Regional Assessment of Gender Responsive Adolescent Health in South Asia

UNICEF Regional Office for South Asia
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The assessment was undertaken by Renuka Motihar with guidance and inputs from Sheeba Harma, Regional Gender Advisor UNICEF ROSA. Acknowledging all the contributions received from UNICEF country offices in South Asia towards this assessment.

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### Acronyms

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<th>Acronym</th>
<th>Abbreviation</th>
<th>Definition</th>
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<tr>
<td>ADAP</td>
<td>Adolescent Development and Participation</td>
<td>Postnatal Care (PNC)</td>
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<td>AFHS</td>
<td>Adolescent Friendly Health Services</td>
<td>Public service announcements (PSA)</td>
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<td>ANC</td>
<td>Antenatal care</td>
<td>Prevention of Mother to Child Transmission (PMTCT)</td>
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<td>ARLG</td>
<td>Adolescent Radio Listeners Group</td>
<td>Rashtriya Kishor Swasthya Karyakram (RKS)</td>
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<tr>
<td>BCC</td>
<td>Behaviour Change Communication</td>
<td>Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH)</td>
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<td>CO</td>
<td>Country Office</td>
<td>Regional Office for South Asia (ROSA)</td>
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<td>COAR</td>
<td>Country Office Annual Report</td>
<td>South Asian Association for Regional Cooperation (SAARC)</td>
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<tr>
<td>C4D</td>
<td>Communications for Development</td>
<td>Social and Behavioural Change Communication (SBCC)</td>
</tr>
<tr>
<td>CPD</td>
<td>Country Programme Document</td>
<td>Sustainable Development Goals (SDGs)</td>
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<tr>
<td>DHS</td>
<td>Demographic and Health Survey</td>
<td>Sexual and reproductive health rights (SRHR)</td>
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<tr>
<td>GAP</td>
<td>Gender Action Plan</td>
<td>Science, technology, engineering and mathematics (STEM)</td>
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<td>GBV</td>
<td>Gender-based Violence</td>
<td>United Nations Development Assistance Framework (UNDAF)</td>
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<td>GRAH</td>
<td>Gender Responsive Adolescent Health</td>
<td>United Nations Educational, Scientific and Cultural Organization (UNESCO)</td>
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<td>IEC</td>
<td>Information, Education and Communication</td>
<td>United Nations Population Fund (UNFPA)</td>
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<td>IFA</td>
<td>Iron Folic Acid</td>
<td>United Nations Children’s Fund (UNICEF)</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
<td>Water Supply and Sanitation (WASH)</td>
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<td>HPV</td>
<td>Human Papillomavirus</td>
<td>Weekly Iron and Folic Acid Supplementation (WIFS)</td>
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<td>MDGs</td>
<td>Millennium Development Goals</td>
<td>Wash in School (WinS)</td>
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<td>MICS</td>
<td>Multiple Indicator Cluster Survey</td>
<td>World Health Organization (WHO)</td>
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<tr>
<td>MHM</td>
<td>Menstrual Hygiene Management</td>
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<tr>
<td>MoHFW</td>
<td>Ministry of Health and Family Welfare</td>
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<tr>
<td>NACO</td>
<td>National AIDS Control Organisation</td>
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<tr>
<td>NGO</td>
<td>Non-Governmental Organization</td>
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UNICEF’s work globally on gender equality is guided by the Gender Action Plan (GAP) 2014-2017, which advances gender equality and empowerment of women and girls in key areas of UNICEF’s work. The GAP identifies four targeted gender priorities including Gender Responsive Adolescent Health (GRAH). Gender disparities in health status and outcomes become more evident in adolescence as girls and boys undergo puberty and experience greater diversification in life transitions.

UNICEF addresses adolescent health in multiple sectors, through Health (pregnancy, maternal health, immunization including Human Papillomavirus (HPV)), HIV (prevention and treatment), Water, Sanitation and Hygiene (WASH) (menstrual hygiene management (MHM)), Nutrition (adolescent girls and anaemia), Education (life skills education for adolescents which includes awareness raising on Sexual and Reproductive Health (SRH), HIV) and Communication for Development (C4D) (communication campaigns, radio and television dramas/series on gender norms including health). Building on the Sustainable Development Goals (SDGs) and the Global Strategy for Women's, Children's and Adolescents' Health (Every Woman Every Child 2.0), UNICEF’s 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 adolescents’ rights to health, influencing government policies, strengthening service delivery, and empowering communities, including adolescents. Additionally, in the new UNICEF Strategic Plan 2018-2021 and in the new GAP 2018-2021, GRAH will continue to be a key area of focus.

Adolescence presents a precarious period for both girls and boys, when gender norms and expectations increase gender inequality and encourage behaviours that impact on adolescent boys’ and girls’ well-being and health outcomes. In adolescence, pregnancy-related causes become prominent health risks for girls; complications related to pregnancy and childbirth are among the leading causes of death of adolescent girls. Infants born to adolescent mothers face a heightened risk of morbidity and mortality. In addition to adolescent boys, social norms around masculinity encourage risk-taking and, in many settings, heighten their risk of tobacco, alcohol, substance abuse, road traffic injuries and violent behaviours. There are also mental health problems which lead to increased suicidal cases amongst adolescents.

The regional GRAH assessment aimed to support UNICEF to assess current programming and strengthen GRAH outcomes in the South Asia region. The assessment followed four phases: preparatory; data collection and information gathering; analysis and report writing; and finally, dissemination via a Webinar to the regional and country offices. These phases were undertaken from September to December 2017 under the guidance of the UNICEF Regional Gender Adviser. The assessment in South Asia region included eight countries: India, Bangladesh, Nepal, Pakistan, Sri Lanka, Bhutan, Maldives and Afghanistan.

The overall assessment findings show that while GRAH is a targeted priority for a few countries, it will be a priority for other countries in the next Country Programme Document (CPD) for example, Nepal. In examining what the country offices have undertaken, the assessment found that the understanding of gender responsiveness varied across staff across all countries. It was mostly limited and generally translated into number of girls and boys reached or covered. Also was not uniform whether initiatives were gender responsive or not and addressed or integrated critical gender issues or not. There was limited data, evidence, cross-sectoral and gender integration impact at the policy, behaviour change communication and system level responsiveness that needed to be strengthened.

Majority of GRAH interventions focused on MHM in schools with adolescent girls, Anaemia issues were addressed through weekly Iron Folic Acid (IFA) supplementation, predominantly for girls in schools. The findings show limited interventions on IFA supplementation with out of school girls and boys. Small scale interventions on adolescent friendly health services (AFHS), adolescent pregnancy and work on addressing underlying gender norms and inequalities (mostly through communication campaigns) were undertaken by countries such as Bangladesh, Nepal and India. In working with Government stakeholders, Bangladesh supported the development of a National Adolescent Health Strategy while India had provided technical support to the implementation of the government led national adolescent health programme - Rashtriya Kishor Swasthya Karyakam (RKSK). The analysis also noted that India, Bangladesh and Nepal have undertaken more extensive work on GRAH - worked with governments closely in developing policies and guidelines, capacity building, providing technical assistance and
implementing adolescent friendly health services, life skills, MHM, anaemia and adolescent nutrition. However, across these countries the confidentiality and quality of adolescent services and the utilization, scale and uptake of services by adolescent girls and boys was not always clearly analyzed, reported or documented.

The assessment noted good programming interventions reaching adolescent girls on MHM and WASH through in-school and some limited out of school platforms in Pakistan, Sri Lanka and India. Similarly, there were promising programming interventions for addressing anaemia and Weekly Iron and Folic Acid Supplementation (WIFS) for girls in schools. Creative and locally contextual communication materials have been developed in Afghanistan. Similarly, good interventions were noted in Bangladesh on AFHS and work on early pregnancy and child bearing in convergence with early child marriage and life skills education work. While the overall results and impact is yet to be analyzed, good interventions were noted in India on adolescent nutrition addressing women and girls with collectives/self-help groups as an entry point with a focus on women and girls’ empowerment. Initial work on resilience building including suicide prevention and mental health issues have been undertaken in Bhutan in partnership with the government. Across country offices there were attempts to converge across sectors through working groups for example, ending child marriage working group and multi-sectoral nutrition plan working group in Nepal.

UNICEF offices within the region have undertaken diverse approaches and interventions to promote GRAH. However, across the region, there is no uniform package of needed interventions for adolescent girls and boys that could target this priority holistically. GRAH is also greatly affected by other key issues, including child marriage and teenage pregnancy, which has a direct correlation to adolescent, infant mortality and under-nutrition and has inter-generational effects. Due to these linkages, there is room for much needed improvement in forging stronger links between child marriage and health with an increased focus on young adolescent mothers/couples and their children. Further, addressing anaemia will need to also target out-of-school girls and boys. While this priority area has seen a number of good initiatives, there is scope to take them to scale and track results.

