest components highlighted in bold)

<table>
<thead>
<tr>
<th>Component</th>
<th>Component 1 Expenditure</th>
<th>Component 2 Expenditure</th>
<th>Component 3 Expenditure</th>
<th>Component 4 Expenditure</th>
<th>Component 5 Expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trainings and capacity building, including interpreters</td>
<td>$6,160 (55%)</td>
<td>$3,186 (62%)</td>
<td>$4,002 (14%)</td>
<td>$33,766 (86%)</td>
<td>$0</td>
</tr>
<tr>
<td>Production of materials for awareness/printing of IEC materials, tools for screening</td>
<td>$4,961 (44%)</td>
<td>$1,917 (38%)</td>
<td>$24,696 (85%)</td>
<td>$3,497 (9%)</td>
<td>$0</td>
</tr>
<tr>
<td>Equipment</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$1,138 (3%)</td>
<td>$0</td>
</tr>
<tr>
<td>Transportation</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$1,063 (3%)</td>
<td>$128 (100%)</td>
</tr>
<tr>
<td>Other programme costs:</td>
<td>$161 (1%)</td>
<td>$0</td>
<td>$277 (1%)</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Total</td>
<td>$11,282</td>
<td>$5,104</td>
<td>$28,948</td>
<td>$39,464</td>
<td>$128</td>
</tr>
</tbody>
</table>
Table 13: ASP programme intervention cost disaggregated by component areas

<table>
<thead>
<tr>
<th>Intervention Component</th>
<th>Labour Cost</th>
<th>Non-labour Cost</th>
<th>Total cost per component</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Component 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identification of adolescents at risk for suicide and with mental health problems</td>
<td>$25,874.83</td>
<td>$12,602.87</td>
<td>$38,477.70</td>
<td>11%</td>
</tr>
<tr>
<td>Component 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gatekeeper training for school staff</td>
<td>$16,539.05</td>
<td>$6,424.67</td>
<td>$22,963.72</td>
<td>7%</td>
</tr>
<tr>
<td>Component 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Awareness-raising intervention for adolescents</td>
<td>$30,353.83</td>
<td>$30,268.81</td>
<td>$60,622.64</td>
<td>18%</td>
</tr>
<tr>
<td>Component 4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capacity building of mental health and primary health workers</td>
<td>$106,299.28</td>
<td>$40,785.00</td>
<td>$147,084.28</td>
<td>44%</td>
</tr>
<tr>
<td>Component 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assessment of the impact of ASP programme in Kyzylorda Oblast</td>
<td>$61,475.27</td>
<td>$1,451.00</td>
<td>$62,926.27</td>
<td>19%</td>
</tr>
<tr>
<td>Administration and management Fee</td>
<td>$5,212</td>
<td>$5,212.46</td>
<td>$5,212.46</td>
<td>2%</td>
</tr>
<tr>
<td>Total</td>
<td>$240,542</td>
<td>$96,744</td>
<td>$337,287.07</td>
<td>100%</td>
</tr>
</tbody>
</table>

5.3.3 Cost-Efficiency Analysis

As part of the data analysis conducted, cost per output of four components of the programme was also estimated. The labour and non-labour costs for each component of the programme were aggregated and divided by the programme results obtained for these components to estimate the cost per output (see Table 14).

Component 1 of the programme focused on identification of adolescents at risk of suicide and/or mental health problems. Adolescents were assessed through mental health screening and those at risk were referred for treatment. About 48,754 students were screened and 1,697 were identified as at risk of suicide or mental health problems. The costs per student screened and identified were $0.79 and $22.67 respectively.

The second component of the programme provided gatekeeper training for school staff as part of its interventions. The purpose of this was to increase mental health literacy and awareness about SB, and to train school staff in how to communicate with adolescents at risk of suicide and mental health problems. During implantation, 20 master trainers were instructed in how to pass on what they had learned to gatekeepers in schools, at a cost of $22,963 to the programme or $1,148 per
master trainer. These master trainers cascaded these trainings down to teachers and psychologists in over 400 schools in Kyzylorda Oblast during the three-year implementation period.

The third component of the programme facilitated awareness-raising activities for adolescents. In addition to increasing mental health literacy, this intervention promoted the development of problem-solving skills and health-seeking behaviours. Further, some of the skills learned were used to identify at-risk persons. The total number of students reached with the awareness activities conducted was 50,580, at a cost of $60,622. **The cost per student reached with the mental health awareness activities was $1.20.**

The thrust of the fourth component was to ensure capacity building of mental health workers and primary health workers. The aim was to increase the competence in treating adolescents with mental health and suicidal risks at health facilities. 441 health workers were trained during programme implementation at a total cost of $147,084. **The cost per health worker trained was $333.52.**

These estimates of cost per output produced captured only the cost incurred by the Federal Government of Kazakhstan and UNICEF and did not capture the contribution at the local government level. Contributions at local government level include the salaries of most of the government workers engaged during programme implementation, and their travel costs and *per diems* etc.

To make a better judgement on the efficiency of these cost-per-output estimates, there is a need to benchmark the figures against estimates from similar interventions in the region or elsewhere around the world. However, there is paucity of such information. One of the ways to use this estimate is for it to serve as a baseline with which subsequent interventions can be compared, especially during the scale-up phase of the programme.

Another option would have been to compare the education component with the health component in terms of unit costs. However, the units are not comparable: for education, the unit costs are at the level of master trainers and students, whereas for health they are at the level of health workers. Valid comparisons might be made between the number of patients reached by healthcare workers and the number of students reached, or between the number of teachers and health workers trained.

While differences between the education and health components cannot be brought out in the cost-efficiency analysis, differences were observed during implementation. Therefore, any insights from implementation should feed into design modifications for scale-up.
Table 14: Cost–output analysis for components 1-4 of the ASP programme

<table>
<thead>
<tr>
<th>Component – indicator</th>
<th>Output</th>
<th>Result</th>
<th>Cost</th>
<th>Cost Per Output</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Component 1</strong></td>
<td>Total number of students screened for mental illness</td>
<td>48,754</td>
<td>$38,477.70</td>
<td>$0.79</td>
</tr>
<tr>
<td></td>
<td>Total number of at-risk students identified</td>
<td>1,697</td>
<td>$38,477.70</td>
<td>$22.67</td>
</tr>
<tr>
<td><strong>Component 2</strong></td>
<td>Total number of master trainers trained to deliver gatekeeper training</td>
<td>20</td>
<td>$22,963.72</td>
<td>$1,148.19</td>
</tr>
<tr>
<td><strong>Component 3</strong></td>
<td>Total number of students reached by the awareness programme</td>
<td>50,580</td>
<td>$60,622.64</td>
<td>$1.20</td>
</tr>
<tr>
<td><strong>Component 4</strong></td>
<td>Total number of healthcare workers trained</td>
<td>441</td>
<td>$147,084.28</td>
<td>$333.52</td>
</tr>
</tbody>
</table>

5.3.4 Cost-effectiveness of the ASP pilot

This analysis was done retrospectively and as such faced challenges in modelling the pilot’s cost-effectiveness. The pilot programme had limited timespan, and relevant data required for the modelling was not available. In addition, studies have posited that for suicide prevention programmes, outcomes available may not be easily quantifiable, and it has been shown that the outcomes experienced during interventions may not be completely attributable to the interventions themselves (Ashwood et al., 2015). However, the main outcomes of suicide prevention programmes are not restricted to the prevention of mortality through suicide, but include the improvement of the overall mental health and productivity of adolescents. If this dimension – the improvement in mental health – is introduced, then there is a very high chance that the benefit of the intervention will produce a favourable cost-effectiveness value. For example, one suicide prevention programme focused on the use of Cognitive Behavioural Therapy (CBT) as a means of reducing depression in a group of patients that had previously attempted suicide. The outcome measured was the number of depression-free days the patients experienced because of the intervention. This outcome was converted into Quality-adjusted Live Years (QALYs) using utility weights assigned to depression in prior research studies, and the intervention was found to be cost-effective (Rothbard, 2006). Furthermore, other costs such as those associated with loss of productivity or short-term disability are also considered as valid outcomes for suicide prevention programmes and these all contribute to the cost-effectiveness of such interventions (Vasiliadis et al. 2015).
6. Key Learnings from the ASP

The learnings from the ASP presented in this section arose from a discussion by main stakeholders of the preliminary report findings at a conference on mental health held in Kazakhstan, and with follow-up discussion with the UNICEF project lead.

Programme Effectiveness

Overall, there is evidence to show that the ASP pilot programme has contributed to achieving some of its desired results, particularly in overcoming stigma-based barriers to delivering ASP activities, engaging and responding to national goals in developing a feasible programme model, and improving adolescent mental health and well-being, and reducing suicidal ideation.

There is good evidence that the programme had substantial effects at output and outcome levels, which provides a good rationale for continuing with the programme model. The ASP pilot also importantly contributed to increasing awareness of mental health issues among adolescents (and their parents), decision makers, gatekeepers and health providers. Furthermore, the programme has also clearly strengthened the skills of adolescents to cope with mental health problems and provided them with knowledge of where and how to seek care. In this regard, the ASP pilot has been a success but the evidence to support the idea that it has contributed to reducing the number of suicides is not conclusive.

