ADOLESCENT HEALTH
NATIONAL STRATEGIC PLAN
2019 - 2030

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CONTENT

LIST OF TABLES

LIST OF FIGURES

Adolescent Health National Strategic Plan 2019-2030

ACKNOWLEDGMENTS

The Government of Belize extends its gratitude to the adolescents from all districts who joined local and national stakeholders in developing the Adolescent Health National Strategic Plan for Belize. The inputs you provided at district and national consultation sessions were critical in shaping the priorities of this plan.

ABBREVIATIONS

AA-HA!	Global Accelerated Action for the Health of Adolescents
AH-TWG	Adolescent Health Technical Working Group
CEO	Chief Executive Officer
CSO	Civil Society Organization
HIV	Human Immunodeficiency Virus
MICS	Multiple Indicator Cluster Survey
NGO	Non-Governmental Organization
SDG	Sustainable Development Goal
SISB	Single Information Systems for Beneficiaries
TOR	Terms of Reference
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization

EXECUTIVE SUMMARY

This Adolescent Health National Strategic Plan (2019–2030) seeks to improve opportunities for positive development for adolescents aged 10–19 years in Belize.

Adolescents make up about 22 per cent of the ethnically diverse population of Belize. The endorsement by the Government of Belize of core commitments to early childhood development, using a rights-based life-cycle approach, is a golden opportunity to address the negative outcomes many adolescents face today.

This plan reflects this commitment to reach out to adolescents. Investment in this age group today will have profound impacts on their lives, and the lives of their children, and will benefit our society and economy at large. This necessitates developing affordable, effective and efficient structures that align all sectors to working toward the well-being of adolescents.

A wide range of factors affect adolescent health. Education, which is a protective factor for adolescent health, is inadequate, as not all students who enrol in primary school complete high school. Overall health of adolescents is also impacted by the environment in which they grow and develop. At organizational level, there are major areas of weakness, which manifest in the absence of a well-structured adolescent health programme with multisectoral collaboration and accountability mechanisms.

The Adolescent Health National Strategic Plan was developed using a participatory approach, engaging adolescents and service providers through consultations at national and district levels to elicit their inputs and validation.

The plan's vision is that, in Belize, empowered adolescents reach their positive development.

This plan contributes towards the achievement of this vision by seeking to address issues concerning the positive development of adolescents, injury and violence, health and mental health and sexual and reproductive health.

It does so using four key strategies: institutional strengthening, service coverage and quality, monitoring and evaluation and advocacy and social mobilization.

The plan is rights-based and takes a life-cycle approach, keeping adolescents at its centre. Its design is based on ensuring provisions for adolescents through strong collaborations between implementing agencies.

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Adolescent Health National Strategic Plan 2019-2030

CHAPTER 1: INTRODUCTION

Agenda 2030 set out 17 Sustainable Development Goals (SDGs) which were adopted by all Member States of the United Nations in 2015.

To build on this long-term development plan, and to guide its implementation of the SDGs, the Government of Belize adopted the Growth and Sustainable Development Strategy (GSDS) 2016–2020. This identifies four critical success factors for Belize to achieve the SDGs. One of these is to: "Enhance Social Cohesion and Resilience", including the provision of "Adequate Access to Health Care".

The Adolescent Health National Strategic Plan 2019–2030 has been developed to provide this access to Belizeans at a critical stage of life.

This strategic plan is aligned with the Government's international and national commitments and its national action plans, policies and strategies. These include the Convention on the Rights of the Child; Every Woman, Every Child, Every Adolescent Strategy; Children's Agenda (2017–2030); National Youth Policy, Sexual and Reproductive Health Policy and the Belize Policy on Persons with Disability.

1.1 Adolescent: A critical stage of life

Adolescents are defined as individuals between the ages of 10 and 19 years. This period of life is further divided into early (10–14 years) and late adolescence (15–19 years), recognizing the different needs and services that are required for growth and development in safe and nurturing environments.

Investments in adolescent health and well-being are vital to progress towards the SDGs, and can result in a 10-fold economic benefit. Investments in their health and education are direct investments in the core determinants of human capital. They not only transform the lives of adolescents in resource-poor settings, they generate high economic and social returns and capacity for sustainability.

INVESTING IN ADOLESCENTS: A TRIPLE DIVIDEND

Investments in adolescent health and wellbeing bring a triple dividend of benefits now, into future adult life, and for the next generation of children. Adolescents are biologically, emotionally, and developmentally primed for engagement beyond their families. We must create the opportunities to meaningfully engage with them in all aspects of their lives. Inequities, including those linked to poverty and gender, shape all aspects of adolescent health and wellbeing: strong multisectoral actions are needed to grow the resources for health and wellbeing and offer second chances to the most disadvantaged. Adolescents and young adults face unprecedented social, economic, and cultural change. We must transform our health, education, family support, and legal systems to keep pace with these changes.

Source: Lancet Commission on Adolescent Health and Well Being, 2016[1]

1.2 Situation of adolescents in Belize

Investments targeting adolescents today will have an impact on their lives, the lives of their children and will make our economy stronger.

Belize has policies, plans and programmes targeting adolescents, however, measurement of their effectiveness and efficiency is inadequate.

The Adolescent Health Technical Working Group (AH-TWG) conducted an extensive review of data using administrative reports, population and other surveys and insights gathered through nationwide consultations with policymakers, service providers, researchers and adolescents.

Enabling environment

While legislative frameworks and policies related to adolescent health, and protecting their rights, have been approved, there is a need to strengthen their application and to ensure homogeneity.

