Background

As the current UNICEF Kyrgyzstan Country Programme 2012-2016 is coming to an end this year, the Country Office (CO) is in a process of planning the next Country Programme for the period of 2018-2022. Building on national priorities, the SDGs and UNICEF comparative advantages, the CO has recently conducted a thorough situation analysis of children in Kyrgyzstan, an external evaluation of the current Country Programme, and a gender review of programmes to inform the development of the new Country Programme. As a result, adolescent health and wellbeing is recognized as one of the key priorities for UNICEF for next five years. In particular, child and forced marriages, increased adolescent suicide rates, adolescent health issues, religious extremism and radicalization, and magnified road accidents among children are considered as child rights violations relevant to adolescents (10-19 years) in Kyrgyzstan and need prioritization of interventions and programmatic focus within the next Country Programme.

Given the complexity of issues listed above, the CO recognizes the importance to develop cross-sectoral approaches to programming. To this end, the structure of the Country Programme 2018-2022 is planned as following:

1) Outcome 1: Child Rights Monitoring and Enabling Environment
   By 2022, an enhanced policy environment and national/sub-national systems are in place for the realization of child rights, with a focus on equity, guided by knowledge and evidence, while empowered rights holders demand their entitlements
   Output 1. The state and non-state child rights mechanisms have the capacity to generate credible evidence to inform policies and effectively monitor their results
   Output 2. Children and adolescents have skills to channel their voice and influence the decision-making process affecting their lives

2) Outcome 2: Equitable access to Integrated Services for Children
   By 2022, the most vulnerable children enjoy equitable access to and utilize quality integrated services that promote their protection, survival, development, and welfare, as well as inclusion in the society.
   Output 1. Sectoral ministries and state bodies have knowledge and skills to develop and implement inclusive policies for children
Output 2. Social (health, education, ECD, welfare) and justice professionals have necessary knowledge, skills and tools to provide equitable access to child and adolescent friendly services

Output 3. Children and their caregivers have necessary knowledge and skills to demand inclusive, gender and environmentally sensitive services and adopt positive practices

To support the CO in developing the work around adolescent health programming, Adolescent Health Officer Susanna Lehtimaki from NYHQ Health Section was invited to a country mission followed by a visit by Regional HIV Advisor Ruslan Malyuta from CEE/CIS RO. The objective of the first mission from NYHQ was to conduct a brief data analysis of the key health issues and risk factors in adolescence based on existing data; identify key data gaps; and define entry points for programming. The mission (agenda as an annex 1) included several meetings with UNICEF programmes and key partners as well as a round table at the Ministry of Health and a cross-sectoral meeting for UNICEF programme staff.

Overview of Adolescent Health in Kyrgyzstan

In Kyrgyzstan, the proportion of young people is relatively high: adolescents (10-19 years) comprise almost one fifth of the population and more than half of the population is currently under 25 years. The majority of them live in rural areas with limited access to health, education and social services and recreational activities.1 In recent years, investments made in health of infants and children under five have resulted in enhanced child survival in Kyrgyzstan. Thus far, adolescent health has not been prioritized in national programmes, however, decreasing child mortality rates enables to emphasis adolescent health issues so as to ensure that the progress made in early childhood continues throughout the second decade of life to adulthood.

Following the global trend, injuries are the most significant cause of death in adolescence in Kyrgyzstan, in both 10-14 and 15-19 age groups (Figure 1).2 In early adolescence (10-14 years), key causes of premature deaths (calculated as years of life lost, YLL) are drowning, road injuries and lower respiratory infections. When adolescents grow older, the health profile changes and in addition to road injuries, self-harm and violence (green areas in the figure below) become significant causes of death while the importance of communicable diseases (orange/red) reduces.

According to the statistics by NatStatCom3 road injuries are increasing especially among adolescent boys. Between 2004 and 2012, the suicide rate among young boys increased by 1.3 deaths per 100,000 aged 15-29 years, from 15 to 16.3. Among girls the rate has more than doubled over the same period, from 3 to 6.6.4 However, due to stigma, families may not report suicide cases, thus the figures are assumed to be higher.

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1 UNICEF. Situation Analysis of Children in the Kyrgyz Republic. 2016, in press.
3 Национальный статистический комитет КР. Молодежь в Кыргызской Республике 2014, Бишкек.
4 UNICEF. Gender Programme Review: the Kyrgyz Republic. 2016, in press.
Whereas **AIDS-related deaths** among children have declined, the deaths are increasing in both early and older adolescent age groups.