Implications for Programme Implementation

There were key learnings from the implementation of the pilot, which have a variety of implications for improving implementation at local and national levels. These include:

1. **Over-coming stigma related to mental health**: the issue of adolescent mental health and suicide is incredibly sensitive in the Kazakhstani context. UNICEF invested heavily in over-coming this opposition, and mobilising wider health and education actors to address adolescent mental health. Opposition to the programme were mostly stigma-related, and UNICEF’s approach worked well to ensure that there was good alignment to national goals and policies, with political buy-in from national and regional health policy and decision-makers. The framing of the programme also adapted to contextual sensitivities, shifting from being focused on suicide to emphasizing mental health and well-being and life skills. This appeals to a broader audience and results in broader support. More specifically, developing stronger awareness of mental health issues amongst parents would also contribute to improving parental consent for adolescents to be screened and treated. This may require developing awareness training materials which are specifically targeted at parents and further developing school psychologists training package to include specific parent targeted activities.
2. **A multidisciplinary approach:** The ASP learnt that involving wider health and education providers, beyond psychiatric staff, worked well to broaden access to care rapidly, but also built an effective team approach in managing adolescents at risk. Continuity of care was strengthened through this collaborative approach, for instance, through school psychologists and GPs meeting during training, and identifying ways of working together during care and follow-up. Multidisciplinary teams comprising of a school psychologist, a GP and a mental health worker were appointed from each educational organisation to follow up adolescents at risk. The teams used a so-called dynamic follow up scheme which involves examining and following up adolescents identified at risk with prescribed levels of activities for each team member. This facilitated a more comprehensive way of working with high risk adolescents.

3. **Availability of treatment options for those with high and complex needs:** While the ASP increased access to treatment in general, there was a lack of treatment options for those with high or complex needs. For instance, adolescent mental health problems are often closely associated with a family history of mental health problems, suicides and childhood trauma, which requires the inclusion of specific approaches for treatment which targets both adolescents and their families. Indeed, during the implementation of the ASP pilot, many cases of adolescents at risk were observed to have a correlation with a family history of mental health problems, suicides and childhood trauma. These cases required expert knowledge and specialised services which were not widely available, particularly in rural areas of the project.

4. **Improving access to pharmacological treatment:** The inclusion of pharmacological treatment (such as antidepressants and tranquilisers) has proved to be a challenge during the ASP pilot. This was due to three key factors: (a) the treatment cost involved for adolescents and their families (antidepressant treatment for adolescents has been estimated at USD15.00 to USD20.00 per month, which is more than what many families in the region can afford); (b) the availability of medicines (i.e. lack of provision or stock outs) particularly in rural areas of the pilot meant that families of adolescents identified at risk and requiring pharmacological treatment would have had to travel to urban areas to access the appropriate medicines (which has financial and opportunistic cost implications which many families could not afford); and (c) the unwillingness of many GPs to prescribe antidepressant. Indeed, despite being no specific restrictions for GPs to prescribe antidepressants, many of them felt it was outside of their terms of reference to do so. As a counter measure, the ASP pilot challenged the situation and requested the Kyzylorda Department of Health to include antidepressants and tranquilisers into its procurement plan. However, bureaucratic and procurement challenges prevented this from happening, and UNICEF has had to directly procure antidepressants. As for tranquilisers, despite being at a low cost, having been included in the list of essential drugs available at PHC level this implied complex prescribing procedures which many GPs and mental health providers decided to avoid.

5. **Use of evidence and data:** Overall the evaluation team felt that there were missed opportunities for gathering evidence to test the implementation model and to make important decisions about the cost-effectiveness of different programme components and how these could be varied for which benefits. It is difficult to measure the programme’s effects at the impact level, since suicides are a very rare event even in areas of high prevalence. However, the programme did alter the programme model as it scaled, for instance, including a control area, and incorporating a life skills programme (in Mangystau). The lack of costing data and a clearer monitoring and evaluation framework limited the extent to which data was available and was used for testing the intervention model. Importantly, it also meant that routine access to gender-based differences in access to treatment could not be routinely monitored and disaggregated. As a pilot, the ASP
programme was a ‘proof of concept’ study, and an innovative response to the high public health need identified in Kazakhstan. An evidence uptake strategy, with careful attention paid to the types of evidence required at different stages, would have benefitted the project’s generation of evidence, particularly for cost-effectiveness. This means undertaking stakeholder mapping and reviewing evidence needs at different points and making effective use of the right types of technical expertise to deliver this evidence.

Implications for Scaling

1. **Leveraging political will:** A key aspect of the success of the ASP pilot has clearly been the political will, ownership and leadership demonstrated at all levels of government, and which transcribed into an effective multi-sectoral approach. This is also demonstrated by UNICEF’s ability to leverage government resources at both federal level, for funding the pilot, and local level, in the implementation of the programme. The pilot started in an area with high political will, and generated the momentum needed to reach other geographical areas at a later stage. The ability of the programme to leverage these funds demonstrates good value for money and bodes well for buy-in and sustainability.

2. **Mobilising wider providers across health and education:** In the context of rising demand for access to mental health services, attention to resourcing of government services was needed to avoid over-burdening the health system in the short-term. In particular, not all gatekeepers and health providers felt that they had sufficient skills and confidence to carry out their roles, and gaps in HR also limit the effectiveness of the referral pathway. These issues need to be addressed with policy decision makers as part of comprehensive health planning and resourcing to meet adolescent mental health needs in Kazakhstan. This also in general reflects the lack of specific pre and in-service training for educational psychologists and others on mental health.

3. **Engaging with parents:** In the ASP, school psychologists started to engage with parents more comprehensively in the second year of the pilot, due to increasing levels of confidence. Information provided to parents was initially brief and focused on gaining informed consent for their children to take part in the programme. Providing a more comprehensive package for educational psychologists to work with parents would have increased their capacity to provide better care for families with adolescents at risk, increase identification of risky behaviours by parents, and overcome parental resistance.

4. **Developing sustainable models:** UNICEF provided initial investments, programme management support and technical assistance to develop the ASP. However, the programme later developed models which worked with local NGOs to deliver the programme and care. This appeared to improve accountability, local engagement and reduced programme delivery costs.

5. **Incorporating a gender equity focus:** The ASP was delivered through schools, and the EVT often found that it was assumed that issues of gender and equity were adequately addressed by using this targeted screening approach. However, this risks ignoring a range of factors which may be contributing to self-directed violence, such as gender-based norms which may stigmatize some groups (particularly males) from accessing services and support. An equitable approach would consider and to the extent possible integrate addressing under-lying drivers into the response.

6. **Improving the use of data and evidence:** The EVT found that the monitoring and evaluation framework for the ASP needed further developing. Currently, routine data is better at capturing identification and referral from schools to health services, but less so at monitoring access to treatment, follow up care and outcomes. This requires the development of adequate monitoring
and data systems at national level, and provides an opportunity to build cross-sectoral engagement from health and education.
This evaluation is summative in nature: it was conducted once the programme ended and evaluates the programme’s changes at impact, outcome and output levels. Our recommendations are forward-looking, informing the future development of the ASP programme (which is currently being rolled out at national level by the Government decision), and are structured around: (i) capturing learning from the ASP pilot on UNICEF’s role and future programme implementation; (ii) how the components of the programme could be improved; and (iii) issues to consider in the scale-up and replication of the model. The process of developing these recommendations was based on the findings of this evaluation, the assessment of lessons learned (see Section Six above), and in collaboration with UNICEF Kazakhstan. For each category (capturing learning, improving programme components, and scaling and replication), recommendations are represented in order of priority (from the highest to the lowest priority), and are addressed to specific stakeholders.

7. Recommendations

**Capturing Learning**

**Recommendation One: UNICEF should strengthen evidence generation for piloting of innovative approaches, particularly in health systems, and to test what works**

This evaluation was initiated several months after the programme had ended and evidence of programme impact was extracted against the overall programme ToC. This was challenging, given the lack of an overall M&E framework and strategy, and it was difficult to assess the extent to which the pilot has contributed to desired results. For future programme development, UNICEF would strongly benefit from the use of research and evidence uptake tools, which can be helpful in planning what types of evidence are needed at which points, ahead of scaling. This requires specific expertise, e.g. from health economists, to review the programme’s Monitoring, Evaluation, Research and Learning framework in the inception phase and to plan for evidence needs once scale-up of the programme is required. There were important insights around the effectiveness of the project at output level, particularly as the project started to be implemented in other regions, which could inform the types of intervention models that might work best to address adolescent health needs. This could be used to more effectively answer questions that are needed to scale the project, particularly around how different intervention models affect the project’s cost, and resulting in what kinds of benefits.

*Addressed to: UNICEF Kazakhstan*
Recommendation Two: The programme’s core aims and objectives should be well articulated and clearly and consistently presented to all stakeholders

There was some variation in how the ASP pilot was understood and interpreted, particularly between national and local levels. This reflects the programme’s development, in finding ways of framing the issue in acceptable ways. However, at this stage, strong common messaging on the programme’s aims would facilitate working with and getting endorsement from stakeholder and beneficiary groups. While appreciating different audiences may need tailored forms and/or levels of information and may need to be leveraged in different ways, there remains a strong case for a consistent streamlined message running through the project’s branding, materials and face-to-face communications. This would facilitate capturing learning as the programme develops in different areas.

Addressed to: Local and central Government (MoH, MoES, DoH, DoES)

Recommendation Three: address over-referral to psychiatric services through enhanced training for GPs and, to a lesser extent, school psychologists

While there was some evidence that the ASP has overcome GPs resistance to addressing adolescent mental health problems, it was still current practice to refer to psychiatry in almost all cases, despite the chronic shortage of psychiatrists (and their concomitant high workload) and psychiatrists’ common assessment that most adolescents did not need psychiatric intervention. This ‘erring on the side of caution’ was partly attributed to GPs’ lack of confidence in their care decision making and should be addressed through on-going training and mentoring.