Table 1: Legal environment

AGE IN YEARS	Convention on the Rights of the Child	Summary Jurisdiction (Procedure) Act	Child	Adult	Age of criminal responsibility	Work permitted under Labour Act	Marriage with parental consent	Driving licence	Right to vote; Right to purchase and consume alcohol
0									
1									
2									
3									
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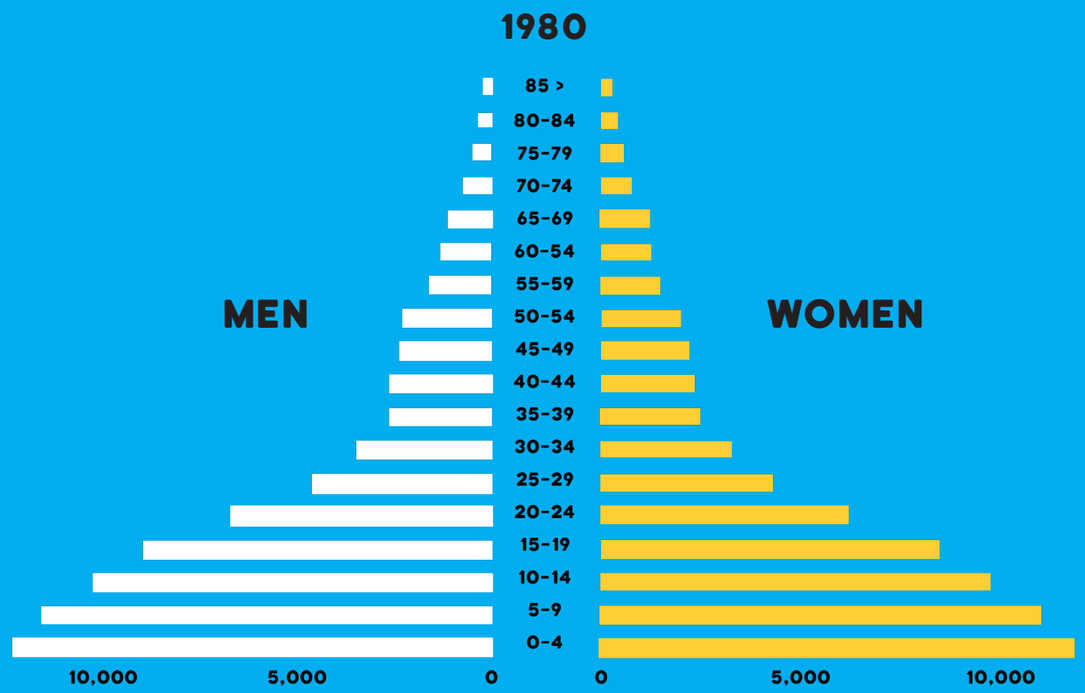
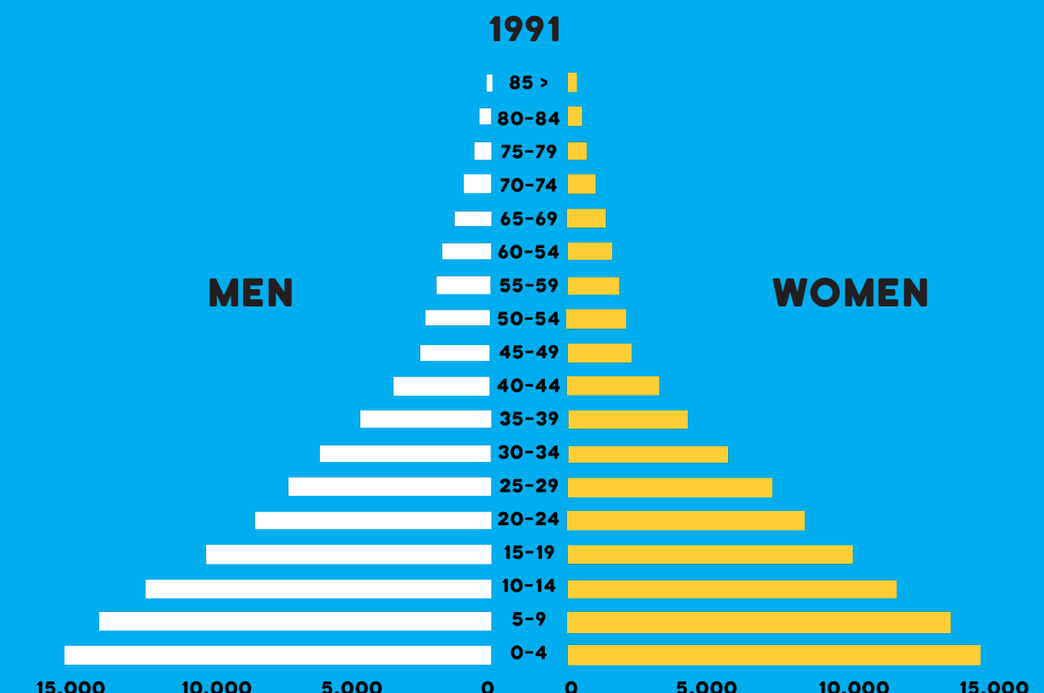
18									
>18									