When analyzing adolescent profiles on disability-adjusted life years (DALYs), **mental health issues** (blue, upper left corner) are a significant cause of morbidity among both younger and older adolescent groups. In early adolescence, **anemia rates** are relatively high. For DALYs, see figure 2 below.

According to UNICEF Gender Programme Review⁵, several forms of violence against women and children are perpetrated in Kyrgyzstan, including domestic violence, gender-based and sexual violence, bride kidnapping, child marriage, trafficking in women and children, abuse and neglect, and violence at school both by children and staff. DHS 2012 confirms that while 6.3% of adolescent girls 15-19 years responded to have experienced physical violence since age 15, 3.9% during the last 12 months, and 2.7% by a partner.

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⁵ UNICEF. Gender Programme Review: the Kyrgyz Republic, ibid.
or a husband, only 62.3% of girls responded that they never sought help or reported of experienced violence. Hence, violence remains largely underreported.

Globally, child marriage is a key driver of adolescent pregnancies. Compared to high burden countries, such as Niger, India and Bangladesh, child marriage is relatively rare event in Kyrgyzstan. However, according to MICS, marriages among adolescent girls 15-19 years have increased from 7.7% to 13.9% between 2006 and 2014.

Regional comparison of adolescent pregnancies show that adolescent fertility rates in Kyrgyzstan are second highest in the CEE/CIS region at 42.1 per 1,000 live births per 1,000 women under 20 years. The rates have increased by one quarter between 2000 and 2012. In absolute terms, over 4,700 adolescent girls 15-19 years gave birth in 2013 and of them, almost 300 gave birth already to a second child. Adolescent birth rates are highest in Talas, Batken and Jalal-Abad Oblasts, and among girls from rural areas, lowest wealth quintile and minority families with Uzbek background. However, according to MICS 2014 data, the coverage of maternal health services, including antenatal care and skilled birth attendance is on the same level among adolescent girls and older women and there is no significant constrains to access between different age groups.

In terms of HIV knowledge, adolescent girls are doing worse than women from older age groups. MICS 2014 data shows that while over 90% of women 25-29 years old know where to get tested for HIV, only 43% of girls 15-19 years old know the place. Similarly, 22% of older women have comprehensive HIV knowledge compared to 17% of adolescent girls. Figures for comprehensive knowledge of mother-to-child transmission are 65% and 50%, respectively. Given the increasing adolescent birth rates, the low level of HIV knowledge among adolescent girls is a risk for mother-to-child transmissions.

Poverty rates are relatively high among adolescents and young people in Kyrgyzstan. Poverty rates have increased in recent years by almost 40% among adolescents 14-18 years between 2009 and 2013.

School attendance is one of the key protective factor for better health outcomes in adolescence and later in life. According to MICS 2014, the proportion of out-of-school children (OOSC) gradually increases after 14 years of age and is more common among boys than girls. Based on the responses of school-aged children in the national OOSC 2012 study, the majority (54%) of causes for not attending school related to family matters followed by school (31%) and health (15%) -related reasons. In most cases, family-related reasons were associated with poverty, for example not having clothes/shoes or school supplies, earning money or helping the family at home or with livestock. However, a recent OOSC analysis from 2014 indicates that unlike a common perception, OOSC are more often from urban than rural areas. Furthermore, within this study, wealth had very little influence on attendance rate: if anything,
UNICEF Adolescent Health Focus

Building on the SDGs and the Global Strategy for Women’s, Children’s and Adolescent Health (EWECA), UNICEF’s new Strategy for Health 2016-2030 recognizes adolescents as one of the priority target populations and commits to address key adolescent health issues by advocating for adolescent’s rights to health; influencing government policies; strengthening service delivery; and empowering communities, including adolescents. Adolescent health is also one of the core areas of cross-sectoral adolescent programming along with secondary education, safety and protection of adolescent girls and boys, adolescent engagement and evidence generation and monitoring. Under leadership of ADAP Section at UNICEF NYHQ, a cross-sectoral programme guidance is under development that can support COs in strengthening cross-sectoral programming for adolescent heath, wellbeing and development. Figure 3 below outlines UNICEF core areas of work on second decade of life.