Addressed to: Health care providers, and specifically GPs

Recommendation Four: Improving treatment options for those with complex needs

The experience from the ASP found that treatment options for high risk adolescents remained limited. This includes evidence-based options, such as psychotherapy, as well as working with families with complex needs. Adolescents at risk often come from families which themselves have complex needs, and addressing a history of family suicide and/or recent childhood trauma necessitates services and competencies which are not widely available. Specialist services need to be available at local level. Future programmes should consider how these can be adequately resourced. It would therefore be beneficial to consider including training and education on psychotherapy in national scholarship programmes such as the Bolashak programme⁸. This would strengthen the

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⁸ The Bolashak programme (Which translates into “future”) is an international educational grant founded by the President of the Republic of Kazakhstan Nursultan Nazarbayev. The purpose of the programme is to train specialists in the priority sectors of the country’s economy. The program includes both obtaining a scientific degree from higher education institutions, as well as scientific internships in leading international companies and universities across the world.
availability of qualified professionals on the supply side, and help meet the demand for mental health services in the country.

**Addressed to:** Department of Health at Oblast level; Ministry of Health at national level

**Recommendation Five: Improve access to pharmacological treatment**

The ASP learnt that access to pharmacological treatment needs to be in place ahead of efforts to increase demand. Training with GPs and others is needed to overcome any resistance to prescribing, and it is vital that the local Department of Health is also prepared to ensure that there is a good drug procurement plan in place.

**Addressed to:** Local and central Government (MoH, MoES, DoH, DoES)

**Recommendation Six: Provide a mechanism for debriefing to carers of those at risk of suicide, so that they can receive professional support**

This evaluation revealed that gatekeepers and health providers working with adolescents at risk are privy to sensitive and sometimes distressing information and often feel a heightened sense of responsibility for these adolescents. As a result, emotional burnout and anxiety over care decisions were expressed. Options such as peer support groups and one-to-one debriefs with a senior mental health professional such as a master trainer could be explored, emphasising the importance of non-judgemental disclosure of difficulties and confidentiality. Bereavement support following the loss of an adolescent is particularly important. It is possible that support mechanisms for school psychologists, GPs, etc. may decrease the likelihood of turnover and improve confidence among practitioners.

**Addressed to:** Local and central Government (MoH, MoES, DoH, DoES)

**Recommendation Seven: Providers and primary health care practitioners in particular should attend the training in full, to build confidence with working with those at risk**

Supporting gatekeepers and primary and mental health workers to be granted protected days/times to attend the dedicated project training sessions would reduce the risk of participants being split across duties and support their ability to gain more comprehensive knowledge and skills. Training also provides an opportunity to develop multi-disciplinary teams and follow-up.

**Addressed to:** Health care providers, and specifically GPs

**Scaling and Replication**

UNICEF, as well as the GoK, has already started to scale the ASP to different areas of Kazakhstan. The recommendations below have been framed around three key areas, which include addressing gender and equity, ensuring systems readiness, and developing future models of care.

**Addressing gender and equity**

**Recommendation Eight: Improve understanding of the gender-based norms which affect incidence of self-directed violence, and further develop a gender differentiated approach**

It was commonly reported in this evaluation that gender and equity concerns were addressed through using a screening approach, which provided services equally to all groups. Patterns and drivers of suicide are strongly gendered, including those which may prevent young men from seeking...
services. In developing the ASP, there was very little contextual evidence considered of the underlying drivers of suicide, which can be normative and are gender-based. This risks ignoring important drivers of mental ill health, such as norms which stigmatize young men from seeking services, or providing services which are not sensitive to the differing needs of young men and women. Future iterations of the programme could consider using an approach which focuses on specific drivers such as harmful gender-based norms and which pays attention to gender and equity and how this affects young men and women’s experiences and outcomes. The M&E framework should be developed to ensure better monitoring of outcomes disaggregated by sex.

Addressed to: UNICEF, local and central Government (MoH, MoES, DoH, DoES)

Ensuring systems readiness

Recommendation Nine: Develop more differentiated screening models which can identify complex needs

In Kazakhstan, correlates of poor mental health in adolescents operate at the individual, sociocultural and situational levels and screening measures should include items to assess risks across these. Risk factors to be included in comprehensive screening should continuously be monitored and modified based on local evidence. Current known factors include personal and family history of mental disorders and/or SIB, lack of social and peer support, recent stressful life events and/or loss, particular personality traits such as aggression and impulsivity (beyond the normal bounds of adolescence), and substance abuse in the individual or in the family.

Global and context-specific evidence in this population demonstrates strong links between mental health and abuse which future adolescent programmes need to consider. Sectors which address violence (such as domestic violence services) have developed models based on routine enquiry – where questions on experiences of abuse are included for specific groups and through specific services regardless of whether signs of abuse are present – and could offer important learning for the ASP. Asking questions about more sensitive areas, such as childhood trauma or experiences of violence, were deemed too difficult in the early stages of the ASP. However, now that the programme is more established, a more comprehensive approach could be considered. For instance, screening questions for mental health outcomes and exposure to violence could be introduced at the point of primary health care registration rather than waiting for when abuse is reported.

The most appropriate model should be one which can improve identification rates and access to services, but which is based on sound evidence of cost-effectiveness. Further iterations of the programme could test intervention models more soundly using an overall cost-effectiveness framework, for instance, by varying programme components, providers and levels of technical assistance.

Addressed to: UNICEF, local and central Government (MoH, MoES, DoH, DoES)

Recommendation Ten: Enhance the curriculum for pre- and in-service training for educational psychologists

School psychologists play an essential role in the implementation of the ASP model in schools and colleges. However, in the initial stage of the ASP pilot, it was observed that school psychologists’ knowledge of mental health issues and how to address them was very limited, and gaps in their
university training identified. The ASP pilot component which delivered short capacity building activities to school psychologists to improve their skills and knowledge on how to deal with adolescents at risk and their families, has significantly empowered school psychologists. Nevertheless, enhancing the pre and in-service training of educational psychologists using more concrete case studies, practical approaches and improving their communication skills would strengthen the ASP approach.

Addressed to: Local and central Government (MoES, DoES)

Recommendation Eleven: strengthen engagement with policy-makers and decision-makers to ensure that the mental and primary health care systems are adequately resourced to meet demand

UNICEF’s approach was careful to work with national stakeholders and in alignment with national goals on improving mental health. However, in their role as technical specialists and advocate for child rights, UNICEF needs to work with government partners to ensure that education and health providers are resourced to meet demands and that strategic planning considers these needs ahead of increasing demand.

Addressed to: UNICEF, local and central Government (MoH, DoH, and national mental health agencies)

Future Models of Care

Recommendation Twelve: UNICEF’s role should shift from implementer to lead technical assistant, capturing what is working for adolescent mental health and well-being as the ASP goes to scale in Kazakhstan

The issues of adolescent mental health and suicide are critically sensitive in Kazakhstan and UNICEF acted well as a catalyst for the programme set up. In future, we would recommend that UNICEF take on an advocacy and technical assistance role. This is partly due to the perception that local actors may be more appropriate and more cost-effective in providing services, but also because UNICEF now has learning and expertise which could be more appropriately used in technically assisting scaling up interventions which work for adolescent mental health.

Addressed to: UNICEF Kazakhstan

Recommendation Thirteen: continue to use local organisations as advocates and implementers of the ASP

In Kyzylorda, the Bilim Foundation has taken over the implementation of the model since the end of the ASP pilot in 2017. This is a promising model of working with local actors to overcome stigma in accessing care, which should be further explored. The Bilim Foundation has introduced several innovations which both address wider adolescent mental health and well-being needs, such as monitoring of outcomes and electronic patient records, and life skills training for adolescents in the programme.

Addressed to: UNICEF, local and national governments, local NGOs

Recommendation Fourteen: continue to improve the use of evidence and data, particularly through a strengthened monitoring and evaluation framework

Interventions to strengthen the use of routine monitoring data are needed at national level, and are
needed so that UNICEF and the GoK can deliver an equitable approach. The development of a comprehensive M&E framework would result in a greater accountability of the health sector for results (for instance, focusing on access to follow-up care). It also presents an opportunity to build the skills of national and local champions on adolescent mental health (e.g. the National Mental Health Centre, MOES and others) to track the ASP’s effectiveness in reaching its goals, benchmark local areas against national standards, and could be used to build ownership of delivery at oblast level.

*Addressed to:* the Ministry of Health, the Ministry of Education, National Centre for Mental Health, Child Rights Committee at MOES
References


23. Wasserman C. et al., 2014. Assessment of Suicide Preventive Activities in Kazakhstan: Kyrgyz and East Kazakhstan Region (UNICEF)


Annex 1: Terms of Reference

We present the original terms of reference though this was significantly updated during the Inception Period.

UNITED NATIONS CHILDREN'S FUND in KAZAKHSTAN

TERMS OF REFERENCE

Evaluation and costing of the pilot project on prevention of adolescent suicide in Kyzylorda Oblast, Kazakhstan
(Institutional Consultancy)

Programme (Outcome WBS & Name): Families with children, adolescents, and young people living close to or below the national subsistence minimum are more resilient (to economic and social deprivation, and stress) and they benefit more from equitable access to quality and inclusive social services and transfers.

Project (Output WBS & Name): Output 1.5: District-level authorities resource innovative approaches and policies to reduce the incidence of adolescent suicides; Youth Resource Centres (YRCs) provide outreach and awareness to vulnerable adolescents.

Activity: 1.5.2e. The pilot is costed and evaluated; the piloting process and programmatic lessons learned are documented.

Grant: SC140792

1. Purpose and objectives of the evaluation:

The main purpose of the evaluation is to assess the extent to which the pilot on adolescent suicide prevention has contributed to promoting the mental health and reducing suicidal behaviour among adolescents.