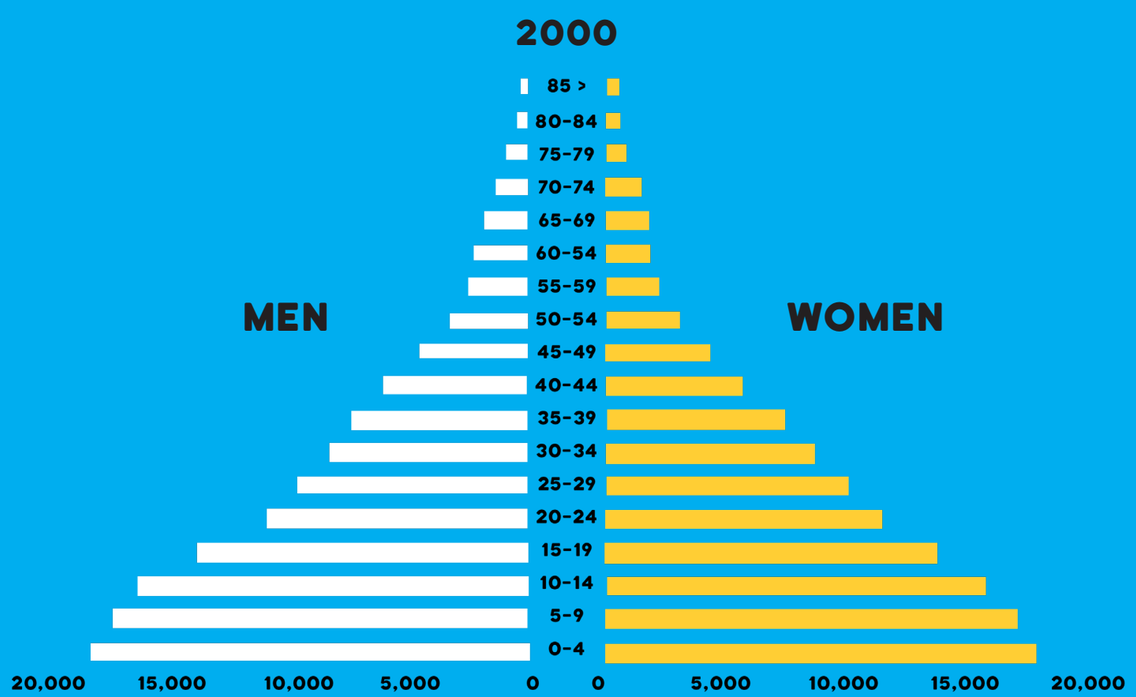
Population and economy

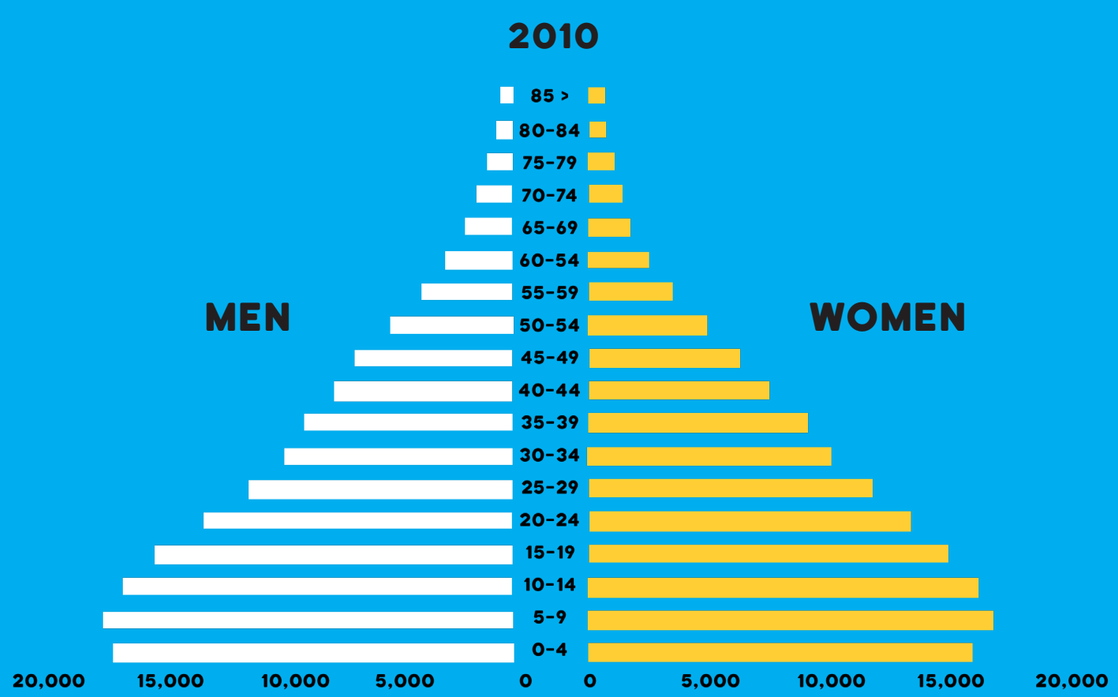
Adolescents account for 22 per cent of the population of Belize. Although the national unemployment rate is declining, among young people aged 14–24 years it increased from 19.9 per cent in 2017 to 21.3 per cent in 2018.2 For girls and women in this age group, the unemployment rate in 2018 was 2.3 times higher than for boys and men.[3]

Figure 1: Belize population pyramid, 1980, 1991, 2000, 2010









Source: Statistical Institute of Belize, 2018

Education

Education is a powerful determinant of adolescent health, human capital and a driver of socioeconomic progress. In Belize, for every girl enrolled in primary education (standard 1) in 2017–2018, 1.07 boys were enrolled.4