Whereas infants and children aged under 5 years have benefitted from evidence-based programmes and global initiatives enhancing newborn and child survival, adolescent health lacks standard programming, research and well-established monitoring systems that produce an evidence base for clinical and public health practice. However, in recent years several global efforts have been made to bring together the lessons learnt and evidence from programmes targeting adolescent health. Supported by the interagency Adolescent Health Stream under SG’s Global Strategy for Women’s, Children’s and Adolescent Health,

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WHO is currently developing a **Global Framework for Accelerated Action for the Health of Adolescents (AA-HAI)** that will support countries to develop national action plans and programming for adolescent health within and beyond the health sector. The guidance is intended to go to World Health Assembly in May 2017. These global efforts are an opportunity to attract stronger networks, advocates and funding for adolescent health also on a country level, and once finalized, the guidance can help the government along with development partners to strengthen programming for adolescent health and wellbeing in Kyrgyzstan.

**Relevant Programmes in Kyrgyzstan**

**Work by the Key Partners**

During the mission, meetings with UNFPA and WHO was held to clarify the existing initiatives by the two key UN partners. Kyrgyzstan has an active Health SWAp and within its HIV and MCH subgroups, UNICEF works closely with development partners including GIZ, USAID and the UN agencies. This mission was relatively short to discuss with all key national and international partners, however to fully define the scope of the adolescent health programme and UNICEF role vis-à-vis other organizations in the country, a further partner analysis is required.

One of the key areas of UNFPA work in the country is Youth Friendly Health Services (YFHS), and the organization has supported the MoH to develop a concept on YFHS including standards for health services, key competencies/functional duties of health specialists and M&E framework for monitoring the quality of services. Based on the recently updated Global Standards for Quality of Health Services by WHO, UNFPA is currently reviewing and revising the existing standards.

In terms of Comprehensive Sexuality Education (CSE), UNFPA in collaboration with GIZ and UNICEF has developed a healthy lifestyle curricula for general and vocational schools that aims at creating a health supportive environment in schools and dorms. The programme is active in vocational schools and covers topics such as reproductive health, sexual identity, violence, menstrual health, early pregnancy prevention, alcohol, tobacco and drugs use. In addition to training of teachers, medical specialist and dorm mentors, young people themselves are supported to deliver peer-to-peer support. The programme is currently developed further to target adolescents with disabilities. In addition, UNFPA is part of the Inter-Agency Task Force on youth policy development and works with UNICEF and other agencies to enhance youth participation.

WHO is a key partner of UNICEF in health with a focus on supporting the MoH to develop a comprehensive e-health strategy; strengthen civil registration, vital statistics and Health Management Information System (HMIS), and adapting global/regional tools and methodology of evidence-informed policy-making. In August 2016, WHO EURO organized a regional meeting on school health and NCDs in Bishkek that also informed the government on the global AA-HAI! Framework. Currently, the country does not have an action plan on school health and given that the field is highly politicized at the moment, it may take some

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time for development partners to invest in school health system strengthening. Under the leadership of WHO, the UN IATF on NCDs Prevention and Control conducted a country mission to Kyrgyzstan this year to assess the existing national plans and policies relevant to NCDs and its risk factors, and recommends to strengthen the implementation of policies related to reduction of tobacco use, harmful use of alcohol, unhealthy diet and physical inactivity\textsuperscript{16}. Given that many of these health-compromising behaviors are established in adolescence and continue to adulthood, these recommendations are relevant for the adolescent health work.

UNICEF Programme areas

UNICEF Kyrgyzstan Youth programme focuses on strengthening peacebuilding, participation and youth employability in selected municipalities in the Southern and Northern part of the country. In addition to the work with municipalities and CSOs (e.g. establishing and maintaining youth centers), it works closely with the national Agency of Youth (former Ministry of Youth and Sports). The government of the Kyrgyz Republic is developing a broad national youth strategy and a policy that focuses on participation and will cover the youth between 14 and 28 years old. As adolescent health is not only a responsibility of the health sector and addressing it requires multisector action, to extend possible, the strategy is an opportunity to build linkages to adolescent health, e.g. from the basic human/child rights point of view.

In collaboration with C4D, Youth is currently developing a local version of the U-report that will support the youth to raise their voice and participate in discussions e.g. related to elections. In terms of links to health programming, once fully functioning, the “M-report” provides an opportunity for adolescent engagement. The tool enables to rapidly collect information, opinions and feedback from adolescents that can inform and keep stakeholders accountable of e.g. quality to and access of health services provided to adolescents.