The assessment proposes a draft framework on GRAH for the South Asia region with six possible areas of intervention1. This includes issues that are relevant to the region and that country offices are already working on to some extent such as issues of MHM, anaemia and micronutrient deficiencies; adolescent pregnancies; sexual health and HIV including life skills and AFHS; non-communicable diseases and risk factors (including obesity); mental health, wellbeing and violence. Non-communicable diseases, obesity and mental health are emerging issues that country offices are recognising and in some cases beginning to work on. Addressing gender norms and cultural, inequalities is cross cutting across all the issues. The key strategies for addressing and implementing the priority areas include: Advocate for every adolescent’s right to health; influence government policies; strengthening service delivery and empowering communities and adolescents.

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<th>Key Recommendations</th>
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<tr>
<td>Developing a uniform GRAH definition and framework, guidance notes and capacity building for specific sectors and stakeholders that are implementing adolescent health and nutrition programmes in the region.</td>
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<td>Strengthen adolescent health related disaggregated data and evidence base to collect and analyze across sex, age, and other social determinants (wealth quintile, location, ethnicity, etc.).</td>
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<td>Analyze current census and Demographic and Health Survey (DHS) data for adolescent health to draw out data in creative infographics and easy to read and use documents.</td>
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<td>UNICEF can be a storehouse and repository for data and information on adolescent issues including health and nutrition issues to be used for policy making.</td>
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<td>South to South exchange, collaboration and capacity building of researchers and practitioner learning exchange on GRAH for better knowledge sharing and dissemination.</td>
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<td>Improved coordination and learning's shared between country offices on what works and what has not worked to address GRAH.</td>
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<td>Define how to measure, track results and impact related to gender responsive outcomes with detailed guidance.</td>
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<td>Case studies of AFHS, work on early pregnancies, good and promising practices in or across countries with possible replication and scaling could be developed and shared.</td>
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<td>Dedicated and increased funding and allocation of budgets for GRAH within the region and country offices.</td>
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<td>Social protection and gender responsive investment case for one to two countries on specific adolescent health issues linked to early child bearing and nutrition could further strengthen the scale up of the policy engagement with Governments.</td>
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1 Adapted from the UNICEF LAC GRAH framework
UNICEF Gender Action Plan phase 2.0 (2018-2021), notes five targeted priorities for Adolescent girls’ well-being and empowerment with a focus on the most disadvantaged girls – for whom multiple linked investments are required for transformative change. The five targeted priorities span Goals 1, 2, 3 and 4 in the UNICEF Strategic Plan 2018-2021, and are a focus in both humanitarian and development settings:

- Promoting adolescent girls’ nutrition, pregnancy care, and prevention of HIV/AIDS and HPV;
- Advancing adolescent girls’ secondary education, learning and skills, including Science, technology, engineering and mathematics (STEM);
- Preventing and responding to child marriage and early unions;
- Preventing and responding to gender-based violence (GBV) in emergencies;
- Facilitating accessible and dignified MHM.

Adolescent girls face gender specific vulnerabilities, with lifelong consequences: pregnancy, higher risks of HIV, risk of HPV and cervical cancer, and inadequate nutrition. Strengthening health systems is essential to reach the most marginalized girls, boys and women and the deprivations adolescent girls face due to gender inequality increase multifold when they are also disadvantaged by poverty, ethnic identity, geographic location, disability, and/or fragile and crisis conditions. Approaches to gender equity programming therefore include addressing discrimination against girls and other structural determinants.

What is Gender Responsive Adolescent Health (GRAH)?

Gender disparities in health status and outcomes become more evident in adolescence as girls and boys undergo puberty and experience greater diversification in life transitions. Gender and adolescent health issues are addressed across different outcomes of UNICEF’s Strategic Plan, including health, with regard to adolescent pregnancy and maternal health; HIV and AIDS, with respect to HIV testing, treatment, care and psychosocial support for both boys and girls; nutrition, in addressing anaemia among adolescent girls; water, sanitation and hygiene, in promoting puberty education and menstrual hygiene management; and child protection, in addressing the practice of Female genital mutilation/cutting (FGM/C).

The consolidation of these health risks and rights violations under a gender and adolescent health umbrella allows for a more integrated response in addressing the different issues adolescents face in this period of their lives. Under this umbrella, UNICEF is advancing gender-responsive adolescent health outcomes by focusing on the specific needs, transitions, relationships and vulnerabilities that adolescent boys and girls experience during this important time in their life course, while also fostering the sense of self awareness, autonomy, and agency that characterizes adolescence. UNICEF is enhancing the policy and social environment for better health outcomes for adolescent girls and boys; increasing and integrating gender-responsive services for girls’ and boys’ needs; and addressing the underlying gender norms and inequalities in health risks that adolescents face.

(Source: UNICEF 2015 Annual Results Report – Gender)

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2 UNICEF Strategic Plan 2018-21: Goal 1: Every Child Survives and Thrives, Goal 2: Every Child Learns, Goal 3: Every Child is Protected from Violence and Exploitation, Goal 4: Every Child lives in a safe and clean environment, Goal 5: Every Child has an equitable chance in life
The GRAH assessment for South Asia followed four phases: Preparatory; Data Collection/information gathering; Analysis and report writing; and Dissemination via Webinar to the regional and country offices. These phases were from September to December 2017.

The assessment in South Asia region included all eight countries:

- Afghanistan
- Bangladesh
- Bhutan
- India
- Maldives
- Nepal
- Pakistan
- Sri Lanka

Across these countries, the assessment included a review of ongoing adolescent health and nutrition programming, policy work, advocacy, communications, data gathering/research/evidence generation that have been undertaken through various sectors in UNICEF – Health, HIV, Nutrition, WASH, Education and C4D. An in-depth review of select countries (Bangladesh, India and Nepal) were also undertaken where more concerted gender responsive adolescent health interventions and policy advocacy initiatives were being implemented.

The specific issues by sector that have been included in the assessment are given in the table below.

<table>
<thead>
<tr>
<th>Sector within UNICEF</th>
<th>Issues of Focus in the Assessment</th>
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<tbody>
<tr>
<td>Health</td>
<td>Maternal health including Adolescent pregnancy and early child bearing</td>
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<td></td>
<td>Access to family planning (counselling) and SRH information and services</td>
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<tr>
<td></td>
<td>Immunisation including human papillomavirus (HPV)</td>
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<tr>
<td></td>
<td>Mental health, self-harm, suicide and violence related issues</td>
</tr>
<tr>
<td>HIV</td>
<td>HIV prevention and treatment including Prevention of Mother to Child Transmission (PMTCT)</td>
</tr>
<tr>
<td>Nutrition</td>
<td>Addressing anaemia and nutrition including Iron and Folic Acid (IFA) supplementation</td>
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<td></td>
<td>Micronutrient deficiencies</td>
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<tr>
<td>WASH</td>
<td>Menstrual health and hygiene management (MHM)</td>
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<tr>
<td>Education</td>
<td>Awareness raising and SRH information; life skills education to include SRH and HIV information through school based or community based programmes for young people</td>
</tr>
<tr>
<td>Communications for Development (C4D)</td>
<td>Addressing gender norms and adolescent issues including health - behaviour change communication campaigns, radio and television series</td>
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The review also examined the level of stakeholder analysis, needs assessment and problem analysis, types of partnerships and resources across the country office interventions related to GRAH.
Assessment Phases

The assignment followed four phases:

1) Preparatory Phase:

- This phase included the collation of project and relevant UNICEF documents related to adolescent health and nutrition from the country offices on adolescent health interventions, advocacy, policy work, communications, evidence, research and results. Additional documents included the UNICEF Gender Action Plan (2014-2017 and 2018-2021), GAP evaluation 2015 (Regional Synthesis and Country Reports 2016) and 16 Annual Results Reports for Gender.
- Planning meetings were undertaken with the UNICEF ROSA Regional Gender Advisor to better formulate the assessment scope, designing the GRAH assessment questionnaire and approach to gender responsive adolescent health understanding and focus in UNICEF programming.
- Focal points from Health, Nutrition and Gender sections at each country offices were contacted for the questionnaires and potential interviews.