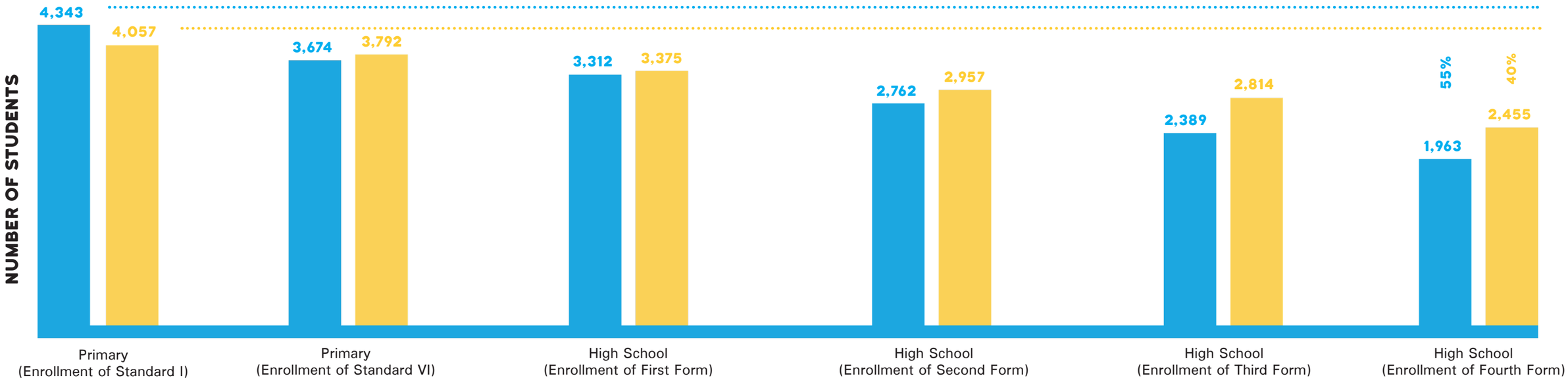
Education is compulsory between 5 and 14 years of age but a large proportion of students do not complete their secondary education. Indeed, 55 per cent of boys and 40 per cent of girls drop out between standard 1 and fourth form. The Government of Belize has instituted a secondary-school subsidy to increase the transition rate from primary to high school.

Injuries and gender-based violence

In 2017, the major cause of death among adolescents aged 10–14 years was road traffic accidents, while among adolescents aged 15–19 years it was unintentional injuries and assault (homicide).5

Gender-based violence, which includes domestic violence, remains a problem in Belize. Between 2013 and 2017, 14.5 per cent of reported cases were among adolescents. Of these, 89.6 per cent were girls and women, and 75.8 per cent were older adolescents, aged 15–19 years.[5]

Figure 2: Enrolment by gender from standard 1 to fourth form, Belize 2017-2018



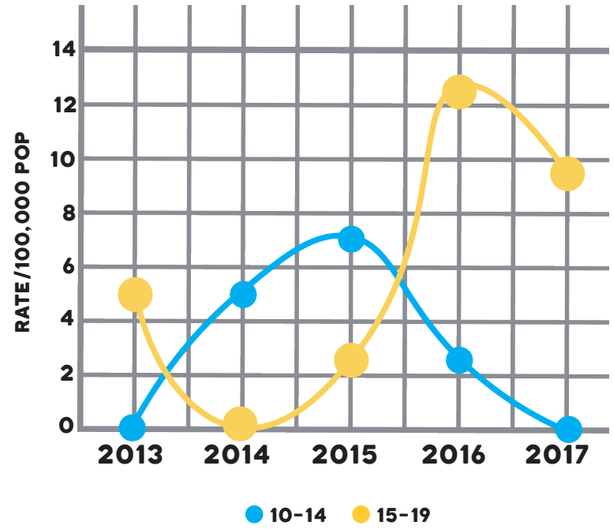
Source: Belize Ministry of Education, 2017-2018

Health: Adolescent mental health

Mental health is a growing cause of illness in adolescents, yet there is no structured programme of mental health screening of children and adolescents.

Between 2008 and 2017, 56 adolescents aged 10–14 years and 276 adolescents aged 15–19 years attempted suicide,5 together representing 36 per cent of attempted suicides in all age groups. Ministry of Health administrative reports identify three causes related to mental health for the admission of adolescents: disorders due to psychoactive substances use, attempted suicide and mental health disorders due to anxiety and stress-related disorders. The suicide rate among adolescents aged 15–19 years has increased significantly between 2013 and 2017.

Figure 3: Suicide rate per 100,000 among adolescents aged 10-19 years between 2013 and 2017, Belize



Source: Ministry of Health administrative reports

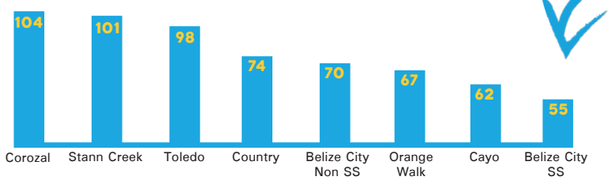
Health: Adolescent sexual health and contraception

The age-specific fertility rate among adolescents is high. In 2015–2016, there were 74 births to girls and women aged 15–19 years for every 1,000 girls and women in that age group (adolescent birth rate).[6]

Despite the efforts of the Ministry of Health to provide diverse contraceptive options, the prevalence rate of modern contraceptives among adolescent girls aged 15–19 years is 37.4 per cent, the lowest among all age groups. Adolescents also exhibit the highest unmet need rate for family planning.

Early sexual debut is a significant concern. A sexual behaviour survey conducted in 2014[7] found that the mean age at first sexual intercourse among youth is 16.4 years.

Figure 4: Adolescent birth rate by district, Belize



Source: Multiple Indicator Cluster Survey 2015

Health: Non-communicable diseases among adolescents

A high percentage of adolescent girls and boys experience obesity,[8] which increases the risk of non-communicable diseases during adolescence and in adulthood. Adolescent girls aged 15–19 years require urgent and special attention, as they were found to have higher rates of diabetes morbidity among adolescents between 2013 and 2017.

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1.3 Adolescent health priorities

The following table highlights the issues faced by adolescents in Belize, and the rates colour-coded by district. This prioritization is based on data in the situation analysis, evidence-based prioritization and those outlined in the Global Guidance for Accelerating Action for Health of Adolescents (AA-HA!).