Specific objectives of the evaluation are:

1. To identify extent to which the adolescent suicide prevention project in Kyzylorda Oblast has achieved its objectives, the results that have been achieved to date, including any unintended results from the pilot, as well as their particularity at outputs at the individual, household and community levels.

2. To identify the opportunities and constraints the project has faced and draw lessons and good practices from them.

3. To assess the cost benefit of the pilot (final costing methodology depends on availability of data).

4. To identify the extent to which cross-cutting strategies such as human rights-based approach, results-based management and gender equity have been mainstreamed in the design and implementation of the programme.

Period of the project to be covered by evaluation: May 2015-May 2017

Geographical coverage: The evaluation will cover Kyzylorda Oblast. Interviews with key government informants in Astana are also expected.

The evaluation will be summative with consideration of possible impact of the pilot. It will provide recommendations for UNICEF’s further involvement in adolescent suicide prevention and mental health promotion. The MoRES determinant analysis framework will be used explicitly to identify which bottlenecks were removed and how change was achieved. The added value of the evaluation will be in the use of the findings and recommendations for: (a) Assessment of the pilot’s viability as a cost effective intervention for adolescents suicide prevention and mental health promotion, and (b) documentation of Kazakhstani
experience in customizing methodologies and approaches with possible use by other countries confronting similar issues in respect to adolescents’ mortality and mental health.

| a) **Scope of evaluation:** |
| The evaluation will therefore focus on, but will not be limited to the following issues: |
| **A. Relevance** |
| a. How relevant is the adolescent suicide prevention pilot, to national goals or objectives in respect to adolescent mental health promotion and suicide prevention? |
| b. Are the originally identified assumptions still valid? Has the project included strategies to reduce the impact of identified risks? |
| c. How relevant is the ASP pilot in contribution to the implementation of the rights of the child during adolescence in respect to mental health and suicide prevention as specified in the General Comments No. 20? |
| d. What concerns do the stakeholders have about the ASP pilot? Are there any anecdotal or observable changes in the opinion or views of the stakeholders about the relevance of the ASP pilot etc.? |
| e. Has the ASP pilot been relevant in terms of promoting Gender and Equity (access, outcomes for girls and boys, etc.)? |
| f. How did the external environment (political, economic, cultural etc.) affect the internal management of the ASP pilot? |
| **B. Effectiveness** |
| b) To what extent the pilot has achieved planned outputs and outcomes? Was the pilot effective in raising mental health awareness and affecting suicidal behaviour of adolescents who participated in the project since 2015? |
| c) Were the activities, planned under the ASP pilot, necessary and sufficient (in quantity and quality) to achieve the outputs? |
| d) Has it been feasible to collect data for baseline indicators? Was the developed theory of change / logical framework sufficient to explain how the ASP pilot should work? How adequate is the monitoring system established to support the ASP project? |
| e) How effective were the ASP pilot implementation mechanisms (coordination, management, etc.) in achieving the current results/outputs of the project? |
| f) Were established partnerships effective to support the ASP pilot in achieving its objectives? |
| **C. Efficiency** |
| g) Was the resource allocation appropriate for the achievement of the results and outputs of the pilot? |
| h) Did the ASP pilot use resources in the most economical manner to achieve expected results (current cost and flow of funds)? |
| i) What were the costs of the pilot, in terms of which benefits gained? |
| j) What has been the financial and non-financial contribution of Government (both local and national), CSOs and UNICEF? |
| k) How efficiently have the duty bearers and rights holders been interacting in the design and implementation of the ASP pilot? How effectively were duty bearers and right holders involved in the design and implementation of the ASP pilot? |
| l) In terms of costing of the ASP pilot what proportion of resources was attributed to each of the duty bearers? Was this distribution cost-efficient? |
| **D. Impact** |
| m) Were the indicators selected to monitor the project SMART enough to determine the outputs and outcomes? What kind of disaggregation is needed for the pilot? |
| n) How successful was the pilot in targeting, reaching and addressing the specific needs of the most disadvantaged adolescents and their families? Which strategies were implemented? |
| o) Are there any observed unintended direct or indirect results of the pilot on duty bearers and right holders? Are there are any observed spillover effects for health system strengthening, service provision, school environment, duty bearers and right holders? |
| p) Is there any observable evidence of the contribution of the ASP pilot to short or medium term improvements in suicide prevention? In what ways, if any, do adolescents, school/college staff, health |
providers, communities benefit from the pilot? Are there differences related to gender, social economic status and rural-urban division?

q) How do the stakeholders’ (both duty bearers and rights holders) perceive the results of the ASP pilot? What do they like or dislike about it? What do they want to change? What do school/college psychologists and staff, health workers, parents, education and health officials say about the ASP pilot?

E. Sustainability

r) What are strengths and weaknesses in design, coordination, management and monitoring of the ASP pilot? How does the ASP pilot contribute or hinder the national programme on suicide prevention or other programmes targeting adolescents?

s) What has been the buy-in from the duty-bearers and rights-holders and what roles have they played in the implementation of the pilot?

t) What has been the financial and non-financial contribution of Government (both local and national), CSOs and UNICEF?

u) What are the institutional capacity development actions required to ensure effective and efficient management, implementation and monitoring of the ASP pilot?

v) What kind of systems and instruments were setup to facilitate the rollout of the ASP pilot for a national replication?

The following 10 determinants, or “conditions”, will help categorise critical bottlenecks and barriers:

<table>
<thead>
<tr>
<th>Determinants</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Norms</td>
<td>Widely followed social rules of behavior that are followed within a society</td>
</tr>
<tr>
<td>Legislation/Policy</td>
<td>Adequacy of laws and policies to reduce/avoid barriers</td>
</tr>
<tr>
<td>Budget / expenditure</td>
<td>Allocation &amp; disbursement of required resources that constrain effective coverage</td>
</tr>
<tr>
<td>Management / Coordination</td>
<td>Bottlenecks that obstruct accountability and transparency, as well the impediments to coordination and partnership</td>
</tr>
<tr>
<td>Availability of essential commodities / inputs</td>
<td>Essential commodities/ inputs required to deliver a service</td>
</tr>
<tr>
<td>Access to adequately staffed services, facilities and information</td>
<td>Target population’s physical access to the relevant services, facilities and information</td>
</tr>
<tr>
<td>Financial access</td>
<td>Direct and indirect costs that prevent target group from utilizing available services or adopting certain practices</td>
</tr>
<tr>
<td>Social and cultural practices and beliefs</td>
<td>Individual/community beliefs, behaviours, practices, attitudes</td>
</tr>
<tr>
<td>Timing and Continuity of use</td>
<td>Completion/ continuity in service, practice that undermine the effectiveness of such service, practice, or other intervention</td>
</tr>
<tr>
<td>Quality of care</td>
<td>Adherence to quality standards (national or international)</td>
</tr>
</tbody>
</table>

2. Methodology and Evaluation process, and evaluability and ethical considerations

The Evaluation shall be conducted in accordance with the UNEG evaluation principles (openness, transparency, participation, etc.) and standards using the Evaluation criteria (relevance, efficiency, effectiveness, impact, sustainability). The evaluation will include an evaluability assessment which will outline the final evaluation questions to answer this ‘terms of references’, evaluation framework and methodologies to be used, including secondary data and costing analyses to be conducted. All final deliverables will be subject to data availability.

The consultant will work closely with UNICEF staff at key phases of the evaluation process to ensure that equity focus and Ethical requirements are fully met in the final Evaluation Report.

Continuous adherence to the ethical standards throughout the evaluation, and the contracted organisation is required to outline the ethical principles that they will be using, as well as to include a risk mitigation plan in the inception report. Consequently, the contractor should allocate additional resources (Human and Financial) to ensure compliance with the ethical requirements. The evaluation design and implementation should consider ethical safeguards where appropriate, including protection of confidentiality, dignity, rights and welfare of
human subjects particularly children, and respect of the values of the local community. Please refer to UNEG ethical guidance for evaluation, which outlines the ethical principles in part of evaluation intentionality, obligations of evaluators, obligations to participants and evaluation process and product. Based on UNICEF Procedure For Quality Assurance In Research the evaluation should undergo independent External reviews for each required stage (Inception Report, Research design, Final Report).

The Evaluation is expected to start from 27th October 2017 to with the final deliverable due by the 15 March 2018 at the latest. The payment schedule will be set out in the contract, dependent on the payment deliverables below.

All submissions should be electronic (Word and Power Point). Deliverables cannot be reproduced, distributed or published without written permission from UNICEF.

Evaluation approach as per UNEG norms and standards for evaluation.

UNICEF brings a human rights perspective and strives to mainstream gender issues in all its work for children, with the Convention on the Rights of the Child (CRC) as a principal reference, and recognizes the mutually supportive relationship between the CRC, the Convention on the Elimination of all Forms of Discrimination against Women and the Convention on the Rights of Persons with Disability. UNICEF recognises that the empowerment of women is especially important for the realization of the rights of girls and boys, and for the creation of healthy families and society.

The evaluation is a part of an organisational focus on equity and a process of strengthening reforms that target inequities affecting the most disadvantaged children and adolescents in Kazakhstan. According to UNICEF, equity means that all children have an opportunity to survive, develop, and reach their full potential, without discrimination, bias, or favouritism. This interpretation is consistent with the CRC, which guarantees the fundamental rights of every child, regardless of gender, race, religious beliefs, income, physical attributes, geographical location, or other status.

An equity-based approach to UNICEF’s evaluation seeks to understand whether the undertaken interventions managed to address the needs and uphold the rights of the specific groups of the most vulnerable adolescents in Kazakhstan. Equity-based evaluations should also generate knowledge and recommendations for UNICEF’s further focus in protecting the rights of adolescents. To ensure comprehensiveness of the evaluation and taking into account the multi-dimensional essence of equity the evaluation should use a mixed-methods approach.