2) Data Collection and Information Gathering Phase:

- GRAH assessment questionnaire to Country offices. Follow up and review of completed questionnaires.
- Review of documents received on adolescent health programming collated from the Health, Nutrition, HIV, WASH and education sectors. Examining interventions and results.
- In-depth review of countries where more work has been done on gender responsive adolescent health - India, Bangladesh and Nepal.
- Select Skype Interviews with key staff in country offices (Bhutan, Nepal, Sri Lanka and Bangladesh) for additional information and filling gaps. Face to face interview with the India Country office Deputy Representative and Gender and Development specialist.
- Categorizing information by country and issue. Conducting an initial analysis of the information/programmes received.
3) Analysis and Report Writing Phase:

This phase involved analysis of the gender responsiveness, strengths, weaknesses, barriers and opportunities for GRAH. Synthesising findings from the literature review, responses from questionnaires, data and select interviews were undertaken into a comprehensive report with key findings and recommendations made at the policy, programme, partnerships and collaboration level.

The policy/advocacy/intervention work on adolescent health and nutrition was analysed through an equity and gender lens using the following guiding queries:

- Whether the interventions were gender responsive or not
- Strengths of the intervention/policy work/advocacy
- Weaknesses and barriers and how/whether they were overcome
- Whether reaching the most vulnerable and marginalised, remote geographic areas (more specifically, exploring whether the interventions reached the target group, the most marginalized adolescent girls/boys, migrants, those in urban slums, remote areas, with disabilities, and others – who are most marginalised in that country context)
- Is the intervention at large scale or is it patchy or at very small scale?
- Type of partnerships – with government, civil society
- Examining Demand and supply side. For example, is the system responsive enough? Is the skill building responsive to meet the demand side?
- Examining effectiveness - has the work on policy been effective

The review also included recommendations on promising, best practises (interventions) that have emerging potential and could be a case study for other countries to learn from or replicate.

4) Dissemination Phase:

This last phase included sharing of the key findings with UNICEF regional and country offices through a webinar open to the participation of UNICEF colleagues in the region and beyond, allowing for wider uptake of recommendations, and discussions on the findings and way forward. The final report was disseminated across UNICEF in South Asia and beyond.

Limitations of the Assessment

The GRAH assessment relied on secondary documents and questionnaires received from the country offices. The impact and results information on GRAH was limited across documentation received. The competing schedules at each country office and lack of clearly documented areas on GRAH resulted in partly completed questionnaires in one case. Two countries did not complete the required questionnaire. This was supplemented wherever possible by country office skype interviews to further address the gaps and acquire additional information. The interviews/questionnaires should have been ideally undertaken jointly by the Gender focal point/specialist in consultation with the Health, Nutrition, WASH, Adolescent Development and Participation (ADAP), Education and C4D staff as a gender target area implemented across sectors, however, that was often not possible because of conflicting schedules and priorities or lack of convergence and collaborated action between sectors. There was a lack of compiled information for GRAH across sectors.
In Afghanistan, there are 7.7 million adolescents in the age group of 10-19 years, of whom nearly half are girls. According to the 2013 National Nutrition Survey, approximately 31 percent (over a million) adolescent girls suffer from anaemia and 24 percent (approximately 2.4 million) are iron deficient. A Multiple Indicator Cluster Survey (MICS) carried out by UNICEF during 2010-2011 estimated that 15.2 percent of adolescent girls are married before the age of 15 years in Afghanistan, and 46 percent are married before the age of 18 years. The study found that the proportion of pregnancy related deaths among ten to 14-year-old adolescent girls is five times higher compared to that among 20-24 year age group of women, and two times higher than that among 15-19 year age group.

According to the Gender Evaluation undertaken by ROSA in early 2017 and the GRAH questionnaire for this assessment received from UNICEF Afghanistan, the country office is contributing to the GAP targeted priority of promoting gender-responsive adolescent health from a variety of angles.

Some of the cross-sectoral interventions include: improving hygiene knowledge and behaviour among adolescent girls and boys in schools including MHM; addressing anaemia and iron deficiencies among adolescent girls- WIFS; de-worming and changing social and gender norms which impact adolescent health. UNICEF’s Health section has supported Ministry of Public Health (MoPH) to include adolescent health and safety in Afghanistan’s National Reproductive, Maternal, New born, Child and Adolescent Health (RMNCAH) policy and strategy. The Health section has been working with Community Based Health Care Directorate/ MoPH and are taking a life skills training approach to working with adolescents. In early 2018, MoPH will be holding a review workshop with key stakeholders on Adolescent Health and Well-being and UNICEF has mobilized resources to train community health workers as peer counsellors as part of this initiative. UNICEF has also partnered with UNFPA to improve the enabling environment by addressing the underlying gender norms and inequalities that risk adolescent health.

Emerging Needs

The emerging needs for Afghanistan office in advancing GRAH include advocacy on gender responsive adolescent health at the policy, health facility, and community, household and individual levels and integration of service delivery for adolescents. Other needs include coordination at all levels, internal intersectoral coordination, fundraising and investment at the headquarters and local levels.

Future plans at the country office include plans to support Tetanus Toxoid vaccination and weekly IFA supplementation for adolescent girls until 2020 depending on availability of fund/resources.

The weaknesses/limitations faced by the country office include lack of gender and age disaggregated data to understand reach, coverage in reaching marginalised communities and the lack of financial resources available at a national level across the country to continue and expand the anaemia programme.
Through sustained advocacy, UNICEF launched in 2015, the weekly iron and folic supplementation (WIFS) for adolescent girls in schools, in 14 of the 34 provinces. The programme is currently being expanded to additional provinces and, also to out-of-school girls through non-formal education and other channels. The anaemia programme is being implemented jointly by Ministry of Education (MoE) and Ministry of Public Health (MoPH). In addition, counselling on improvement in dietary diversity, personal hygiene and sanitation, is being carried out through Behavioural Change Communication (BCC). UNICEF supports with procurement and distribution of IFA and Albendazole, training of focal point teachers, providing technical assistance to MoPH and MoE, data collection, monitoring and reporting. UNICEF also supports with developing guidelines and Information, Education and Communication (IEC) material for Weekly Iron and Folic Acid supplementation. The project was funded by USAID for 2015-2017, but is not funded/resourced beyond 2017.

UNICEF together with UNFPA have also advocated for addressing the underlying gender norms in adolescent health risks and incorporated this into the National Youth Development Strategy developed by Department of Youth affairs in the Ministry of Information and Culture.

Focus on MHM included training of teachers and WASH in Schools (WinS). A WinS Strategy is being developed with Ministry of Education (MoE) with relevance to the National Education Strategic Plan and the Health Policy at MoE. Community based programmes such as community dialogues and community led total sanitation, with a focus on hygiene behavioural change through a package of integrated gender specific information and services supports to improve the health of adolescent girls.

According to the Gender Evaluation undertaken by ROSA in early 2017, a gendered analysis of adolescent health and well-being can be found in the Bangladesh CPD 2017-2020. The section refers to the particular challenges of teenage mothers and the health and nutrition risks to mothers and their children. The risks to adolescent girls are known to be elevated owing to high rates of child marriage. In its new CPD, the Bangladesh Country Office (CO) is extending its scope beyond a service delivery approach to address risky behaviour, violence and aggression, depression, suicide, and social norm aspects strongly related to ideals of masculinity and femininity.

In making this a priority, UNICEF has established itself in a complementary role to UNFPA which has had the lead role in Sexual and Reproductive Health Rights (SRHR) in Bangladesh. UNICEF is focusing on aspects of SRHR related to education, hygiene, nutrition, adolescent empowerment, and participation, while UNFPA takes a core focus on family planning and GBV. Since making adolescent health a priority, UNICEF is also a technical member of the Ministry of Health’s Gender, Equity and Voice group.

While UNICEF Bangladesh is still at an early stage of developing GRAH at scale and assessing its impact at a national level, it is now well-placed to further this work and have a positive impact on adolescent health through addressing social norms to service delivery.
### Development of Government Adolescent Health Strategy

UNICEF Bangladesh’s important contribution to adolescent health has been support to Ministry of Health and Family Welfare (MoHFW) in drafting the Bangladesh National Adolescent Health Strategy (2016–2030), which is multi-sectoral and prioritizes adolescent nutrition, mental health, child marriage and teenage pregnancy. UNICEF is also supporting the development of a costing national plan of action. UNICEF has further contributed to the revision of the Gender Equity Strategy 2014–2024 of the health sector, approved by MoHFW in 2015.

### Adolescent Friendly Health Services (AFHS)

Through advocacy and support to the MoHFW, Adolescent-Friendly Health Services (AFHS) have been established in pilot areas. UNICEF raised US $4.8 million with funding from the Dutch Government to implement a new programme, “ADOHEARTS” that reached 36,975 adolescent girls and 11,690 adolescent boys in 2016. In 2015, UNICEF provided technical assistance to government health managers in four districts and two city corporations to develop their 2016-2017 AFHS plan based on the AFHS guidelines which UNICEF developed.