Education’s efforts to preventing out-of-school children (OOSC) is an opportunity to build linkages to adolescent health programming including HIV/MARA. OOSC programme is being piloted in 40 schools within 8\textsuperscript{th}-11\textsuperscript{th} grades. Similarly, UNICEF Kyrgyzstan is pioneering the Menstrual Hygiene Management (MHM) programme is schools that along with healthy practices can contribute to girls’ empowerment, gender equality and educational attainment. Furthermore, Child protection has implemented a School without Violence programme in 38 schools that has demonstrated good results in reducing violence in schools.

To effectively address child rights issues\textsuperscript{17}, a secretariat under Vice Prime Minister’s office is established and its technical task forces focus on several subjects including adolescence. UNICEF’s technical expertise in social protection and juvenile justice are contributing to the work of the newly established body. On a service delivery level, poor coordination between social and health workers hampers the early identification, referrals and access to services of families and children in difficult life situation. To improve the situation, UNICEF has supported e.g. the development of case management guidelines that define roles of different actors in social, health, education, and justice sectors. Jointly with UNFPA and UNPD,

\textsuperscript{17} CRC review was conducted in 2014, a report available at: http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CRC/C/KGZ/CO/3-4&Lang=En
the office has also plans to invest in families’ wellbeing through the work on parenting skills that has potential to address mental health issues, violence and suicides.

**Entry points and recommendations for UNICEF Kyrgyzstan**

Based on the round table discussion with key partners including the Ministry of Health, early pregnancies and marriage, violence, mental health and substance use (tobacco, harmful use of alcohol) were identified as key priorities for programming (see annex 2 for more detailed list of identified key barriers and bottlenecks).

As school enrollment rates are high in Kyrgyzstan, **school is an opportune platform** to deliver a variety of health interventions e.g. through school policies and multi-component interventions targeting behaviour risk factors at a young age. A curriculum with teacher and peer trainings supported by UNFPA are a good starting point. However, from the health service delivery perspective, due the very limited financial and HR resources in the health sector and politicized situation in school health, UNICEF and other development partners will probably not invest in school health care in near future. Furthermore, given the strong experience of programming for Most-at-Risk-Adolescents (MARA) in the region as well as UNICEF work in OOSC, strengthening **primary health care level services** (FMCs etc.) was identified as an entry point for UNICEF adolescent work within the health sector with a focus on adolescents in difficult life situation/MARA.

The Health Management Information System (HMIS) in the Kyrgyz Republic does not provide consisted data, and age-disaggregation varies between 10-14, 13-17, 15-17 and 15-19 years old. According to global WHO guidelines, an appropriate age-disaggregation should be 10-14 and 15-19 (a list of adolescent health indicators proposed by WHO can

### Opportunities for programme building

- Development of the new Den Sooluk an opportunity to introduce adolescent health and to strengthen data and monitoring (age-disaggregation by 10-14, 15-19)
- Adolescent pregnancy is a growing issue: links to early marriages and education need to be built for prevention, integration to MCH
- Building on the lessons learnt from the region. HIV/MARA approach an entry point with an opportunity to expand to psycho-social wellbeing/mental health, harmful use of alcohol, tobacco and drugs use
- As financing identified as a key issue for sustainable programming for adolescent health, need to take integrated approach (PHC level strengthening a starting point)
- C4D for changing social norms and awareness of health rights (e.g. child marriage, health promotion, demand creation) along with adolescent participation/engagement (e.g. M-report) to increase accountabilities
be found here\textsuperscript{18}). Development of the new national health programme *Den Sooluk* is an opportunity to introduce measures to enhance adolescent health, and **strengthen monitoring and data** including appropriate disaggregation by age, wealth, residence etc.

Given the interlinkages between increasing adolescent pregnancies and child/early marriages in the country, it would be important to identify measures to address both issues. **C4D plays a significant role** in changing harmful social norms and creating demand for social change. Building on lessons learnt from **adolescent participation** (both UNFPA, UNICEF) and further guidance e.g. by ADAP can support in engaging adolescents in planning, implementation and monitoring of interventions. Furthermore, collecting and analysing both qualitative and quantitative **data from adolescents** themselves is crucial for the programme development including identifying adolescent health needs, expectations and demand-side barriers and bottlenecks. Once finalized, **the M-report can be used** as one of the tools to engage adolescents.