Evaluation should assess the UNICEF ‘theory of change’ for adolescent suicide prevention as related to the evaluated areas. The “theory of change” guiding the evaluation shall be included in the evaluation report. The “theory of change” will specifically look at how UNICEF contributed to the changes by executing its Core Roles according to the established priorities for the country office. There is consensus that the following Core Roles are indispensable for a sustainable UNICEF engagement and its universal presence in support of results and the realisation of the rights of children everywhere:

- **The ‘Voice’ for children and adolescents** – advocating and communicating around key national policies, social issues, mindsets and attitudes;
- **Monitoring and evaluation** – assisting independent assessments of the functioning of the Child Rights guarantee systems, the progressive realisation of child rights and the reduction in equity gaps in child well-being;

9 [http://www.unevaluation.org/ethicalguidelines](http://www.unevaluation.org/ethicalguidelines)
• **Policy advice and technical assistance** – through well-designed UNICEF positions (based on local, regional, international best practices) on key issues, supporting the development of the normative frameworks, policy or programme as well as private sector standards that can improve equity;

• **Leveraging resources from the public and private sectors** – accompanying and redirecting reforms;

• **Facilitating national dialogue towards child friendly social norms** – bringing together government, private sector and civil society, as well as convening divergent forces to enhance public debate, participation and action around equity and child rights;

• **Enabling knowledge exchange** – fostering horizontal cooperation and exchange of experience among countries and regions on ‘what works’ for enhancing child well-being and equity.

**Evalubility assessment, reliability of the disaggregated data and limitations to evaluability:**

The project design described by the Theory of Change with a chain of indicators arranged hierarchically from the output to long-term impact indicators. Subject to the further described limitations, the project overall design responds to the following evaluability criteria:

**Clarity:** long-term impact and outcomes are identified and steps towards achieving them defined;

**Relevance:** the project objectives relevant to the needs of the target group as identified by situation analysis and available evidences, the intended beneficiary group are identified;

**Plausibility:** there is a continuous causal chain that connects interventions with the intended outcome/impact;

**Validity and reliability:** valid indicators for each expected output and outcome identified, baseline and follow up (in 12 months after intervention) data is available and disaggregated by gender and age. The baseline covered for 10% of the total number of adolescents covered by the project. Despite data collection was done by school and college psychologists up to now there is no indications noted on possible unreliability of data.

**Information availability:** considered to be sufficient (project reports, baseline and follow up data, interim documentation of the project and so on) and available for evaluation purposes;

**Institutional context:** there is no significant limitations overseen.

**Utility:** it would be beneficial to re-check the view of primary users (beyond UNICEF) on the outline and questions to be answered by the evaluation.

**LIMITATIONS TO EVALUABILITY**

The following is considered to be as limitations to the evaluability:

- Disaggregation of data (be gender and age) is available only for the adolescents participated in the baseline and follow up assessment (see also the above overview of the project provided in Chapter 3. Overview of adolescent suicide prevention pilot in Kyzylorda Oblast);

- Only adolescents from schools sampled and participated in the baseline and follow up (in 12 months) data collection (assessment of the impact of adolescent suicide prevention project). Adolescents from colleges (total number – 5216) were not covered by the assessment;

- the outcomes of the project (as described in the overview of the project) cannot be compared with a control group, therefore identification of some linkages in the causal chain, which are most critical to the success, could be to some extent challenging;

- a complexity of the project (multiple interactions between project components) might complicate identification of the attribution of causes and identification of effects;

- Stigma surrounding suicide and suicide prevention (particularly, myth that asking about suicide and related behaviours may induce suicidal ideation) is still very strong and might affect some stakeholders’ views about the project relevance, effectiveness and so on.

**Evaluation methodology:** In order to deliver this assignment, the international experts/or institution will have to make and arrangement for contracting the national consultant(s) to assist in evaluation design, to undertake the field data collection and data entry, and to provide raw data for analysis and interpretation under guidance of the UNICEF CO and in close cooperation with Ministries and other partners.
The Evaluation team is expected to submit a work plan within the first 10 days of assignment and to confirm the evaluation methodology, tools and sample size with the UNICEF. The Ethical Review will be conducted through either Ethical Review Board (ERB) of the company or ERB at Nazarbayev University via UNICEF-Nazarbayev University MOU. If neither of these options will be available then the regional LTA holder will be used for the ERB. The Evaluation team will have the sole responsibility for the hiring, training, supervision and payment of the national consultants needed for this evaluation. Upon request, UNICEF may recommend people who were engaged in similar research previously, but it will be the responsibility of the evaluator to select and manage these consultants. Logistical support such as transport and office use will need to be agreed upon before the evaluation is initiated.

The Evaluation team is expected:

- to elaborate the methodology for the field data collection by the set of evaluated components and questions, including sampling, research techniques, and budget estimation.
- are encouraged to propose own solutions ensuring reliability of collected data and cost-effectiveness of research approaches. In any case, the field research should provide findings to answer research questions as outlined above.
- is required to conduct a desk-research primarily of official documents and secondary data which are not available in English and extract information if need.
- will be responsible to design the evaluation tools and to conduct survey/Interviews s in accordance with the methodology proposed in response to this Request for Proposals.

In gathering data and views from stakeholders, the evaluation team will ensure that it considers a cross-section of stakeholders (decision makers, programme personnel, beneficiaries, etc.) with potentially diverse views to ensure the evaluation findings are as impartial and representative as possible. The approach followed from the outset of the evaluation will be as participative as possible. Stakeholders will participate in the evaluation through interviews, discussions, consultations, providing comments on draft documents and making management responses to the recommendations of the evaluation.

During the inception phase, the evaluation team will design the evaluation methodology to be present in an inception report. The methodology should:

- built on the theory of change for ASP pilot and on the common objectives arising across interventions to develop an evaluation matrix.
- be geared towards addressing the evaluation questions. A model looking at groups of “main activities” across a number of interventions rather than at individual actions should be adopted. These could be organised around the determinants framework.
- take into account the limitations to evaluability described earlier as well as budget and timing constraints.

To the extent possible, secondary data will be assessed during the Inception phase to start addressing evaluation issues and identifying the information gaps prior to the in-country mission.

The Evaluation team is to:

- Work jointly in interviews with relevant national and local partners;
- Develop research instruments (including data entry tool) and field-test them before the onset of the evaluation;
- Organise data collection process and carry out field research work with local team of experts;
- Discuss comments/feedbacks of the results of the field research and provide clarifications, apply data quality check/validation efforts when required;
- Discuss the draft evaluation report through organising a consultative process under the guidance of the UNICEF CO Deputy Representative, Health, Youth, and Adolescents Development Officer with major in-country stakeholders, as well as in promotion of the evaluation report and preparing management response.
3. Supervision and reporting:
The consultant will be supervised and report to UNICEF Youth and Adolescents Development Officer in Kazakhstan with a regular de-briefing on the progress of the assignment to the UNICEF Deputy Representative and will work on a regular basis with all involved staff of UNICEF CO: Child Rights Monitoring Specialist and Programme Specialist (beyond the border) and with identified national and sub-national stakeholders/partners.

4. Structure of evaluation report
The evaluation report structure must be compliant with the UNICEF-Adapted UNEG Evaluation Reports Standards, 2010 (see the attached files: UNEG_UNICEF_Eval_Report_Standards.pdf and Unicef_Revised_evaluation_policy.pdf) and http://intranet.unicef.org/epp/evalsite.nsf/0/2BDF97BB3F789849852577E500680BF6/$FILE/UNEG_UNICEF Eval Report Standards.pdf the GEROS Quality Assessment System (see the attached file: GEROS_Methodology_v7.pdf) and include:

- The title page and opening pages;
- Executive Summary (2-3 pages);
- Annexes;
- Object of Evaluation;
- Evaluation Purpose, Objective(s) and Scope;
- Evaluation Methodology;
- Findings;
- Conclusions and Lessons Learned;
- Recommendations;
- Gender and Human Rights, including child rights.

UNICEF will keep the right to share the shorter (external) version of the report with the Government and make it public.

5. Procedures and logistics:
Travel arrangements including purchase of the air tickets is the responsibility of the selected company/institution and estimated cost of travel should be clearly indicated in the financial proposal. Calculations of travel costs should be based on economy class travel regardless of the length of the travel. Cost estimates should be exclusive of all taxes as UNICEF is exempted from all taxes. UNICEF does not provide or arrange health insurance coverage for contractors.

6. UNICEF general terms and conditions
UNICEF’s general terms and conditions will apply to the contract awarded to the vendor. Please note that, in the evaluation of the technical merits of each proposal, UNICEF will take into consideration any proposed amendments to the UNICEF General Terms and Conditions. Proposed amendments to the UNICEF general terms and conditions may negatively affect the evaluation of the technical merits of the proposal.

UNICEF reserves the right to withhold all or a portion of payment if performance is unsatisfactory, if work/outputs is incomplete and not provided timely as indicated in the individual work plan of Contractor. This ToR is an integral part of the contract (PO) signed with the consultant.

UNICEF retains the right to patent and intellectual rights, as well as copyright and other similar intellectual property rights for any discoveries, inventions, products or works arising specifically from the implementation of the project in cooperation with UNICEF. The right to reproduce or use materials shall be transferred with a written approval of UNICEF based on the consideration of each separate case. Consultants should always refer to UNICEF Kazakhstan support in developing the materials when publishing the results of the research conducted while in Kazakhstan in academic journals, books and websites.
Annex 2: Summary of the Contribution Analysis process

The process of conducting contribution analysis can be summarised in six steps (Mayne 2011). It is important to note that this is an iterative process which takes into account participants’ feedback and includes steps to seek out additional evidence and revise/strengthen the claims to contribution.