AFHS has four main operational strategies:

- Enhancing enabling environment for better health of adolescent girls and boys
- Strengthening health system to increase and integrate GRAH services – capacity building and training of frontline workers
- Creating demand for addressing the underlying gender norms and inequalities in adolescent health risks with health and non-health sectors
- Promoting adolescent participation

In 2016, UNICEF partnered with Bangabandhu Sheikh Mujib Medical University to assess the availability, quality, and overall acceptance of the adolescent health service delivery for adolescent girls and boys in the same locations and the recommendations of this report are to be followed through.

### Life Skills Education and Better Health Education Training

Convergence with GRAH is evident in the child protection programme that encourages adolescents as change agents through Adolescent Clubs. Through UNICEF’s technical assistance to the Ministry of Education and the Directorate of Secondary and Higher Education, Life Skills Based Education has been integrated into the national curriculum by the National Curriculum and Textbook Board which included training of teachers in the curriculum. Support to the Directorate of Primary Education was provided for the training of trainers and teachers on ‘Better Health Better Education’ and training of teachers on the Gender Toolkit in 20 United Nations Development Assistance Framework (UNDAF) districts to strengthen children’s life skills and understanding of gender issues.

### Behaviour Change Communications

UNICEF has been providing BCC support to Bangladesh Betar’s Adolescent Radio Listeners Group (ARLG) with provision of solar radios and creation of a 50-episode interactive radio drama series produced by Betar. These series offered adolescents with messages on “sanitation, hygiene (particularly menstrual hygiene), health (particularly reproductive health), nutrition (particularly prevention of anaemia, low birth weight children, inclusive breastfeeding, complementary feeding), child marriage and other puberty issues.” Adolescents who listened to the series discussed among themselves, shared their views with their families and peer groups, and provided feedback to the programme. An estimated 5,400 members of the 360 ARLGs are registered with Bangladesh Betar. Further, messages and campaigns on immunization and WASH were also launched, reaching nearly 4 million people on children’s and women’s health issues.

### WASH and MHM

Training of adolescent girls on WASH and MHM were undertaken in addition to provision of drinking water source and separate toilets for girls and boys, Group Hand washing Devices.

### HIV

Adolescents at risk of HIV and street child drug users and young men having sex with men and transgender; and adolescent girls previously involved in commercial sex have been a focus through health and other services.
According to the Gender Evaluation undertaken by ROSA in early 2017 and the GRAH questionnaire and interviews held, UNICEF Bhutan is promoting gender-responsive adolescent health from multiple angles, including addressing anaemia among adolescent girls; supporting pregnant and breastfeeding mothers with nutrition; addressing menstrual hygiene management in schools and nunneries; and, by means of reproductive health and HIV prevention programming. UNICEF Bhutan is also contributing to this target area through school and community-based hygiene, violence prevention, and leadership and protection skills building initiatives, which centre around the needs and issues experienced by both adolescent girls and boys.

Bhutan CO is implementing a Resilience Programme that includes suicide prevention through NGOs and youth groups. This was developed in partnership with the government to address the increasing incidence of suicide amongst young people. The programme is still in the initial stages and focuses on the self, understanding the problem, understanding others problems, etc. The effort will be to institutionalize this programme through the Department of Education with training of counsellors planned for early 2018.

A major strength of UNICEF Bhutan’s efforts in promoting gender-responsive adolescent is that it is being addressed from multiple angles, including nutrition programming, menstrual hygiene, reproductive health outreach, and HIV prevention – not just at school-level but also through efforts at the community level. Further, by addressing issues such as violence, youth leadership and protection-skills building, UNICEF is supporting the creation of a more sustainable enabling environment which centres on the needs and issues experienced by adolescent girls and boys. There is also an effort to improve data available by conducting an MHM needs assessment and improve the adolescent anaemia programme using data for advocacy. In terms of weaknesses, the scale and numbers impacted is not fully reported. While some activities are targeting the needs of adolescent girls and mothers, data on gender disparities in adolescent health is not completely available, and it is therefore difficult to ascertain whether UNICEF is adequately addressing these.

### Emerging Needs

The emerging needs for Bhutan include introduction of preconception services to empower adolescents, youths and young people to make the right decision in issues related to sexual, reproductive and maternal health; strengthening and scale up of AFHS across the country. The future plans focus will be on adolescent nutrition, with an emphasis on anaemia. The focus so far has been on programming related to girls (within the context of gender); however, evolving, with increasing focus on designing programmes for the varying needs of girls and boys.

### Menstrual Hygiene Support for Adolescents in Schools and Nunneries

The Country Office Annual Report (COAR) 2015 reports that during menstruation, adolescent girls often risk their health using unhygienic cloths and rugs and even miss out on class lessons. Recognizing this, UNICEF supported the Comprehensive School Health Division of the Department of Youth and Sports to pilot a MHM programme in 10 schools and three nunneries. The programme trained school health coordinators and young girls on MHM and to make reusable sanitary napkins, which were expanded to ten more nunneries in eastern Bhutan. A needs assessment on MHM in schools and nunneries has been conducted and the final report was released on 17 November 2017 by UNICEF Bhutan in partnership with the government. This will help to expand and strengthen the programme across the country.
HIV Counselling and Empowerment for Adolescent Girls

Through UNICEF support, a total of 110 health workers were trained to enhance their knowledge and skills on working with adolescents. HIV counselling and testing camps were established for communities living in remote areas in eastern Bhutan where higher HIV prevalence is reported. All HIV-positive pregnant women identified were put on anti-retroviral therapy. Peer outreach was initiated at community level to raise awareness on mother-to-child HIV transmission and to increase utilization of prevention services. Health workers and village health workers trained in interpersonal communication continue to improve care seeking behavior and practices of mothers and caregivers on maternal, newborn, and child health. With UNICEF support, the Thimphu City Football Club used sports as a means of empowering girls – especially in remote parts of Bhutan – to become agents of change for health and other areas.

Health and Nutrition

UNICEF supported the development of the National Anaemia Control Strategy (policy) and have conducted training and rollout of the National Anaemia Control Strategy (programme). Weekly IFA and biannual deworming tablets supplementation is provided to all girls 10-19 years in schools. The anaemia prevention and control programme is currently being revised to expand to nunnery and include out of school girls in the future. Adolescent friendly health clinics are being implemented across 20 district hospitals with appointment of a counsellor. This was initiated in 2013-2014 by UNFPA and focussed on SRH issues. It may include stronger partnership with UNICEF in the future with more comprehensive services. Growth monitoring kits have recently been introduced by UNICEF in these clinics.

Hygiene and Sanitation

UNICEF supported the training of 24 district engineers and 391 masons (in Mongar, Samdrup Jongkhar, and Wangdue) to support households in constructing improved toilets. Initial assessment of two districts (Mongar and Samdrup Jongkhar) revealed that use of improved sanitation had increased from 25 to 95 percent through community engagement, behaviour change communication, and adoption of improved toilet designs. This was made possible through a demand-driven approach – engaging whole communities, including schools and institutions, to motivate behaviour change – initiated by the Rural Sanitation and Hygiene Programme of the Ministry of Health, with UNICEF support. Further, 25 Health Assistants were trained on facilitating demand-creation workshops, and 10,000 households from two districts attended the workshops. Within a year of the initiative, improved sanitation coverage increased from 26 to 63 percent in Mongar, and to 46 percent in Samdrup Jongkhar Districts. Adolescents were engaged in this at community and school levels.

India

According to the Gender Evaluation undertaken by Regional Office for South Asia (ROSA) in early 2017 and the GRAH questionnaire and interviews held with India country office Deputy Representative, adolescent health was not identified in the 2015 COAR as one of the gender-targeted priorities for India, however, it was included as a priority area in the 2016 COAR. Strong efforts have been made to reduce child marriage under the Child Protection Unit. The district level scale up model offers life skills training, as well as an adolescent empowerment toolkit delivered through large-scale national government programmes, such as the Rashtriya Kishor Swasthya Karyakram (RKS), and schemes such as Beti Bachao, Beti Padhao (BBBP).

A few field offices in India work on adolescent friendly health clinics. UNICEF India is also working to strengthen adolescent HIV/AIDS prevention and treatment response through consolidation of national and state level information on the magnitude and specificities of the adolescent HIV/AIDS epidemic in India and on improvement of data in this regard.
UNICEF has been instrumental in integrating adolescent health into the Global Call to Action, which the Ministry of Health and Family Welfare (MoHFW) hosted in 2015. At this event, countries reaffirmed their commitments toward ending preventable child and maternal deaths. More specifically, UNICEF worked with MoHFW to revise their strategies and services in favour of adolescent-friendly reproductive health, which extends to promoting the delay of pregnancies among adolescent girls; reduction in risks of pregnancies; institutional deliveries; and, support for lactating mothers. UNICEF also worked with National AIDS Control Organization (NACO) that revised its guidelines on the Adolescent Health Education Programme to engage with adolescents and promote their participation.