As a next step, UNICEF Health Section will organize a meeting with key partners to better define agencies’ role in the adolescent health field including UNICEF programme focus and role vis-à-vis other actors. A framework for action/potential activities (annex 3, 4) can support to facilitate the discussion along with UNICEF Determinants Framework that was used during the first round table. Followed by this mission, UNICEF HIV/AIDS Advisor will provide technical support to develop the MARA approach.

\textsuperscript{18} UNICEF is also currently piloting Adolescent Assessment Card that will be roll-out globally after finalization in upcoming months, see Adolescent Health in Kyrgyzstan ppt for further details.
Annex 1   AGENDA OF THE MISSION

<table>
<thead>
<tr>
<th>Time</th>
<th>Monday, Sep 5, 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>09.00-12.00</td>
<td>Work at the Office, updates by H&amp;N and HIV Programmes</td>
</tr>
<tr>
<td>12.00-13.30</td>
<td>Lunch with the H&amp;N team</td>
</tr>
<tr>
<td>14.00-15.00</td>
<td>New Country Programme/Munir Mammadzade, OIC</td>
</tr>
<tr>
<td>16.00-17.30</td>
<td>Preparations for the Round Table</td>
</tr>
<tr>
<td>09.30-11.00</td>
<td>Swiss Red Cross/Gelmius Siupsinskas</td>
</tr>
<tr>
<td>11.00-12.30</td>
<td>National MCH Center/Dr. Nurgul Esenovna</td>
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<tr>
<td>12.30-14.00</td>
<td>Lunch with HIV</td>
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<tr>
<td>14.00-15.00</td>
<td>WHO/Dr. Kubanychbek Monolbaev</td>
</tr>
<tr>
<td>15.00-16.00</td>
<td>Reflections with the team</td>
</tr>
<tr>
<td>09.30-11.00</td>
<td>Child protection/Munir Mammadzade</td>
</tr>
<tr>
<td>11.00-12.00</td>
<td>Youth/Gulzhigit Ermatov and Gulnara Zhenisbekova</td>
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<tr>
<td>12.00-13.00</td>
<td>Lunch</td>
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<tr>
<td>14.00-15.30</td>
<td>UNFPA/Asel Turgunova</td>
</tr>
<tr>
<td>15.30-17.00</td>
<td>Work at the Office</td>
</tr>
<tr>
<td>09.00-12.00</td>
<td>Work at the Office</td>
</tr>
<tr>
<td>12.00-13.30</td>
<td>Social Policy and C4D/Gulsana Turusbekova and Galina Solodunova</td>
</tr>
<tr>
<td>15.00-17.30</td>
<td>Round table at the MoH</td>
</tr>
<tr>
<td>09.30-10.30</td>
<td>Education/Chynara Kumenova</td>
</tr>
<tr>
<td>10.30-12.00</td>
<td>Osh Office/Ainura Tekenova</td>
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<tr>
<td>12.00-13.00</td>
<td>Call with Ruslan Malyuta, CEE/CIS RO</td>
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<tr>
<td>13.00-14.00</td>
<td>Lunch</td>
</tr>
<tr>
<td>14.00-15.30</td>
<td>Programme meeting – presentation of the findings</td>
</tr>
<tr>
<td>15.30-16.30</td>
<td>Briefing with Representative Yukie Mokuo</td>
</tr>
</tbody>
</table>
### Annex 2 ADOLESCENT HEALTH - BARRIERS AND BOTTLENECKS BY UNICEF DETERMINANTS