Table 2: Adolescent health priorities by district

DISTRICT	ADOLESCENT PREGNANCY	MENTAL HEALTH	NON-COMMUNICABLE DISEASES	VIOLENCE	INJURIES
BELIZE CITY					
CAYO					
COROZAL					
ORANGE WALK					
STANN CREEK					
TOLEDO					

Table 2a: key to indicators for adolescent health priorities

ADOLESCENT HEALTH PRIORITY	INDICATOR	TRAFFIC LIGHT LABELLING	NOTE
ADOLESCENT BIRTH RATE	Number of births to adolescent females aged 15–19 years per 1,000 females in that age group	RED: >100 YELLOW: 70-100 GREEN: <70	Average rate between 2012 and 2016
ADOLESCENT MENTAL HEALTH	Number of reported depression cases in adolescents aged 10–19 years per 100,000 adolescents in that age group	RED: >80 YELLOW: 60-80 GREEN: <60	Average rate between 2013 and 2017
NON-COMMUNICABLE DISEASES	Number of adolescents aged 10–19 years with diabetes per 100,000 adolescents in that age group	RED: >50 YELLOW: 20-50 GREEN: <20	2017
VIOLENCE	Number of homicides in adolescents aged 10–19 years	RED:>20 YELLOW:10-20 GREEN:<10	Total number between 2013 and 2017
INJURIES	Number of traffic-accident-related deaths among adolescents aged 10–19 years	RED:>20 YELLOW:10-20 GREEN:<10	2017

Source: Epidemiology Unit, Ministry of Health, Belize

CHAPTER 2: FRAMEWORK

2.1 Methodology

After a team from Belize comprising representatives from the United Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA), the Belize Family Life Association participated in a workshop on adolescent health for the Caribbean region, the chief executive officers (CEOs) of the Ministry of Health, Ministry of Education, Youth, Sports and Culture and the Ministry of Human Development, Social Transformation and Poverty Alleviation commissioned the development of the Adolescent Health National Strategic Plan, to be prepared in collaboration with adolescents and stakeholders providing services to adolescents.

AA-HA![9] was used as a guide for the development of the strategic plan. The process emphasizes soliciting inputs from adolescents and multi-stakeholder participation. It builds on a thorough needs assessment, landscape analysis and evidence-informed prioritization for strategic programme response. Priorities are identified based on their relative contribution to the health and well-being of adolescents.

In November 2018, two national and four subnational consultations were conducted, attended by 233 adolescents from the six districts of Belize. These ensured that a participatory approach was used for the development of the policy and enabled a systematic and collaborative effort to commit to and strengthen provisions for adolescent health.

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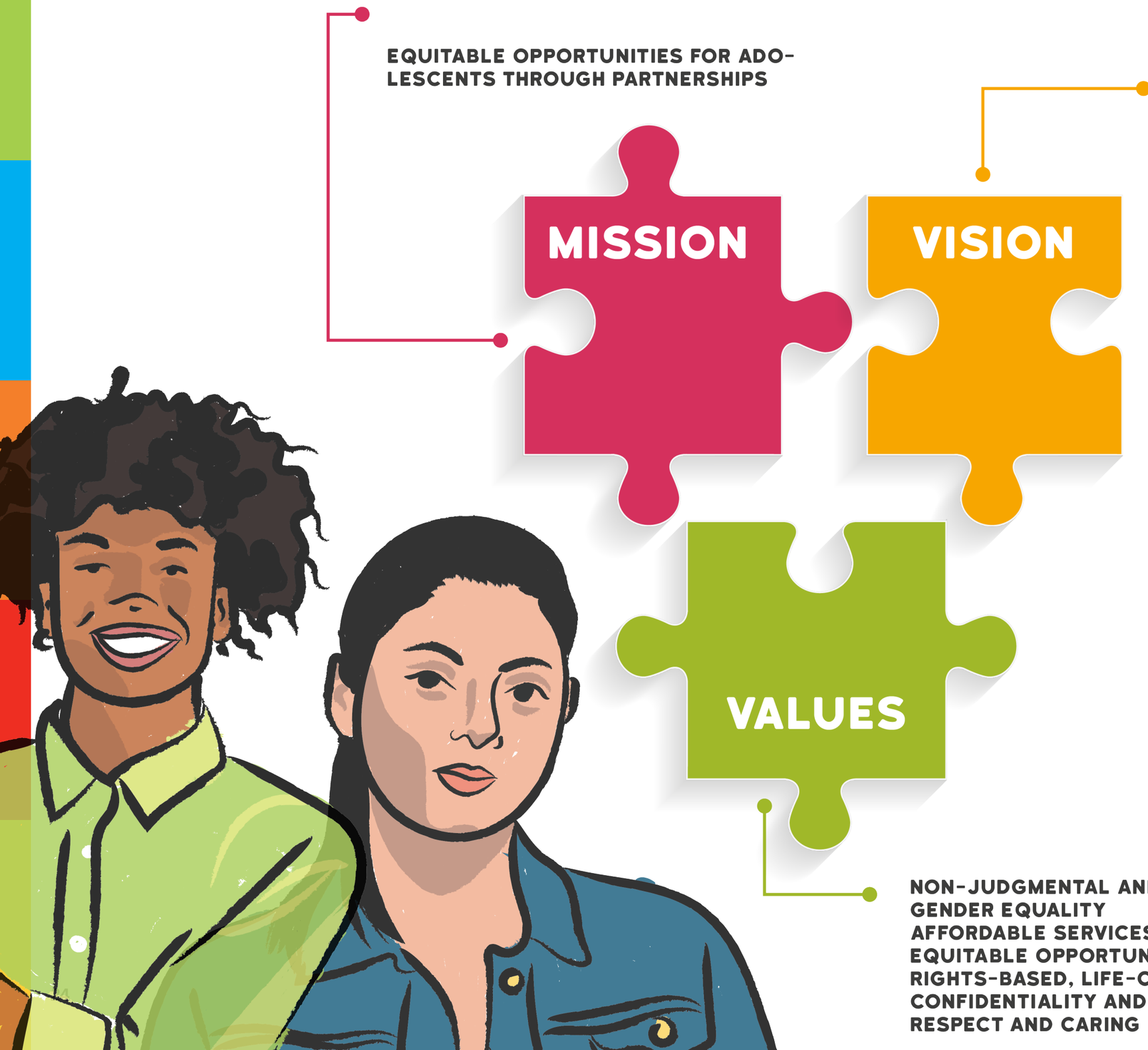
Adolescent Health National Strategic Plan 2019-2030