UNICEF India has made strides in advancing the rights of adolescents at the national level in health sector strategies, which are inclusive of the needs of adolescent girls and mothers. Good progress has been made in addressing anaemia in adolescents and in menstrual hygiene in school. There is a lack of age and sex disaggregated data available and the scale and impact of the work with adolescents making it difficult to assess the extent of its impact in the context of India. Preparation for the new CPD, however, is taking stock of evidence on gender disparities in health that will help to identify research gaps.

### Emerging Needs

The emerging needs for India is to work on school health programme which will engage adolescents. For Sexual Reproductive Health, the emerging focus is to work with adolescent mothers (as per NFHS, 5.8% of 15-19 year olds are pregnant or have given birth). Initiatives on working with boys and men are currently in discussion.

| Adolescent Nutrition | In view of the high anaemia rates among adolescent girls and boys, UNICEF supported the MoHFW’s nationwide Weekly Iron and Folic Acid Supplementation (WIFS) programme in 13 states. It started with a pilot in 2,000 and further scaled up by the government with UNICEF technical and implementation support. The implementation benefitted 85 million school-going girls and boys, and 23 million out-of-school adolescent girls through delivering iron folic tablets and education on deworming, nutrition, and health. WIFS works in and out of school:

- **School:**
  - Weekly IFA for girls and boys + biannual de-worming + monthly nutrition counselling by school teacher (includes, diet, WASH, family life education). Annual at-risk screening via RKSK.
  - Out of School:
    - Weekly IFA + biannual de-worming + monthly nutrition counselling by Anganwadi Workers (includes diet, WASH, family life education) at Anganwadi centres.
    - Quarterly Kishori Divas/Adolescent Health Day.
    - Food supplements.

SWABHIMAAN, an innovative programme on nutrition for women including adolescent girls is being implemented by India CO in three states of UP, Bihar, Jharkhand. It is a multi-sector integrated programme through women collectives (promoted by Aajeevika an Indian government programme) to improve nutrition status of girls and women from 2016 to 2020.

| MHM | In contributing to girls’ health as well as to their retention in school, UNICEF has undertaken several activities to help girls manage menstruation. National guidelines on MHM, with clear requirements for schools and public facilities, were implemented. In the three states of Uttar Pradesh, Bihar and Jharkhand, UNICEF, in partnership with Johnson & Johnson and IKEA Foundation, is applying a holistic social and behaviour change strategy for adolescents, parents and communities on the requirements of safe and healthy menstruation practices. |
According to the Gender Evaluation undertaken by ROSA in early 2017 and GRAH questionnaire, gender responsive adolescent health has not been a targeted gender priority for the Maldives CO. However, UNICEF Maldives is contributing to adolescent health in different ways. Some of the cross-sectoral efforts include: addressing HIV (and drug abuse) prevention and response through prevention awareness and outreach to adolescent girls and boys; working on MHM; improving hygiene knowledge and behaviour among adolescent girls and boys in schools through life skills education; and, addressing GBV.

Concerted efforts are being made to target adolescents (both girls and boys) to improve their knowledge and empower them to improve their overall health and well-being especially in the area of HIV/AIDS prevention, hygiene and MHM. In terms of weaknesses, in the absence of gender-disaggregated data and gender analysis, it is difficult to ascertain whether specific gender barriers are being addressed (with the exception of MHM for girls).

**Emerging Needs**

The emerging needs for Maldives are on nutrition issues, with under-nutrition and over-nutrition, mental health problems including substance abuse and effects related to bullying. The CO’s future focus and priority will be adolescent nutrition with a focus on anaemia among adolescent girls.

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**HIV Prevention and Treatment**

With respect to HIV prevention and response, UNICEF Maldives supported advocacy on HIV/AIDS with policymakers, led by the Ministry of Health. The 2014–2019 National Strategic Plan on HIV/AIDS, jointly supported by United Nations agencies, was launched in 2015.

The CO supported in conducting a comprehensive drug and HIV/AIDS prevention package targeting young people on selected islands. The package included awareness on prevention, drug education and preventive skills trainings, harm reduction, community alliance, and parent awareness. Awareness and outreach support were delivered to 231 young people in five islands.

In addition, 78 young people, including adolescent girls and boys, were trained on drug prevention education. The 2015 COAR reported that “these adolescents and young people are now better informed, and have appropriate skills to make informed decisions that will protect themselves from risky behaviour.”

Further, in response to a situation of high-risk behaviour among adolescents and young people on two islands, targeted secondary prevention training was conducted to equip them with comprehensive skills to overcome risky behaviours. The programme supports the island-level NGOs to facilitate referral of at-risk adolescents to service providers.

At the national level, the national HIV/AIDS programme has built the capacity of 50 peer educators, adolescents, and young people on two islands who were identified as being at high risk for HIV (in past qualitative research). The peer educators engage with young people on key messages that will reduce harmful behaviour and protect them from HIV/AIDS. Further, UNICEF Maldives facilitated technical expertise to include high risk/young key affected population in the Integrated Biological Behavioural Survey of HIV/AIDS. UNICEF reports that this is the first time young people are included in such a survey. Treatment is provided by the Government to all people living with HIV.
With respect to adolescent hygiene, UNICEF has contributed to increased capacities of schools to promote improved hygiene behaviour among adolescent boys and girls. The 2016 COAR reports hygiene education in the new National Curriculum Framework was reviewed to assess the teaching strategies, syllabus contents, and learning experiences of students. The review informed the design and content of the hygiene education programme and gender-sensitive IEC materials on puberty and MHM were developed in consultation with schools’ health assistants, teachers and adolescent girls and boys. IEC materials on MHM have been distributed to schools. School health assistants in the schools of Male’ (capital) are trained on hygiene education and MHM is covered in their training (schools in the islands do not have school health assistants.) SRH and HIV information is included in the Life skills education package for higher secondary schools.

According to the Gender Evaluation undertaken by ROSA in early 2017 and the GRAH questionnaire Adolescent, health has not been a specific focus for UNCEF Nepal but will receive greater emphasis in the new CPD, for which a single outcome will be dedicated to the issue, and there will be more explicit targeting of early pregnancy and child marriage.

The country office has undertaken comprehensive efforts to address adolescent health through AFHS, Rupantaran, WASH/MHM and communication initiatives such as Golden 1000 days – radio Public service announcements (PSAs)/advertisements. One of the weaknesses is the lack of service seeking behaviour data for adolescents for AFHS and lack of data/analysis on geography, ethnicity and wealth quintile to assess the reach and coverage of adolescent health and nutrition programmes.

UNICEF supported the implementation of Nepal's National Micronutrient Status Survey, 2016 where a survey on adolescent (boys and girls) module was included. Information on nutrition status of adolescent girls and boys related to stunting, body mass index (BMI), anaemia and iron deficiency anaemia H. pylori infection indicators and biomarkers were collected. In March 2017, Ministry of Health endorsed the Adolescent Iron Folic Acid Supplementation Guidelines that were prepared with UNICEF’s technical and financial support. From this, weekly iron folic acid supplementation programme to adolescent girls (10-19 years) have been rolled out in nine districts of Nepal in Bhojpur, Panchthar, Khotang, Dolakha, Kathmandu, Surkhet, Bhaktapur, Manang and Rupandehi.

**Emerging Needs**

The emerging needs for Nepal are expansion of AFHS to more districts for girls and boys; expansion of HPV from 2 districts to remaining districts and effective implementation of three-star approach to address the MHM issues in schools and increase school attendance of girls. Adolescent Nutrition Programme focusing on improving body mass index (BMI), reducing stunting and improving anaemia status. Scale up of Weekly Iron Folic Acid tablet supplementation to adolescent girls in all local bodies and expanding adolescent health and nutrition services and quality counselling to adolescent girls as a part of pre-motherhood preparedness activities.
In 2016, UNICEF Nepal WASH and Education sections conducted a study on “Analysis of menstrual hygiene practices in Nepal: The Role of WASH in Schools Programme for Girls Education”. The CO has adopted the three-star approach in WASH that ensures MHM (availability of sanitary pad, incinerator or dustbin with cover) including facilities like gender/child/disability friendly toilets, availability of water and hand washing stations. MHM is a part of WASH programmes in schools that also includes social mobilisation addressing the tradition of “Chaupadi- which forces women and girls to live in separate hut during menstruation due to purity reason” in some districts of Nepal.