<table>
<thead>
<tr>
<th>Categories</th>
<th>Determinants</th>
<th>Identified Bottlenecks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enabling Environment</td>
<td><strong>Social Norms</strong></td>
<td>Acceptance of early marriage especially among certain ethnic minorities; early marriage is seen as a protection measure for girls; sexuality and sex is a taboo especially in schools/families; education is not valued by some families; increasing religious extremism/traditional values; culture of silence related to alcohol use, violence, suicides and mental health issues; society does not interfere with family matters (considered as internal business); harmful stereotypes in juvenile justice system, stigma of narcotics use.</td>
</tr>
<tr>
<td></td>
<td><strong>Legislation / Policy</strong></td>
<td>No mechanism to control religious marriages (no registration) including the age of marriage; no outreach of protection systems in schools; lack of normative act for domestic violence; lack of normative documents for prevention and care of alcoholism; no programme on suicide and violence prevention, psychosocial support. Weak data systems and mechanisms for collection, unsystematized age-disaggregation.</td>
</tr>
<tr>
<td></td>
<td><strong>Budget/ expenditure</strong></td>
<td>Limited resources for school health and juvenile justice system</td>
</tr>
<tr>
<td></td>
<td><strong>Management / Coordination mechanisms in place</strong></td>
<td>Adolescent-related laws and policies are fragmented; no controlling body for monitoring of alcohol, tobacco laws including sales and advertising. Weak coordination between MoH and MoE in school health, lack of normative basis on organization of services.</td>
</tr>
<tr>
<td>Supply</td>
<td><strong>Availability of essential commodities / inputs</strong></td>
<td>WASH in schools could be scaled up.</td>
</tr>
<tr>
<td></td>
<td><strong>Access to adequate services</strong></td>
<td>Weak specialization in adolescent health: capacity of psychologies, social pedagogues, health workers etc. is inadequate. Status of school health workers poor, not enough HR to conduct screening and provide support for students. School directors do not report cases of violence. Weak data. No crisis centers countrywide.</td>
</tr>
<tr>
<td></td>
<td><strong>Financial access</strong></td>
<td>Informal and formal payments hamper access to services and information.</td>
</tr>
<tr>
<td>Demand</td>
<td><strong>Social and cultural practices and beliefs</strong></td>
<td>SRH is a taboo.</td>
</tr>
<tr>
<td></td>
<td><strong>Continued use of services</strong></td>
<td>Adolescent services are fragmented (identification of b&amp;b related to demand needs further analysis with adolescents themselves)</td>
</tr>
<tr>
<td>Quality</td>
<td><strong>Quality of services according to standards</strong></td>
<td>AFHS standards are currently under revision, AFHS not mainstreamed to PHC.</td>
</tr>
</tbody>
</table>
### Annex 3 KEY ACTIONS TO IMPROVE ADOLESCENT HEALTH

<table>
<thead>
<tr>
<th>Advocate for the rights of adolescents to health &amp; wellbeing through appropriate policies, legislation and financing</th>
<th>Strengthen adolescent-responsive services</th>
<th>Empower adolescent girls and boys and their families and communities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Support data capture, evidence generation and use to inform decision making and promote accountability by supporting governments to:</strong></td>
<td><strong>Build capacity of providers and management systems including oversight functions to:</strong></td>
<td><strong>Generate demand among adolescents by supporting partners to deliver evidence-based interventions aimed at:</strong></td>
</tr>
<tr>
<td>- Analyse the situation including determinants of disease or behaviour, develop disease burden profiles using disaggregated data</td>
<td>- Integrate adolescents into routine health service provision incl. maternal and newborn health and provide adolescent-responsive health services incl. preventive and responsive services related to adolescent pregnancies, STDs, undernutrition/overweight and micronutrient deficiencies</td>
<td>- Enhancing adolescents’ knowledge and action on health rights (e.g. related to SRH)</td>
</tr>
<tr>
<td>- Use data for advocacy on SRH, mental health; and prevention of intentional and unintentional injuries, tobacco and alcohol use, sales and marketing</td>
<td>- Prevent HIV among adolescents and provide needed services including ARTs, PMTCT, pre- and post-exposure prophylaxis</td>
<td>- Increasing adolescents knowledge on where/how to access health, nutrition, and social services, water and sanitation</td>
</tr>
<tr>
<td>- Identify gaps in data, strengthen mechanisms and capacities for monitoring, data collection and analysis within and across sectors incl. HMIS and other data systems</td>
<td>- Provide hygiene information</td>
<td>- Support social &amp; emotional skills development in and out of schools with focus on building adolescent agency and empowerment in negotiating inter-personal relationships, substance abuse and harmful social norms</td>
</tr>
<tr>
<td>- Complement existing data with qualitative studies and document lessons learnt so as to influence local, national and global agendas and financing</td>
<td>- Provide gender-segregated, WASH facilities available in schools, health and community centres</td>
<td>- Engage adolescents in planning, implementation and monitoring of interventions and programmes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Support evidence-based policy formulation and implementation by supporting governments to:</th>
<th>Demonstrate good practices and models to support scalability</th>
<th>Engage for social and behavioural change by supporting:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Develop and implement supportive laws and policies related to child marriage, access to health services regardless of age, marital status, guardian consent</td>
<td>- Support modelling of sector-based and cross-sectoral programmes in adolescent health and use results to build national and sub-national capacities, as well as commitment and accountability to legislate, plan and budget for scaling up services and interventions</td>
<td>- Measures/interventions to change harmful social norms related to child marriage, corporal punishment and disempowerment of adolescent girls</td>
</tr>
<tr>
<td>- Prevention of NCDs through regulating e.g. food &amp; beverage industry standards and marketing practices, increase of physical activity in general and inclusion of physical education classes in schools</td>
<td>- Include comprehensive coverage of adolescents by cash transfer schemes, health insurance and other forms of social protection instruments</td>
<td>- Measures/interventions to promote healthy lifestyle that reduces the risk of NCDs</td>
</tr>
<tr>
<td>- Review national health policies and ensure that in addition to SRH, HIV/AIDS, other health areas, such as mental health, are addressed</td>
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</tr>
</tbody>
</table>
**SUPPLY:**
- Inadequate and poorly integrated adolescent services for adolescents (PHC, school health, outreach/community health services)
- Poor quality of basic health care services and weak specialization in adolescent health
- Weak provision of mental health, psychosocial counselling and substance abuse services
- Poor provision of HIV, nutrition and hygiene interventions and information
- Poor access to recreational and sports facilities and public parks
- Limited HR, poor state of health workers