EQUITABLE OPPORTUNITIES FOR ADOLESCENTS THROUGH PARTNERSHIPS

EMPOWERED ADOLESCENTS REACH THEIR POSITIVE DEVELOPMENT



NON-JUDGMENTAL AND NON-DISCRIMINATING
GENDER EQUALITY
AFFORDABLE SERVICES
EQUITABLE OPPORTUNITIES
RIGHTS-BASED, LIFE-CYCLE APPROACH
CONFIDENTIALITY AND PRIVACY
RESPECT AND CARING

2.3 Time frame

The Adolescent Health National Strategic Plan covers a period of 12 years (2019–2030). During this time, it will be revisited every four years to review, evaluate and assess its relevance and implementation in a rapidly changing world.

2.4 Adolescent health outcomes

OUTCOME	INDICATORS
1. ACCESS TO QUALITY SERVICES Adolescents have access to quality services through improved multisectoral collaboration resulting in highly satisfied adolescents.	Percentage of adolescents screened at least once in the last year (includes screening for disabilities and mental health) Percentage of adolescents satisfied with services received
2. REDUCE RISK BEHAVIOURS Adolescents reduce risk behaviours through access to positive cognitive, sexual and social information and physical activity.	Adolescent birth rate
3. PROMOTE HEALTH AND WELL-BEING Adolescents grow, participate and develop in healthy, nurturing and safe environments, where health and well-being are promoted by all at community level.	Adolescents with Single Information Systems for Beneficiaries (SISB) numbers

Adolescent Health National Strategic Plan 2019-2030

2.5 The adolescent individual tracking system

Data producers will be required to establish a mechanism to regularly share and enable the first seven provisions (P1–P7) to be tracked for individual adolescents using their social security numbers.

Further provisions (P8–P11) are constructed utilizing the AA-HA! guidelines. They are complementary to the seven used for individual tracking, and will contribute to achieving adolescent health outcomes.

OUTCOME	PROVISION
OUTCOME 1 **ACCESS TO QUALITY SERVICES**	P1. Every adolescent has a social security card. P2. Every adolescent is screened routinely for wellness (vaccine preventable diseases, disabilities and mental health disorders). P3. Every adolescent has access to appropriate health care including mental health services. P8. Every adolescent receives adequate information and mentoring about the options available for their future that facilitate transition to employment including job search and preparation.
OUTCOME 2 **REDUCE RISK BEHAVIOURS**	P4. Every adolescent has access to health literacy (WHO), information on sexual and reproductive rights [SRR] and sexual and reproductive health [SRH] literacy and practices healthy lifestyles to remain in good health (includes physical activity –sports and recreation). P5. Every adolescent has access to education (any form of education). P9. Every adolescent's parent or caregivers receives relevant information on Adolescent health and development.
OUTCOME 3 **PROMOTE HEALTH AND WELL-BEING**	P6. Every adolescent has access to environments that promote different forms of creative expression, connectedness [family, community, school, peers, church, youth groups, others] and sense of belonging. P7. Every adolescent at risk or living in poverty, victim of any kind of abuse or neglect has an SISB number and receives support from health, justice and social welfare services. P10. Every adolescent is able to participate in spaces that allow them to express their ideas and decide on matters that affect themselves and their communities. P11. Every adolescent interacts in environments that supports safety and prevents injuries, violence and neglect.

P1–P7: tracked for individual adolescents using their social security numbers
P8–P11: not individually tracked; contribute to achieving adolescent health outcomes

Adolescent Health National Strategic Plan 2019-2030

CHAPTER 3: STRATEGIC DIRECTION

Government representatives, civil society organizations (CSOs) and adolescents discussed and agreed on four strategies to improve adolescent health in Belize.

Each strategy is subdivided into components and outputs that will guide the development of their operational plans.

STRATEGIES TO IMPROVE ADOLESCENT HEALTH IN BELIZE

1. INSTITUTIONAL STRENGTHENING
2. SERVICE COVERAGE AND QUALITY
3. MONITORING AND EVALUATION
4. ADVOCACY AND SOCIAL MOBILIZATION

3.1 Strategy One: Institutional strengthening

Institutional strengthening aims to create and/or reinforce the institutional arrangements, collaboration and governance of all government, non-government and CSOs to generate, allocate and use human, material and financial resources effectively, and to attain specific objectives on a sustainable basis through improved national and local capacities.

The health of adolescents is dependent on many factors, extending far beyond the health sector. For this reason, improving adolescent health requires a comprehensive approach and strong multi-sectoral collaboration.

Collaboration in implementing this strategy and achieving its goals is about shared mission and goals, shared data, decision making and resources.

STRATEGY ONE INSTITUTIONAL STRENGTHENING	
COMPONENTS	**OUTPUTS**
1.1 INSTITUTIONAL ARRANGEMENTS, COLLABORATION AND GOVERNANCE	**1.1.1** Memorandum of Understanding signed between line ministries and other stakeholders on the institutional arrangements for stronger collaboration
	1.1.2 Adolescent health technical working group established and functioning as per approved terms of reference
	1.1.3 Adolescent health CEO sub-caucus established and providing guidance to the AH-TWG
	1.1.4 Adolescent health stakeholders mapping updated every two years
1.2 FINANCING	**1.2.1** Adolescent health strategic Implementation plans costed
	1.2.2 Project proposals developed to outsource funds (UNFPA, UNICEF)
1.3 NATIONAL AND LOCAL CAPACITIES	**1.3.1** District technical working groups created to implement the strategic plan and provide local training
1.4 LEGAL FRAMEWORK	**1.4.1** Statutory instrument on adolescent sexual and reproductive health

Adolescent Health National Strategic Plan 2019-2030

3.2 Strategy Two: Service coverage and quality

A critical element of the national adolescent health programme is integrated delivery of the outlined provisions (see chapter 2, section 5).