**Step 1:** The first step to contribution analysis is to set out the cause-effect issue to be addressed by the evaluation. This means identifying the specific cause-effect questions being asked and determining the level of confidence required to answer these questions. It is also the opportunity to conduct initial thinking on the key influencing factors and to assess how plausible the expected contribution is.

**Step 2:** A theory of change is reconstructed to map out the logical framework by which the project postulates to bring about change. This will include identifying the underlying assumptions, risks, unintended effects and other explanatory factors.

**Step 3:** Existing evidence to support the claims of the ToC are gathered and analysed. This includes existing project data and evidence from previous evaluations and relevant research. The aim here is to evidence and strengthen the cause-effect links postulated by the ToC.

**Step 4:** A contribution story (or narrative) is developed using existing evidence on the results, assumptions and influence of other factors. This narrative is then assessed to measure the strengths and weaknesses of the ToC, and the relevance of other factors.

**Step 5:** Following step 4, the evaluation team assess what additional evidence is needed to strengthen the contribution narrative and gathers new evidence to further support the cause-effect claims.

**Step 6:** The contribution narrative is revised and strengthened using new evidence and reassess the narrative’s strengths and weaknesses and the relevance of other factors.
Annex 3: Evaluation framework and KEQ

**IMPACT LEVEL: Adolescents live healthy lives with mental health well-being**

Purpose of the evaluation:
1. To identify the extent to which the adolescent suicide prevention project in Kyzylorda Oblast has achieved its objectives, and the results that have been achieved to date, including any unintended results from the pilot, as well as their particularity at outputs at the individual, household and community levels.
2. To identify the opportunities and constraints the project has faced and draw lessons and good practices from them.
3. To assess the cost benefit of the pilot (final costing methodology depends on availability of data).
4. To identify the extent to which cross-cutting strategies such as a human rights-based approach, results-based management and gender equity have been mainstreamed in the design and implementation of the programme.

**Overarching Key Evaluation Questions**
- How well do these outputs and outcomes contribute to preventing adolescent suicide (model of prevention)?
- What factors affected the achievement of the outputs and outcomes (in terms of implementation, partnership working, use of evidence and data?)
- What is the strength of evidence for each outcome?
- How efficiently did the ASP allocate resources for the implementation of the project?
- How well has the pilot contributed to the implementation of a child rights framework (outlined in ‘general comments no.20’ and those made by the Child Rights Committee to Kazakhstan)?
- What do key stakeholders (adolescents (at risk and general), service providers, teachers, health decision-makers and others) perceive the ASP pilot’s benefits as being? How well does the evidence support these perceptions?
- What are the cost components of the pilot which should be considered for replication?
- What other factors should be considered for replication?

**OUTCOME 1: Adolescents at risk are identified and have access to appropriate mental health services**

<table>
<thead>
<tr>
<th>Category</th>
<th>Key Evaluation Questions (KEQ)</th>
<th>DAC/OECD Criteria</th>
<th>Data collection methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>Output 1: Awareness raising materials about mental health</td>
<td>Are the awareness raising materials appropriate, acceptable and accessible (e.g. posters etc.)?</td>
<td>Relevance</td>
<td>Document review and</td>
</tr>
<tr>
<td>Issues are disseminated to adolescents</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>How has resistance been addressed?</td>
<td>Effectiveness</td>
<td>• KI interviews and FGD</td>
<td></td>
</tr>
<tr>
<td>How can addressing continued resistance be improved in the future?</td>
<td>Sustainability</td>
<td>• KI interviews and FGD</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Output 2: Adolescents are screened for potential mental health problems</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>How sensitive is the screening tool (is it best practice and does it follow international standards)?</td>
<td>Effectiveness</td>
<td>• Document review and data analysis</td>
<td></td>
</tr>
<tr>
<td>Is the screening tool appropriate and acceptable?</td>
<td>Relevance</td>
<td>• Document review and data analysis • KI interviews and FGD</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Output 3: Gatekeepers and health providers participate in mental health awareness raising training</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>How appropriate were the training materials?</td>
<td>Relevance Effectiveness</td>
<td>• Document review and data analysis • KI interviews and FGD</td>
<td></td>
</tr>
</tbody>
</table>
### OUTCOME 2: Health and Education systems strengthened to address mental health issues

<table>
<thead>
<tr>
<th>Category</th>
<th>Key Evaluation Questions (KEQ)</th>
<th>DAC/OECD Criteria</th>
<th>Data sources</th>
</tr>
</thead>
</table>
| **Output 2: Adolescents are screened for potential mental health problems** | Have school and college psychologists received sufficient and timely training to use the screening tool? | Effectiveness Impact | • Document review and data analysis  
• KI interviews and FGD |
| | | | |
| | Is it appropriate to screen adolescents through the school system? | Relevance Efficiency Effectiveness | • Document review and data analysis  
• KI interviews and FGD |
<p>| <strong>Output 3: Gatekeepers and health providers participate in</strong> | Are there any gaps in training? | Efficiency Effectiveness | • KI interviews and FGD |</p>
<table>
<thead>
<tr>
<th>Output 4: A referral system is in place to provide adequate mental health services (including PHC services)</th>
<th>Efficiency Effectiveness</th>
<th>Efficiency Effectiveness Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are there enough human resources trained and available?</td>
<td>Efficiency Effectiveness</td>
<td>Efficiency Effectiveness Impact</td>
</tr>
<tr>
<td>Are there any gaps in the referral system?</td>
<td>Efficiency Effectiveness Impact</td>
<td>Efficiency Effectiveness Impact</td>
</tr>
<tr>
<td>How can the referral system be improved in the future?</td>
<td>Efficiency Effectiveness Impact</td>
<td>Efficiency Effectiveness Impact</td>
</tr>
<tr>
<td>Assumption: Sufficient HRH are in place, trained with the right materials and motivated</td>
<td>Efficiency Effectiveness Impact</td>
<td>Efficiency Effectiveness Impact</td>
</tr>
<tr>
<td>Are there any gaps in human resources?</td>
<td>Efficiency Effectiveness Impact</td>
<td>Efficiency Effectiveness Impact</td>
</tr>
<tr>
<td>Category</td>
<td>Key Evaluation Questions (KEQ)</td>
<td>DAC/OECD Criteria</td>
</tr>
<tr>
<td>----------</td>
<td>-------------------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td><strong>Output 5: Evidence and monitoring data are being collected and analysed</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Has the intervention been systematically monitored (i.e. with an approved M&amp;E framework)?</td>
<td>Efficiency</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Effectiveness</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sustainability</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Was there a budgeted workplan at design stage?</td>
<td>Efficiency</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Effectiveness</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sustainability</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Has any feedback been provided to gatekeepers and/or adolescents and their parents?</td>
<td>Efficiency</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sustainability</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Have lessons learned been systematically recorded, analysed and acted upon?</td>
<td>Efficiency</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Effectiveness</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sustainability</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td>Methodology</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>-------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>What are the cost components of the pilot which should be considered for replication?</td>
<td>Efficiency Sustainability Document review and data analysis KI interviews and FGD</td>
<td></td>
</tr>
<tr>
<td>What other factors should be considered for replication?</td>
<td>Efficiency Effectiveness Sustainability KI interviews and FGD</td>
<td></td>
</tr>
<tr>
<td>What should UNICEF’s role be in the scale up / replication of the intervention?</td>
<td>Sustainability KI interviews and FGD</td>
<td></td>
</tr>
<tr>
<td>What should Bilim Foundation’s role be in the scale up / replication of the intervention?</td>
<td>Sustainability KI interviews and FGD</td>
<td></td>
</tr>
<tr>
<td>Do stakeholders across the care pathway perceive the allocation of resources within the ASP pilot as being sufficient to meet the project’s objectives?</td>
<td>Sustainability KI interviews and FGD</td>
<td></td>
</tr>
<tr>
<td>What should be considered in terms of costing allocations if the project is scaled-up?</td>
<td>Sustainability Document review and data analysis KI</td>
<td></td>
</tr>
<tr>
<td>Assumption: There is strong and reliable evidence the intervention works</td>
<td>What evidence already exists to support the intervention model and how strong is it?</td>
<td>Impact</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Document review and data analysis</td>
<td>KI interviews and FGD</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category</th>
<th>Key Evaluation Questions (KEQ)</th>
<th>DAC/OECD Criteria</th>
<th>Data sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Precondition: Inter-sectoral collaboration with strong political will and leadership</td>
<td>How was inter-sectoral collaboration implemented?</td>
<td>Efficiency</td>
<td>Effectiveness</td>
</tr>
<tr>
<td>Document review and data analysis</td>
<td>KI interviews and FGD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How effective was inter-sectoral collaboration?</td>
<td>Effectiveness</td>
<td>Document review and data analysis</td>
<td>KI interviews and FGD</td>
</tr>
<tr>
<td>Policy context: The PHC reform introduced mental health services at primary care level</td>
<td>How has PHC reform influenced the intervention?</td>
<td>Efficiency</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>Policy context: The intervention may influence the ongoing mental health reform in Kazakhstan</td>
<td>How can the intervention influence the mental health reform?</td>
<td>Sustainability</td>
<td></td>
</tr>
<tr>
<td>Unexpected effect: ASP highlighted the sociocultural and contextual factors contributing</td>
<td>Has the intervention had any unexpected effects?</td>
<td>Sustainability</td>
<td></td>
</tr>
</tbody>
</table>

What institutional strengthening measures are needed to contribute to a sustainable model that can be replicated nationally?