UNICEF Nepal has supported 195 Adolescent Friendly Health Service clinics in 15 districts – that address adolescent pregnancy, antenatal care (ANC), delivery and postnatal Care (PNC) and family planning. Counseling support in mental health is also provided at the primary level. “Shout out for Health” programme received feedback from adolescents regarding the adolescent friendly health services implemented in two districts. In Sambhav programme (Education/ADAP), an adapted version of the Rupantaran package is used that includes nine modules, of which 2 modules are dedicated to issues of ASRH, nutrition, MHM and HIV. This training package has been endorsed by Department of Women and Children and Ministry of Youth and Sports and is being implemented in and out-of-school settings for girls and boys through government agencies as well as civil society organizations. The programme Sathi Sanga Manka Kura (SSMK) - “Chatting with my best friend” is a weekly radio programme for adolescents that covers topics on various adolescent health and nutrition issues. HPV programming has been launched two years ago in two districts and Adolescent pregnancies and young mothers are addressed under maternal health initiatives.

Various communication campaigns on health and nutrition issues were undertaken such as the Golden 1000 days communication campaign that includes working with school children and child clubs. Child club members and school children including adolescents are reached with information related to child marriage and nutrition. The Golden 1000 days’ radio PSAs also highlighted the role of husbands, father in laws in supporting the mother especially in pregnancy and child care. The golden 1000 days’ 17-minute introductory video contains information on the importance of adolescent nutrition, early pregnancy complications and the legal age of marriage. The Radio drama series "Milan Chowk" has content on adolescent nutrition, early pregnancy complications and legal age of marriage.

Due to on-going humanitarian crises in Pakistan, and prioritization of programming on the first decade of life to meet Millennium Development Goal (MDG) targets, the CO has not prioritized programming for the second decade of life. The focus has been on neonatal survival, immunization and nutrition. In Pakistan, there are 19 UN agencies operating with an annual spend of approximately US$ 500 million. UNICEF’s niche in adolescent programming has been in MHM. Within the ‘One UN system’, UNFPA has taken forward the Sexual Reproductive Health (SRH) focus with adolescents. As SRH in schools is viewed as a highly sensitive topic in the country, this area of work has proceeded under a ‘life skills’ banner. UNFPA has also worked on this in terms of policy provision; youth policies and strategies such as through like skills modules in schools; toolkits to engage teachers, students and communities. Adolescent pregnancy is also a core UNFPA priority, while HIV Prevention and treatment is a focus

3 UNICEF ROSA GAP Evaluation CO Gender profiles 2016-2017
for UNAIDS from 2018-21. Prevention of Parent to Child Transmission (PPTCT) is a UNICEF priority while violence, mental health portfolio is handled by WHO.

Within UNICEF, research on girls’ needs and perceptions have informed the development of guiding booklets for teachers and girls as well as a puberty book for Pakistan. Awareness sessions in schools have increased knowledge among school going girls and MHM kits provided by UNICEF allowed them access to supplies if they have emergencies in schools. A national MHM working group comprising of government, UN agencies, NGOs, academia and civil society was formed to advocate for the MHM agenda in the country and two provincial chapters have been established and others are underway. WinS strategies have been approved in two provinces providing governments and implementing partners a clear roadmap on integrating MHM activities in schools. The Balochistan provincial government has allocated almost US$ 200,000 of its own funds to construct/rehabilitate gender friendly WASH infrastructure as part of its Education Sector Plan.

In Sindh province, UNICEF partnered with UNFPA to provide capacity building and technical support for the establishment of an Adolescent Counselling Centre to improve access to quality SRH services. At the regional level, the IKEA II partnership targets teenage pregnancy and aims to continue to promote raising awareness, identifying the areas with the most need, and providing access to services for adolescents and their families and communities.

While gender responsive adolescent health has not been a specific target, UNICEF Pakistan was able to raise awareness and access to MHM services in innovative, locally sensitive ways and has plans to work on adolescent nutrition in the future.

**MHM and WASH**

<table>
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<tr>
<th>UNICEF Pakistan’s accomplishments in adolescent health include support to MHM in the efforts to advancing adolescent girls’ education by convening a national forum for coordinated advocacy and action and inclusion in sector planning. UNICEF provisioned MHM kits resulting in “18,928 girls to manage menstruation with dignity.” At the provincial level, in Balochistan and Sindh provinces, UNICEF collaborated with Real Medicine Foundation, Alberta and Columbia Universities to conduct research on adolescent girls’ perspectives on menstruation leading to generation of evidence to produce MHM awareness materials. The Pakistan CO has undertaken the following:</th>
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<tr>
<td>• Advocacy and support to government to roll out MHM plans linked with provincial scaling up of WASH in Schools strategies.</td>
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<td>• Research on understanding girls’ preference/choices about MHM products, purchasing power related to such items and market survey.</td>
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<tr>
<td>• Access to materials and facilities for effective menstrual hygiene management for women and adolescent girls.</td>
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<tr>
<td>• Development of guiding booklets for teachers and girls as well as a puberty book for Pakistan.</td>
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<tr>
<td>• Communication to promote social change: increase awareness and communication surrounding MHM, among girls, mothers and teachers as well as including men and boys and identify and promote MHM champions to contribute to positive social change regarding menstruation.</td>
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</table>

**Future Plans** include the following:
### MHM and WASH

**Upstream technical support:** with national, provincial and district governments and national NGO partners in the implementation of MHM activities.

**Partnerships:** with youth networks/such as Girl Guides associations, sanitary napkins providers, media, will be explored and initiated.

**Promoting positive societal norms:** nationwide campaign to increase awareness on MHM promoting innovative ideas and tools to improve MHM; leveraging technology such as UNICEF’s U-Report real-time SMS platforms and mobile apps to increase reach on MHM messaging among adolescent girls; using cultural sensitive communications products to reach diverse participants groups including mothers and teachers; engaging fathers and boys to support girls, religious and community leaders to communicate appropriate messaging. Continue to work with leading female sports athletes as champions of change on MHM.

**Resource mobilization:** leverage funding sources for its MHM work including from the UNICEF Gender Innovation Fund.

### Adolescent Nutrition

Adolescent nutrition programmes are not in place in Pakistan. Expected over the course of the next five years in the new CPD. UNICEF will ensure information on the needs of the adolescent age group is collected and analyzed and will ensure that Social and Behavioural Change Communication (SBCC) plans include activities that may target improved awareness of good nutritional practices in this age group.

The new CPD focuses on disadvantaged newborns and children to benefit from integrated maternal, new-born and child health interventions and healthy behaviours by 2022. Much of Pakistan Country office’s advocacy work in health will seek to include adolescents in surveys and datasets, to ensure young married (pre-pregnant and pregnant) women and mothers are not excluded from Government policy or health services.

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### SRI LANKA

According to the Gender Evaluation undertaken by ROSA in early 2017 and the GRAH questionnaire, promoting gender-responsive adolescent health is a targeted gender priority for Sri Lanka. In describing its work with adolescents, UNICEF Sri Lanka reports that “Adolescence is a period of transition in a child’s life and in Sri Lanka, adolescent girls and boys, aged 10 to 19 years, represents approximately 20 percent of the country’s population.”

UNICEF is working with its partners and other UN agencies to better prepare adolescents, particularly those who are vulnerable, for a better future through life skills education and by promoting adolescent participation in discussions related to policies which directly affect their lives. UNICEF is emphasizing adolescent health and nutrition as priority areas. Some of the cross-sectoral efforts pertaining to gender-responsive adolescent health by UNICEF Sri Lanka include Health (such as addressing adolescent pregnancy and maternal health); HIV/AIDS (in terms of HIV testing, treatment and psychosocial support for boys and girls); Nutrition (through addressing anaemia among adolescent girls); WASH by promoting puberty education and MHM (including in schools); and Life Skills Education; and finally addressing GBV (including in schools) and Child Protection.

The country office reports that a National Youth Survey was conducted in 2012-2013 and a National Strategic Plan on Adolescent Health was developed for 2013-2017 supported by WHO, UNFPA and UNICEF. Work on adolescents is included in maternal health including early child bearing through technical and financial support for programmatic interventions and services.

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**Emerging Needs**

The emerging needs for Sri Lanka Nepal are on improving SRH knowledge and prevention of non-communicable diseases.
UNICEF Sri Lanka reporting shows that efforts are noteworthy in the area of MHM which has been a primary focus of this gender-targeted priority. In terms of weaknesses, data was reported primarily at the activity (rather than results) level, and was not consistently gender-disaggregated.

### MHM and WASH

UNICEF Sri Lanka addresses issues of relevance to adolescents in the area of WASH in schools by providing support to develop MHM tools to improve the well-being of adolescent girls and female teachers with field testing in 100 schools as a gender programming priority. These contribute not only to promoting gender-responsive adolescent health, but also support advancing girls’ secondary education (another gender priority area in UNICEF GAP 2018-2021). Based on a UNICEF-supported national study on Knowledge, Attitudes, Practices and Behaviour in WASH, including MHM in schools which was published in 2015, the Government is improving WASH facilities in schools taking into consideration the interests, needs and priorities of both girls and boys, specifically related to MHM.