The strategic plan categorizes services into provisions and guides service providers to make explicit links between programme objectives, implementation strategies and activities.
The settings where the services are delivered to adolescents are home, community, health facility, education, work and virtually.

A standards-driven approach is recommended, to improve quality of care for adolescents, with detailed guidance on actions required at facility, district and national level to support the implementation of global standards.

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STRATEGY TWO SERVICE COVERAGE AND QUALITY	
COMPONENTS	**OUTPUTS**
2.1 CAPACITY BUILDING	**2.1.1** Baseline study conducted on human resources, competencies and training curricula required for the provision of adolescent health services
	2.1.2 Multisectoral training curricula for adolescent health service providers developed
	2.1.3 Training plan developed for adolescent health front-line officers (i.e. parents, teachers, peer educators, police officers, community health workers, non-government organizations, NGOs, etc.) in the provision of adolescent-friendly services
	2.1.4 Communication for development plan developed for front-line officers on adolescent-friendly services
	2.1.5 Technical and vocational institutions and universities adjusted or improved professional development curriculum targeting adolescents
2.2 COVERAGE EXPANSION	**2.2.1** Comprehensive analysis conducted of coverage of services and adolescent health indicators (process, output and outcome indicators)
	2.2.2 Outreach-delivery-of-services plan (mobile clinics, home visits, health fairs, school-based programme, community policing programme, community-based drug prevention, faith-based interventions) developed, that contributes to the positive development of adolescents

STRATEGY TWO SERVICE COVERAGE AND QUALITY	
COMPONENTS	**OUTPUTS**
	2.2.3 Compulsory age for education revisited
	2.2.4 Compulsory age for education revisited
	2.2.5 Educational subsidy increased for students up to fourth form
2.3 CONTINUOUS QUALITY IMPROVEMENT	**2.3.1** Educational subsidy increased for students up to fourth form
	2.3.2 Health and Family Life Education and Positive Youth Development curricula updated
	2.3.3 Ongoing secondary education reform process completed
	2.3.4 Continuous quality improvement strategy for the delivery of adolescent-friendly services developed and implemented
	2.3.5 South-South cooperation projects on adolescent health implemented
	2.3.6 Collaborative sessions on adolescent-friendly services implemented (sharing best practices)
	2.3.7 Adolescent health screening tool developed

3.3 Strategy Three: Monitoring and evaluation

The purpose of monitoring and evaluation is to measure progress, identify challenges and improve results for adolescents.

Monitoring is the systematic collection of data to track progress in the delivery of provisions to adolescents. It is cyclical and allows for changes to the strategic plan. The indicators to be monitored help identify the actions and resources needed to achieve the programme's milestones and targets within the agreed timeframe.

The findings and recommendations that emerge from the programme evaluation feed directly and promptly into programme planning and priority-setting.

The Ministry of Health shares responsibility with other ministries and partner agencies through joint objectives, planning and funding.

STRATEGY THREE MONITORING AND EVALUATION	
COMPONENTS	**OUTPUTS**
3.1 INFORMATION TECHNOLOGY AND MANAGEMENT	**3.1.1** Multisectoral (health, education, police, human services, etc.) monitoring and evaluation framework on adolescent health developed and implemented
	3.1.2 Tracking system for services provided to adolescents developed and implemented
	3.1.3 Periodic analysis of annual reports related to adolescent health (e.g. injury and violence using Road and Traffic Accident Surveillance System data, education, sexual and reproductive health, non-communicable diseases and mental health)
3.2 ACCOUNTABILITY	**3.2.1** Annual statistical report on adolescent health published
3.3 RESEARCH AND EVALUATION	**3.3.1** Evaluation of the Adolescent Health National Strategic Plan conducted yearly to assess progress
	3.3.2 Gender analysis of adolescent health outputs and outcomes conducted every two years
	3.3.3 Memorandum of understanding agreed with data producers and academia to obtain disaggregated data on adolescent health (disaggregated by urban/rural location, sex, age group, income level, etc.)

INVENTORY OF DATA SOURCES ON ADOLESCENT HEALTH:

1. GLOBAL SCHOOL-BASED HEALTH SURVEY – EVERY TWO YEARS
2. MULTIPLE INDICATOR CLUSTER SURVEY (MICS) AND MICS+ –EVERY FIVE YEARS;
3. NATIONAL HIGH SCHOOL DRUG PREVALENCE SURVEY –EVERY TWO YEARS10
4. CHILD LABOUR SURVEY
5. U-REPORT
6. SEXUAL BEHAVIOUR SURVEY –EVERY FIVE YEARS
7. OUT OF SCHOOL CHILDREN SURVEY
8. GANG AND VIOLENCE SURVEY
9. EPIDEMIOLOGICAL MENTAL HEALTH STUDY
10. SITUATION ANALYSIS ON ADOLESCENT HEALTH
11. HUMAN CAPITAL ANALYSIS
12. ADMINISTRATIVE REPORTS PRODUCED BY IMPLEMENTING AGENCIES

3.4 Strategy Four: Advocacy and social mobilization

Advocacy is the process of building support for a specific issue or cause, and influencing others to take action in order to achieve policy change for adolescents.