What role does inter-sectoral collaboration and political will and leadership have to play in the scale up and/or replication of the intervention?
<table>
<thead>
<tr>
<th>to poor mental health in adolescents</th>
<th>What are the effects of the unintended results on the project’s outcomes?</th>
<th>Impact Sustainability</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Document review and data analysis</td>
<td>• KI interviews and FGD</td>
</tr>
</tbody>
</table>
Annex 4: Data collection process

1. ToC Reconstruction workshops

The first ToC workshop was held at central level in Astana on the 22nd of November 2017, with representatives from the Ministry of Health (MoH) and its National Centre for Mental Health Centre (NCMH), the Ministry of Education and Science (MoES), Bilim Foundation, and UNICEF. The results of this workshop were a better understanding of how the ASP project worked, partners and stakeholders roles and responsibilities in the project, the contextual factors which may have influenced the intervention, and how the intervention in turn influenced the broader context (including unexpected results of the project). It also facilitated the identification of key outputs, outcomes, assumptions and preconditions of the project, which are presented in Section 3 of this report.

The second ToC workshop was held in Kyzylorda on the 23rd of November 2017, with representatives of the Department of Education and Sciences (DoES), psychologists, neurologists, psychiatrists and a general practitioner (Table 1).

<table>
<thead>
<tr>
<th>Participants</th>
<th>Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department of Education</td>
<td>1</td>
</tr>
<tr>
<td>General practitioner</td>
<td>1</td>
</tr>
<tr>
<td>Psychologist (breakdown below)</td>
<td>18</td>
</tr>
<tr>
<td>School psychologists</td>
<td>9</td>
</tr>
<tr>
<td>Master Trainers</td>
<td>7</td>
</tr>
<tr>
<td>Head of Master Trainers</td>
<td>1</td>
</tr>
<tr>
<td>Mental Health Centre psychologist</td>
<td>1</td>
</tr>
<tr>
<td>Narcologist (breakdown below)</td>
<td>3</td>
</tr>
<tr>
<td>Clinical narcologists</td>
<td>2</td>
</tr>
<tr>
<td>Deputy director of narcology clinics</td>
<td>1</td>
</tr>
<tr>
<td>Psychiatrists</td>
<td>4</td>
</tr>
<tr>
<td>TOTAL</td>
<td>27</td>
</tr>
</tbody>
</table>

There appeared to be a somewhat limited understanding, particularly at regional level, of the concept of ‘Theory of Change’. This was addressed by the Itad team by presenting a simple example of the underlying theory, purpose and development of a ToC. The results of the second ToC workshop were the validation of the reconstructed ToC at central level, and was also the opportunity to discuss the opportunities and challenges which affected the ASP project. Furthermore, the workshop also facilitated the identification of KI to be interviewed (individually or in the form of focus groups) during the data collection work in Kyzylorda Oblast between the 22nd and the 30th of November 2017.
The reconstructed ToC presented in Section 3 of this report was further complemented through the results of the KI interviews and FGD, which process and achievements are presented in the next paragraphs. More specifically, all respondents were asked:

- “From your perspective(s), what was the main purpose of the ASP project?”; and
- “What do you see as the core elements of the project?”

Therefore, the reconstructed ToC summarises the views of central and regional level actors and stakeholders, as well as those of gatekeepers, health service staff, adolescents and their parents.

2. Process of piloting the data collection tools

The data collection tools for this evaluation were developed in an interactive process ahead of the in-country visit. These tools took the form of semi-structured questionnaires, which (due to their semi-structured nature) allowed to probe deeper on specific topics of the evaluation, and gave flexibility to assess some of the key features and/or recurring challenges observed. A specific questionnaire was designed for each category of respondents, namely:

- Key Informants;
- Master Trainers;
- Health providers;
- Gatekeepers;
- Parents; and
- Students.

The questionnaires were presented to UNICEF Kazakhstan in Itad’s Inception Report (November 2017) and subsequently validated. These tools were further validated by Itad’s ethical review process (see paragraph on Ethical considerations below) on the 23rd of November, before being piloted in Kyzylorda Oblast. Every questionnaire was tested at least once with respondents, before undergoing final revisions/adaptations by the evaluation team. These revisions included the rewording of some questions to be more specific and appropriate, as well as the addition or removal of other questions to insure the data collection process would yield the most relevant and insightful responses. After piloting and reviewing the questionnaires, the tools were systematically used for all KI interviews and FGD.

3. Achievements of the data collection process

Between the 24th and the 30th of November 2017, the Itad evaluation team interviewed a total of 120 respondents in a combination of individual interviews and FGD (Table 2).

<table>
<thead>
<tr>
<th>Type of interview</th>
<th># of discussions</th>
<th># of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>FGD</td>
<td>16</td>
<td>106</td>
</tr>
<tr>
<td>Individual interviews</td>
<td>14</td>
<td>14</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>120</td>
</tr>
</tbody>
</table>
Most FGD were held in groups of 2 to 9 respondents, with the exception of one instance where 16 respondents (school teachers) participated in a FGD. The evaluation team would have normally divided this large group into two sub-groups to enhance individual participation in the discussion; however, due to time constraints, it was deemed more appropriate to keep them into a single group on this occasion.

The breakdown of the different types of respondents interviewed is presented in Table 3. This excludes interviews and discussions held with UNICEF Kazakhstan and Bilim Foundation staff.

Table 3: Type of respondents interviewed

<table>
<thead>
<tr>
<th>Respondents</th>
<th>Category</th>
<th>#</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central level</td>
<td>MoH</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>NCMH</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>MoES</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td><strong>Sub total</strong></td>
<td><strong>4</strong></td>
</tr>
<tr>
<td>Akimat</td>
<td>DoH</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>DoES</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td><strong>Sub total</strong></td>
<td><strong>5</strong></td>
</tr>
<tr>
<td>Master Trainers</td>
<td>MT psychiatrist</td>
<td>1</td>
</tr>
<tr>
<td>Psychiatrists</td>
<td>MH Centre</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>PHC</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td><strong>Sub total</strong></td>
<td><strong>5</strong></td>
</tr>
<tr>
<td>GPs</td>
<td>PHC</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>YHC (Youth Friendly Services)</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td><strong>Sub total</strong></td>
<td><strong>8</strong></td>
</tr>
<tr>
<td>Psychologists</td>
<td>School psychologists</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>PHC psychologists</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>YHC psychologists</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td><strong>Sub total</strong></td>
<td><strong>15</strong></td>
</tr>
<tr>
<td>Narcologists</td>
<td>Mental Health Centre</td>
<td>2</td>
</tr>
<tr>
<td>Teachers/Support staff</td>
<td></td>
<td>32</td>
</tr>
<tr>
<td>Parents</td>
<td>of general students</td>
<td>18</td>
</tr>
<tr>
<td></td>
<td>of adolescents at risk</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td><strong>Sub total</strong></td>
<td><strong>20</strong></td>
</tr>
<tr>
<td>Students</td>
<td>General</td>
<td>24</td>
</tr>
<tr>
<td></td>
<td>at risk</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td><strong>Sub total</strong></td>
<td><strong>28</strong></td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td><strong>120</strong></td>
</tr>
</tbody>
</table>

During the data collection work, the Itad team visited a mix of schools/colleges, primary health centres, a mental health center, a youth health centre, as well as visits to the local government’s (Akimat) DoH and DoES (Table 4).
Table 4: Sites visited in Kyzylorda Oblast during data collection

<table>
<thead>
<tr>
<th>Sites sampled</th>
<th>Category</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kyzylorda Region</td>
<td>Schools</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>College</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Primary Health Centres</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Mental Health Centre</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Youth Health Centre</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>DoH</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>DoE</td>
<td>1</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td><strong>15</strong></td>
</tr>
</tbody>
</table>

The evaluation team rapidly reached saturation through the questionnaires, which means that after interviewing the majority of respondents, responses from the interviews were not yielding any information that had not already been reported. This gave the opportunity to probe more in depth on key elements of the evaluation which started to appear during the last rounds of interviews and FGD.

The data collection process resulted in a wealth of information that is, at the time of writing, being transcribed and coded for further, more in-depth, and thorough analysis. The resulting analysis and conclusions will be presented in the final evaluation report.
Annex 5: Steps in analyses employing thematic networks

<table>
<thead>
<tr>
<th>Analysis Stage A: Reduction or breakdown of text</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1. Code material</td>
</tr>
<tr>
<td>a. Devise a coding framework</td>
</tr>
<tr>
<td>b. Dissect text into text segments using the coding framework</td>
</tr>
<tr>
<td>Step 2. Identify themes</td>
</tr>
<tr>
<td>a. Abstract themes from coded text segments</td>
</tr>
<tr>
<td>b. Refine themes</td>
</tr>
<tr>
<td>Step 3. Construct thematic networks</td>
</tr>
<tr>
<td>a. Arrange themes</td>
</tr>
<tr>
<td>b. Select Basic Themes</td>
</tr>
<tr>
<td>c. Rearrange into Organising Themes</td>
</tr>
<tr>
<td>d. Deduce Global Themes</td>
</tr>
<tr>
<td>e. Illustrate as thematic networks</td>
</tr>
<tr>
<td>f. Verify and refine the network</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Analysis Stage B: Exploration of text</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 4. Describe and explore thematic networks</td>
</tr>
<tr>
<td>a. Describe the network</td>
</tr>
<tr>
<td>b. Explore the network</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Analysis Stage C: Integration of exploration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 5. Summarise thematic networks</td>
</tr>
</tbody>
</table>

| Step 6. Interpret patterns                        |

*Source: Adapted from Attride-Stirling, 2001*
Annex 6: A 15-point best practice checklist for thematic analysis