The COAR also reports that in 2015, an MHM Kit, developed in collaboration with the Provincial/Zonal Department of Education and experts from NGOs, was field-tested with boys and girls. It was also tested on male and female teachers in targeted schools in the North, with the objective of scaling up to both provincial and national levels. The trained zonal resource team on MHM provided an opportunity for parents (both mothers and fathers), teachers, and students to discuss and improve MHM in schools with the aim of increasing attendance of girls. In 2016, as the use of the Kit is scaled up, evidence will be generated to measure the impact on school attendance of adolescent girls.

### Nutrition

Adolescent health is integrated into the Sri Lanka UNICEF nutrition programming efforts, for instance, in schools. The COAR 2015 reports “At the school level, UNICEF partnered with other UN agencies to promote healthy eating practices, reaching around 15,000 adolescents.”

### Regional Analysis and Findings

The assessment found that GRAH was a targeted priority for few countries and will be a priority for others in the next CPD for example, Nepal.

**Overview of Country Office Initiatives on Adolescent Health and Nutrition**

Majority of the work by country offices have focused in the area of MHM/WASH and Anaemia through weekly IFA supplementation primarily for girls in schools and life skills education for girls and boys. There was limited work on IFA supplementation with out of school girls and boys with the exception of India. Countries such as Afghanistan, Pakistan had undertaken more work on anaemia and MHM. Locally sensitive and creative communication materials and approaches have been developed for anaemia in Afghanistan. For Pakistan, the first decade was a priority for the office along with the government’s national plans.

Overall, countries such as India, Bangladesh and Nepal have undertaken more extensive work on GRAH - worked closely with governments in developing policies and guidelines. They have supported capacity building, provided technical assistance and implemented Adolescent friendly health services, life skills, MHM, anaemia and adolescent nutrition.

Support to governments in the development of government policies and plans was also provided. For example, UNICEF Bangladesh’s support to MoHFW in drafting the Bangladesh National Adolescent Health Strategy (2016-2030), which is multi-sectoral and prioritizes adolescent nutrition, mental health, child marriage and teenage pregnancy. UNICEF Bangladesh is also supporting the development of a costed national plan of action and contributed to the revision of the Gender Equity Strategy 2014–2024 of the health sector, approved by MoHFW in
2015. UNICEF Afghanistan has supported Ministry of Public Health (MoPH) to include adolescent health in the health policy and strategy and the RMNCAH strategy will include adolescent safety.

UNICEF India is providing technical support to the implementation of the government flagship adolescent health programme (RKS)K. UNICEF country offices have also been using evidence based advocacy and influencing government programmes, for example in Bhutan in revising the MHM and anaemia/nutrition using data and evidence.

Adolescent friendly health services (AFHS) was a focus especially in Bangladesh and Nepal, however, the utilization, confidentiality, quality and comprehensiveness of services are issues to be further examined and strengthened. Some elements of sexual and reproductive health rights and HIV/AIDS, coupled with addressing risky adolescent behaviours have also been addressed.

In Bangladesh, adolescent pregnancy is being addressed more strongly while in other countries it is a part of the maternal health programme. Underlying gender norms and inequalities are addressed through life skills, communication campaigns and ending child marriage materials for example, Rupantaran package in Nepal. There is initial work on addressing mental health issues such as resilience building including suicide prevention in Bhutan.

As the issues addressed are across different sectors within UNICEF, there are attempts to converge within UNICEF country offices through working groups for example, ending child marriage working group, multi-sectoral nutrition plan working group in Nepal.

Across each country office, the data on the reach and coverage with adolescents will need to be further analysed by geography, wealth quintile and ethnicity, etc. WIFS and MHM has focussed more on girls while life skills education and communication campaigns, early marriage prevention work through adolescent/youth clubs has reached both girls and boys.

Family planning has been handled mostly by UNFPA and UNICEF has provided child spacing counselling as a part of maternal health programmes.

### Cross Country Promising and Good Practices

The cross country promising and good practices include the following:

<table>
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<tr>
<th>Adolescent Nutrition</th>
<th>Menstrual Health and Hygiene</th>
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<tbody>
<tr>
<td>• IFA supplementation: Weekly IFA supplementation in schools for girls (and boys in India) with de-worming, diet diversity, nutrition counselling, addressing challenges of procurement/supply, adherence and side effects (having IFA tablets after meals/food).</td>
<td>• Focus on <strong>menstrual health, wellbeing and hygiene.</strong> Not focusing only on menstrual products and disposal.</td>
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<tr>
<td>• Locally sensitive and contextual <strong>communication materials.</strong></td>
<td>• <strong>Puberty education</strong> in locally sensitive, contextual communication materials (Pakistan), understanding bodies, addressing menstrual problems - cramps, prevention of infection, cleanliness and Polycystic ovarian disease - PCOD (as incidence is increasing).</td>
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<tr>
<td>• <strong>Training of teachers, girls and families.</strong></td>
<td>• <strong>Access and availability of sanitary napkins</strong> including biodegradable and eco-friendly materials.</td>
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<tr>
<td>• Promising practices on adolescent nutrition addressing women and girls with <strong>collectives/self-help groups</strong> as entry point and focus on women’s empowerment. Results and impact to be examined in India.</td>
<td>• Gender friendly <strong>WASH infrastructure</strong> in schools.</td>
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<td></td>
<td>• <strong>Training of teachers and health workers</strong> (Afghanistan and India).</td>
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<td></td>
<td>• <strong>Innovative approaches</strong> in Pakistan such as three-star approach.</td>
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</table>
Adolescent Friendly Health Services

- Growth monitoring, nutrition, menstrual health and hygiene, SRH issues, HIV, emotional and mental issues and counselling.
- **Pre-conception/pre-marriage/pre-pregnancy package** (nutrition, MHM, SRH and other issues) still being piloted in Bhutan.
- **Referral for maternal health** – ANC and PNC.
- Focus on utilization and quality of services.

Focus and Coverage of Programmes

**Emerging Issues**

- There is a diversity of interventions across countries in South Asia region, however, without clarity on a uniform appropriate set or package of needed interventions for adolescent girls and/or boys (unmarried, married girls, boys and couples and across adolescent age groups).
- Young mothers/couples do not feature strongly and there are no strong linkages between child marriage and health.
- There are limited programmes for boys and on engaging with young men.
- There is potential to scale up good practices in MHM and anaemia and track results.
- The WASH and SRH results (unless associated with MHM) are not always gender-specific.
- Issues of mental health, suicide are currently being handled to limited extent under the ADAP and have potential to be strengthened.
- There is limited data available and a need to better understand impact and track results.
The assessment examined the understanding of gender responsiveness of adolescent health across countries. It was found to be varied across staff in countries and generally translated into number of girls and boys reached or covered and interventions revealed inconsistencies in the understanding of gender responsiveness.

Given below is a compilation of responses received from various countries:

- While there is no uniform understanding of gender-responsive programming, the same is evolving. Different programmes have varying levels of understanding; in the context of health, and especially adolescent health, the focus has so far been on programming related to girls (within the context of gender). However, this too is evolving, with increasing focus on designing programmes keeping in mind the varying needs of girls and boys.

- Gender responsive programming means the programme which supports both girls and boys based on their deprivation level to improve their current status and empower them for achieving their highest potential development.

- By gender responsive programming we want to ensure equitable access and equal opportunities for women/girls/men and boys in more appropriate and effective ways. There are many ways through which we can ensure gender responsive interventions.
  - Orientation to implementing partners on gender where participation of women/girls, men/boys from different section of the community and its staff are considered in participation/ representation in committees, training/orientation including in decision making.
  - Recruitment of partners' staff.
  - Technically sound monitoring and evaluation system, frequent programme visits, programme review from gender perspective can ensure and evaluate if the programme is gender responsive.

- Gender responsive programming provides girls with a conducive environment for their success.

- Planning and implementing activities after ascertaining gender equity of activities. All the training provided for these programmes include both male and female service providers to eliminate gender discrimination. For the Health sector, as the major service providers (midwives) are female, in most cases the training have majority of female training participants. Other activities of the Health section are targeted to mothers, newborns and children under five, which are gender responsive and have included male involvement for better uptake of services. For the Nutrition section, gender responsive programming means programmes that intend to provide gender-specific services and care to the target group.

- The gender angle is considered in the planning and design stage. For example, in nutrition, maternal and child nutrition, father’s role and supporting the mother is included as a message. It is also looking at how an issue impacts on boys and girls and what kinds of interventions are appropriate for boys and girls. For example, in the area of drug abuse among children and adolescents, the impact on girls is very different and interventions have to be designed to address these issues that impact of boys and girls.