**ENABLING ENVIRONMENT:**
- Social and cultural norms that condone harmful practices and behaviours (related to e.g. child marriage, pregnancy, SRH, NCDs risk factors)
- Weak legal and policy framework that does not support health or protect from harmful practices and behaviours (e.g. control of religious marriages, domestic violence, marketing/sales of alcohol, tobacco, weak law enforcement for road safety, urban planning)
- Poor monitoring systems and lack of consistent, disaggregated data by age (10-14, 15-19; wealth, residency)
- Weak multi-sectoral coordination
- Limited resources/budgeting capacities to address adolescent health

**DEMAND:**
- Poor health literacy of adolescents and caregivers and barriers to make informed healthy choices due to misleading and inadequate information (e.g. due to aggressive marketing of tobacco/alcohol, culture of silence around SRH)
- Lack of access to information of rights/available services (e.g. related to SRH)
- Behavioural risks driven by weak enabling/protective environment, poor parenting practices, peer pressure (e.g. role modelling on eating, physical activity, tobacco use), violence/bullying
- Financial barriers to prevention, care and treatment

**QUALITY:**
- Poor or outdated standards and quality assurance mechanism for education and health care services (e.g. AFHS, health education in schools)
- Insufficient integration of adolescent health in regular health and social services
- Weak mechanisms to ensure compliance to protective laws and policies (e.g. guidance and standards for tobacco and alcohol control, food labelling)

**IMPACT:** Contribute to realization of the rights of every child, especially the most disadvantaged, to appropriate growth, well-being, intellectual and social development, and preparation for a long, productive and healthy life

**Enabling outcomes:**
- Increased capacity to protect adolescent health and prevent harmful practices and behaviours
- Improved interventions, optimized use of resources and shared accountability
- Advanced laws, regulations and programmes to guarantee respect of adolescents’ rights
- Enhanced data, evidence and monitoring to inform decision-making
- Improved health, nutrition, HIV, education and social services that gear towards supporting adolescent health in a holistic manner
- Improved access of adolescents, families and communities to information, services and opportunities that support health, development and wellbeing

**Long-term outcomes:**
- Prevention of early pregnancies, improved SRH
- HIV prevention targeted at most at risk adolescents; testing, treatments and care scaled up
- Evidence-based and targeted mental health and violence prevention interventions provided
- NCDs reduced and healthy lifestyles/protective environments promoted
- Adolescents have access to safe & dignified WASH facilities and practices

**Immediate outcomes:**
- Advocate for every child’s right to health
- Influence government policies
- Strengthen service delivery
- Empower communities incl. adolescents

**Actions:**
- Advocate for every child’s right to health
- Influence government policies
- Strengthen service delivery
- Empower communities incl. adolescents

**Poverty - Inequities - Lack of opportunities - Environmental factors – Political instability**

**Annex 4 DRAFT THEORY OF CHANGE/FRAMEWORK FOR ADOLESCENT HEALTH**