Advocacy helps to ensure that key decision makers know about the existing adolescent health and well-being policies and understand their responsibility for implementing these policies. It also seeks to ensure that sufficient financial resources are allocated for adolescent health and well-being programmes and services, creates support among community members and generates demand for adolescent health and well-being policies. Advocacy informs the public about issues affecting adolescent health and well-being and persuades them to lobby decision makers to act at the grassroots level.

Social mobilization is a process to engage and motivate a wide range of partners, including NGOs, CSOs, community-based organizations, religious leaders, faith-based organizations, professional networks, private sectors, and adolescent groups nationally and locally. It aims to raise awareness of, and demand for, the three outcomes of adolescent health, and to provide sustainable and multi-faceted solutions.

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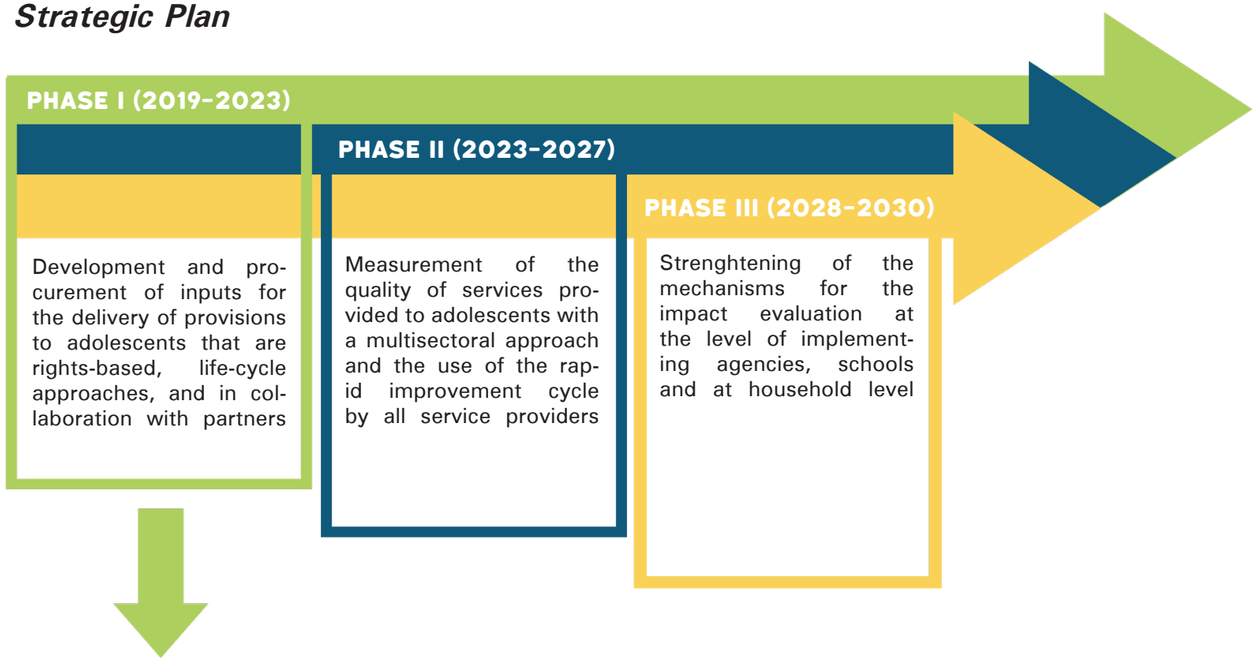
STRATEGY FOUR ADVOCACY AND SOCIAL MOBILIZATION	
COMPONENTS	**OUTPUTS**
4.1 PARTNERSHIPS WITH CIVIL SOCIETY AND COMMUNITY OUTREACH	**4.1.1** Memorandum of understanding developed to establish civil society support to the strategic plan
	4.1.2 Key partners (service providers) familiarized with the Adolescent Health National Strategic Plan
	4.1.3 Parents and community sensitized on the Adolescent Health National Strategic Plan
	4.1.4 Partners, collaboration and financial opportunities for social mobilization identified
4.2 COMMUNICATIONS	**4.2.1** U-Report platform utilized for updates on the Adolescent Health National Strategic Plan
	4.2.2 U-Report database expanded through collaboration with the Ministry of Education, Culture Science and Technology, and Ministry of Youth, Sports, and Transport
	4.2.3 Communication and media plan for adolescent health developed and implemented
4.3 PARTICIPATION AND EMPOWERMENT	**4.3.1** Two adolescents participate as members of the AH-TWG
	4.3.2 Advocacy plans for youth groups (Youth Advisory Group, Child Advisory Board, Youth Advocacy Movement) supported

3.5 Implementation of the Adolescent Health National Strategic Plan

The implementation of the Adolescent Health National Strategic Plan 2019–2030 is responsibility of three line ministries: Ministry of Health, Ministry of Human Development, Social Transformation and Poverty Alleviation and Ministry of Education, Youth, Sports and Culture, working in collaboration with other implementing partners.

The plan will be implemented in three phases as described below:

Figure 5: Implementation phases of the Adolescent Health National Strategic Plan



EXAMPLES OF INPUTS FOR PHASE I

Signed memorandum of understanding among implementing agencies on the delivery of provisions

Adolescent health service standards updated, and providers trained

Quality improvement strategy developed

Mechanisms for the individual tracking of services to adolescents defined

Processes of care provision to adolescents revisited and updated

The stewardship of the strategic plan at the decision-making level will belong to the CEO Caucus.

A core AH-TWG will be established with multisector participation and guided by terms of reference (TOR).

The technical working group will work with the National Committee for Families and Children sub-committees as needed, such as on policy and legislation and monitoring and evaluation.

The Monitoring and Evaluation plan will detail targets and milestones and will be monitored by the technical working group.

Data sources will include administrative reports and data from census and surveys. Where needed, the technical working group will submit formal request through CEOs for the inclusion of disaggregated data or the addition of new variables to measure progress towards achieving the outcome and impact indicators.

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