The findings across country offices show that there is limited understanding of gender responsiveness across country offices - whether initiatives are gender responsive and addressing or integrating critical gender issues or not. There is limited data, evidence, cross sectoral and gender integration impact at the policy, Social and Behavioural Change Communication (SBCC) and system level responsiveness and needs are to be strengthened. Effective interventions, where they exist, should be used as examples to be scaled-up.
To ensure gender responsive programming, the principles of gender responsiveness need to be clearly defined and articulated and kept in mind at the needs assessment, problem analysis, programme design, implementation, monitoring and evaluation stages.

**Types of Strategies for Change**

- **Level 1: Gender Unequal**
  - Perpetuates gender inequality by reinforcing unbalanced norms, roles and relations
  - Privileges men over women (or vice versa)
  - Often leads to one sex enjoying more rights or opportunities than the other

- **Level 2: Gender Blind**
  - Ignores gender norms, roles and relations
  - Very often reinforces gender-based discrimination
  - Ignores differences in opportunities and resource allocation for women and men
  - Often constructed based on the principle of being “fair” by treating everyone the same

- **Level 3: Gender Sensitive**
  - Considers gender norms, roles and relations for women and men and how they affect access to and control over resources
  - Considers women’s and men’s specific needs
  - Intentionally targets and benefits a specific group of women or men to achieve certain policy or program goals or meet certain needs
  - Makes it easier for women and men to fulfill duties that are ascribed to them based on their gender roles

- **Level 4: Gender Specific**
  - Considers gender norms, roles and relations for women and men and how they affect access to and control over resources
  - Considers women’s and men’s specific needs
  - Intentionally targets and benefits a specific group of women or men to achieve certain policy or program goals or meet certain needs
  - Makes it easier for women and men to fulfill duties that are ascribed to them based on their gender roles

- **Level 5: Gender Transformative**
  - Considers gender norms, roles and relations for women and men and that these affect access to and control over resources
  - Considers women’s and men’s specific needs
  - Addresses the causes of gender-based health inequities
  - Includes ways to transform harmful gender norms, roles and relations
  - The objective is often to promote gender equality
  - Includes strategies to foster progressive changes in power relationships between women and men

Source: Gender mainstreaming for health managers: a practical approach/WHO Gender Analysis Tools
A proposed draft framework has been developed with adaptation from the UNICEF Latin America GRAH framework. Six possible areas of intervention for the South Asia region include:

- Menstrual health and hygiene management (MHM), anaemia and micronutrient deficiencies
- Adolescent pregnancies (linking with early marriage)
- Sexual health and HIV including life skills and adolescent friendly health services
- Non-communicable diseases and risk factors (including obesity)
- Mental health and well being
- Violence

These include existing areas of work and emerging needs. Addressing gender norms and socio-cultural, inequalities issues is cross cutting. These can be selected by countries according to their need and priority. The framework and strategies noted below are to be further developed at UNICEF South Asia.

Key strategies for addressing priority areas include the following:

- **Advocate for every adolescent’s right to health**
- **Influence government policies**
- **Strengthen service delivery**
- **Empower communities and adolescents**
Recommendations for Strengthening GRAH in South Asia

The GRAH regional assessment has shown that adolescent health and nutrition interventions are undertaken in varying intensity and scale. There are good learning’s and promising practices that can be strengthened and replicated while new interventions and/or solutions need to be tested and further refined. The tracking of results can be improved and gender responsiveness needs to be understood more clearly across the board in design, implementation, data and tracking results from a UNICEF perspective. There needs to be more dedicated investment and partnerships to expand the work on adolescent health.

Recommendations noted are below and other areas of priority may be identified at the country level to complete this strategic priority area.

### Uniform GRAH definition and framework

- Require standard UNICEF definition and framework on Gender responsive adolescent health – with details and guidance for country offices on how to design, generate evidence, data and implement GRAH programmes with a gender lens.
- Develop a GRAH framework for South Asia region that is relevant and contextual.
- Develop a uniform package of needed interventions for adolescent girls and/or boys (unmarried, married girls, boys and couples) that can be used by country offices, to be adapted by context.
- Capacity building and sensitization of country offices and key staff within gender, health and nutrition teams (working on adolescent health and nutrition) to have a deeper understanding of gender responsive adolescent health and how to include in programming and policy making.

### Data and evidence generation

- Need to have sound problem analysis, needs assessment, and research in countries/region on the adolescent health situation and priority needs. Current data and country snapshots available has minimal information on adolescent health.
- South to South exchange and capacity building of researchers for better data and evidence sharing.

### Programming

- Could be three types of programmes:
  - Girls focused where the emphasis is on girls’ empowerment, health concerns, MHM, advancement and boys in supportive role (awareness, sensitization)
  - Emphasis on boys (masculinity, prevention of violence, husbands and future fathers)
  - Focus on girls and boys (health awareness, healthy behaviours, nutrition, gender issues, SRH, AFHS, life skills (unmarried)). Work with young married women and young couples
- Strengthened coordination between UNICEF sectors - Education, HIV, Health, Nutrition, WASH, C4D and Gender – for convergent programming on adolescent health and nutrition.
- Work on early and frequent pregnancies and child bearing within larger maternal health programmes with a focus on young mothers. Initiate work with young couples within the maternal health portfolio. Enhance the linkage with the large child marriage portfolio across the countries.
- Strengthen and improve the engagement with boys and men on gender issues, SRH and life skills, and Enhancing engagement with husbands on child care, maternal health and nutrition.
- AFHS to be strengthened to enhance its comprehensive scope, utilization, confidentiality and quality.
- Proven programmes in each country to be taken to scale for example, anaemia (WIFS) and MHM.
- Pilot projects for innovative approaches - to be analysed on how they work could be replicated/scaled up.

### Influencing policy, working with governments

- Working with the Ministry of Health in countries to develop and improve the gender integration in the adolescent health sections of the National Health Strategies and Policies. Learnings from Bangladesh on what worked to influence Government could be a good added value.
- Strengthening service delivery and capacity building of health workers working with adolescents.
- Technical assistance and implementation support where required.
- Sharing data, evidence, cross-learning and good practices on scaled up results on GRAH to influence costed action plans and social protection for adolescent girls.
- Supporting Government to generate sex and age and social disaggregated data on adolescents related to their health and nutrition.

### Working with adolescents, parents, families and communities

- Sensitization to the issues of adolescent girls and boys for social and behavioural change.
- As gatekeepers, families and communities are important stakeholders to influence and raise awareness.
- Generating demand for gender responsive adolescent health services (including adolescents themselves) and for accountability from governments.

### Measurement, tracking results, knowledge building and learning

- Ensure results and impact related to gender responsive health and nutrition outcomes are specifically measured.
- Strengthen evidence/impact gathering for existing programmes with tracking over time on – MHM, anaemia, adolescent friendly health services, life skills education.
- Improved coordination and learning’s shared between country offices – on what works and what doesn’t. Case studies of AFHS, work on early pregnancies, good and promising practices (WIFS, MHM, nutrition) in or across countries. Possible replication and scaling.

### Human Resources with UNICEF

- Gender focal points/gender specialists to understand fully what is happening on GRAH in their country across different sectors.
- Sectoral teams from Health and Nutrition working on Adolescent health to technically understand and apply approaches to strengthen gender responsiveness.

### Support from UNICEF ROSA

- Technical support – Sensitization and capacity building on GRAH – definition, framework, guidance, implementation (the how):
  - Capacity building of gender focal points on gender responsive programming, need assessment and designing, implementation and M&E of health, nutrition, protection and WASH programme
  - Identifying entry points to work on GRAH in countries with little adolescent infrastructure (For example, Pakistan)
  - Developing and sharing materials and guidelines to support advocacy for GRAH
- Financial support – advocating for investment and establishing linkages with possible donors.
- Knowledge sharing of good and promising practices, lessons learned for replication and scaling- utilizing the regional health/nutrition/gender network meeting platforms for sharing GRAH related progress.
- Participation in South Asian advocacy events with policy makers and programme planners.

### Financial resources

- Dedicated and increased budget allocation for GRAH within region and country offices.
- Investment case for one to two countries on specific adolescent health issues for example, early child bearing and nutrition (benchmarking with investment cases prepared at WCARO region).

### Partnerships

- Coordination with United Nations entities in country and at regional level to avoid overlap and duplication of work on adolescent health, nutrition and SRH.
- Partnerships with NGOs working on adolescent health issues, communication agencies, research/evidence gathering organizations. Linkages with adolescent health networks in country.
- Using social media/private sector outlets for outreach and messaging on obesity, adolescent nutrition – healthy eating campaigns through Communication for Development.