<table>
<thead>
<tr>
<th>Process</th>
<th>No.</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transcription</td>
<td>1</td>
<td>The data have been transcribed to an appropriate level of detail, and the transcripts have been checked against the tapes for ‘accuracy’.</td>
</tr>
<tr>
<td>Coding</td>
<td>2</td>
<td>Each data item has been given equal attention in the coding process.</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>Themes have not been generated from a few vivid examples (an anecdotal approach), but instead the coding process has been thorough, inclusive and comprehensive.</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>All relevant extracts for all each theme have been collated.</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>Themes have been checked against each other and back to the original data set.</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>Themes are internally coherent, consistent, and distinctive.</td>
</tr>
<tr>
<td>Analysis</td>
<td>7</td>
<td>Data have been analysed – interpreted, made sense of - rather than just paraphrased or described.</td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>Analysis and data match each other – the extracts illustrate the analytic claims.</td>
</tr>
<tr>
<td></td>
<td>9</td>
<td>Analysis tells a convincing and well-organised story about the data and topic.</td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>A good balance between analytic narrative and illustrative extracts is provided.</td>
</tr>
<tr>
<td>Overall</td>
<td>11</td>
<td>Enough time has been allocated to complete all phases of the analysis adequately, without rushing a phase or giving it a once-over-lightly.</td>
</tr>
<tr>
<td>Written report</td>
<td>12</td>
<td>The assumptions about, and specific approach to, thematic analysis are clearly explicated.</td>
</tr>
<tr>
<td></td>
<td>13</td>
<td>There is a good fit between what you claim you do, and what you show you have done – i.e., described method and reported analysis are consistent.</td>
</tr>
<tr>
<td></td>
<td>14</td>
<td>The language and concepts used in the report are consistent with the epistemological position of the analysis.</td>
</tr>
<tr>
<td></td>
<td>15</td>
<td>The researcher is positioned as active in the research process; themes do not just ‘emerge’.</td>
</tr>
</tbody>
</table>

Source: Adapted with permission from Braun and Clarke, 2006
Annex 7: A note on language used in this report

A challenge in suicidology and suicide prevention work has long been finding consensus around accurate and appropriate terminology to clearly define different types of thoughts and behaviours. Standardised language has been attempted by numerous agencies including WHO and the Centers for Disease Control and Prevention (CDC) (WHO, 2014). Definitions which do not consider the intent behind ideations and behaviours risks over- and under-identifying at risk populations.

As such, this report intentionally uses the CDC’s recommended language around Self-directed Violence (SDV). We use this term throughout this report, and use the following language in discussing suicide (Crosby, Ortega and Melanson, 2011):

1. Committed suicide will be presented as suicide, death by suicide, or he/she/they suicided. The word ‘commit’ is a relic from when suicide was illegal and is heavily stigmatising.
2. Completed or successful suicide will be referred to as suicide.
3. Unsuccessful or a failed attempt will be (non-fatal) suicide attempt or (non-fatal) suicidal SDV.
4. Parasuicide fails to consider intent and should be distinguished as suicidal or non-suicidal SDV.
5. Suicidal gesture, manipulative act, or suicide threat should not be used.
6. Suicidality often refers to both thoughts and behaviours and therefore Suicidal Ideation and Behaviour (SIB) will be used instead to denote when both experiences are included, and will distinguish between Suicidal Ideation (SI) and Suicidal Behaviour (SB) when necessary. SI often occurs independently, as most people with SI never go on to act on their thoughts. However all SB is proceeded by thoughts, even briefly in the case of impulsive acts.
7. SDV is a suitable term when the intent of thoughts or behaviour are not known and avoids making assumptions. Self-harm, although sometimes also viewed as problematic, may be used also in this report and clarified as non-suicidal or suicidal in nature.

The reader may notice the use of terminology not supported by the CDC or us, however this is in the context of respondents being quoted or faithfully paraphrased, and in such instances we have chosen to accurately represent their language. The language used by populations around this topic can sometimes be used as a marker of stigmatisation.
Annex 8: Ethical Review

The evaluation methodology did undergo internal ethical review within Itad, and is in line with Itad’s ethical principles. These are in line with the United Nations Evaluation Group’s (UNEG) ‘Norms and Standards for Evaluation (2016)’, which includes:

- Respect for the right of participants to provide information in confidence
- Ensuring that sensitive data is protected
- Ensuring informed consent
- Following a ‘do no harm’ principle

Itad has a statement of ethical principles and adheres to these in all the evaluations that it conducts. Following clear ethical principles, which consider and reduce the potential harm to participants from taking part in the evaluation, is particularly true in the context of this evaluation, which addresses a sensitive topic (suicide) in Kazakhstan. To do so, Itad has taken ethical measures and considerations in every step of the evaluation process. These include:

- Internal ethical review for the data collection process prior to piloting the data collection tools;
- The development of informed consent forms (in both Russian and Kazakh), presented to and signed by respondents, which explicitly state that respondents, should they wish to participate, are providing information of their own free will, and that all information collected through interviews will be kept anonymous; and
- Ensuring confidentiality at all stages of the process (including data and document reviews).

In the context of this evaluation, all respondents agreed to take part in the interviews and signed an informed consent form. The generic ethics consent form was presented in the inception report, as was a confirmation that the project methods and tools had been reviewed by the Itad project director and assessed in line with the Itad ethical principles.

In line with the ‘do no harm’ principle, the EVT focused their questions on experience of the programme, perceptions of access to services and appropriateness of the intervention. Questions did not concern adolescents’ personal experiences of mental disorders, interventions to prevent those at high risk from suicide, or of peers who may have suicided. Furthermore, in order to ensure the anonymity of students at risk, all interviews with students at risk were conducted off the school grounds and in the Kyzylorda Youth Health Centre (YHC) on appointment. This allowed students at risk to remain anonymous in regards to their peers and to access the YHC’s mental health services before and/or after the interviews if they desired to do so. Although students at risk were interviewed individually, their parent(s) or care takers were also present at the time of the appointment and gave their written informed consent to the evaluation team before interviews were conducted with their child.

Annex 9: Generic Interview Guide
TOPIC GUIDE:
Adolescents’ understanding and experiences of the Adolescent Suicide Prevention Pilot programme

[Following informed consent process / initiating recording]

Introduction / Warm-up
1. Let’s start with some introductions. Please tell us how you’d like to be addressed during this discussion [the name you’d like us to use]
2. How old are you?
3. Think back to when you were first introduced to the programme.
   - How was it that you first learned about the programme? Probe: who, when

Perceived programme purpose and students’ response to the programme
4. Tell me about the ASP pilot
   - From your perspective, what is the main purpose of the ASP programme? Probe:
     i. Do they place an emphasis on overall health and wellbeing or specifically on suicide, or a balanced view?
5. Why did you agree to participate in the programme?
6. What are the activities you became involved with? Probe:
   a. Activities around mental health and wellbeing
   b. Activities around suicidal ideation and behaviour
7. How did the school work with you to support your participation in the programme?
8. To what extent do you feel your questions and opinions about the programme were addressed by school staff?
9. Is there anything that you think could have been done differently to involve students in the programme?

Perceptions of programme’s ability to help vulnerable young people and their families (effectiveness)
10. Please share any examples of when you think the programme was able to help a young person in your school.
11. Based on your knowledge of peers identified by the programme as needing extra support, how well did the referral process to health services work? Probe:
   - Was it timely?
   - Were there any barriers or challenges to accessing help? Probe: Physical, economic, administrative, cognitive, psychosocial barriers to access
   - In your opinion, how have peers been treated by health providers and school management in the programme?
   - To your knowledge, how supported or involved do you think parents/guardians have been when their teenager has been identified as needing additional support?
   - Have you or any of your peers had concerns about using the referrals? Why?
   - How effective/useful do you believe the care provided by health services has been for peers needing extra support?
12. [If they have not already done so through the above sub-questions] Please share any examples of when you think the programme failed to identify a fellow student who needed help.
13. In your opinion, how could the identification, referral and support of your peers who need support be done better?
Perceived programme achievements

14. In what ways do you think that the programme was or was not useful?
15. In your opinion, what has been the best feature of the programme?
16. What did you like least about the programme?
17. Thinking about yourself or your peers, in what way(s) has life changed since participating in the programme? Probe:
   - Knowledge of support services / help
   - Knowledge of mental health
   - Attitudes towards help-seeking
   - Attitudes towards mental health or peers with suicidal ideation or behaviour
   - Changes in your own sense of wellbeing (better/worse; nature of those changes)
   - Changes in physical health
   - Changes in coping with stress or challenges
   - Behaviour changes in
     - seeking help
     - speaking to others about mental health and lifestyle choices
     - risky behaviours (drinking, smoking, using drugs)
18. What other factors may have contributed to the changes you’ve seen in yourself or in your peers?
19. Have you seen the issue of adolescent suicide and/or adolescent mental health being addressed in Kazakhstan outside of this programme?
   a. If yes, by whom?
   b. If yes, in what ways?
   c. If yes, what is your opinion of these other sources?
20. As you became involved in the programme, did you discover any unintended impacts or consequences (either positive or negative) that you did not initially expect?
   - Probe for any potentially iatrogenic effects (e.g. any occasions students were incorrectly identified as ‘at risk’; experiences of stigma. etc.)

Sustainability and future programming

21. To what extent do you feel this programme should be provided to students and schools in other parts of the country?
22. Are there other groups the programme should be working with in future [which this pilot did not reach (enough)]? E.g. out of school teens
23. Looking forward, do you have suggestions for how the programme can improve its relationship with students?
24. In what other ways would you like to involved in the programme, if any?

Wrap-up
What else should we have discussed but haven’t yet?