

# Consent and Confidentiality: Increasing Adolescents' Access to Health Services for HIV and Sexual and Reproductive Health

Report of the Regional Consultation  
New Delhi, India, 25-27 July 2006



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WHO Project: ICP HIV 500



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## Executive Summary

The problems in the area of Adolescent Reproductive and Sexual Health (ARSH) and the global increase in HIV infection in young people posing a challenge to policy makers and the health system deserve an urgent and appropriate response. Fulfilling the rights of adolescents requires a balance between providing them with protection and enabling them to assume adult roles and responsibilities. This should be consistent with the local norms and culture. Even though there are adequate provisions for the rights of adolescents in Convention on the Rights of the Child (CRC) and governments are committed to global resolutions International Conference on Population and Development (ICPD), UN General Assembly Special Session on Children (UNGASS), policies vary in the countries and health care providers lack clarity on the application of the legal provisions while providing services to adolescents. Consent and confidentiality issues are a constraint in access to health services for adolescents.

An intercountry consultation was organized in New Delhi from 25-27 July 2006 by WHO to: provide an overview of existing laws and current policy and practices relating to consent and confidentiality for adolescents in selected countries in Asia; review the situation in the countries to identify priorities for action; develop draft guidelines and to prepare action plans.

The participants included presidents of International Paediatric Association (IPA), International Planned Parenthood Federation (IPPF), International Association of Adolescent Health (IAAH), national representatives from five countries, and WHO staff from country offices in the SEA Region and from WHO/HQ. This was the first time that WHO, IPA, IPPF and IAAH had agreed to work together on the issues relating to the rights of adolescents, consent and confidentiality and to work with the Member countries to address the numerous constraints in access to services for ASRH and in the area of HIV prevention and care.

The consultation was inaugurated by Dr Myint Htwe, Director Programme Management, WHO/SEARO on behalf of the Regional Director, WHO South-East Asia Region, Dr Samlee Plianbangchang. The policies and practices relating to issues of consent and confidentiality in five countries (Bangladesh, India, Nepal, Sri Lanka and Thailand) were reviewed. The constraints and opportunities in implementation of the policy were synthesized. The matrix developed was synthesized and lessons

learnt documented. The issues included consent, assent and confidentiality in relation to prevention and care of HIV/AIDS, provision of services for STIs, family planning interventions, and abortion services. The focus was on adolescents and adolescents who are at high risk because of special situations like street children, IDUs, adolescent commercial sex workers etc. The draft guidelines developed by WHO/HQ were presented and discussed. A structure for guidelines was prepared during the consultation. Case studies were used to illustrate the numerous lessons that can be learnt relating to inadequate capacity of the health care providers and actions that the programme managers need to take.

## **Recommendations**

The outline of the guidelines developed during the consultation will be finalized by WHO/HQ in collaboration with WHO/SEARO with support of IPA, IPPF and IAAH. These guidelines should be used to strengthen the capacity of health care providers and of programme managers in increasing access to health services to adolescents in the area of ASRH and in the prevention and care of HIV/AIDS.

The country teams will advocate with policy makers and decision makers to develop effective policies for access to services relating to HIV prevention and care and ASRH. The issues relating to consent, confidentiality and assent with regard to adolescents should be a part of the national policy.

The roadmap developed by the participants will be implemented with support from WHO and partners.

Similar consultations are proposed to be organized to cover other countries in the SEA Region (SEAR) and in other Regions of WHO.

## **Background of the consultation**

Adolescents comprise 22-25% of the population in countries of the SEA Region. The problems relating to sexuality and reproductive health and the increasing trend of HIV/AIDS in adolescents and young people, the poor capacity of health care providers and variation in policy have brought the concerns relating to consent and confidentiality to the forefront. WHO/HQ, the HIV/AIDS department as well as the Child and Adolescent Health (CAH) unit have produced draft guidelines to address these issues. These need to be reviewed, refined and implemented.

Prior to the consultation the country teams were sent a questionnaire to document the policies and practices relating to consent and confidentiality in adolescents which promote or restrict the use of health services relating to ASRH and prevention and care of HIV/AIDS. Based on their inputs a matrix was prepared to consolidate the findings.

The consultation on consent and confidentiality; increasing adolescents' access to health services for HIV and ASRH in the SEA Region was organized from 25-27 July in New Delhi, India. It was organized by WHO with the participation of the International Pediatric Association (IPA), the International Association for Adolescent Health (IAAH), and the International Planned Parenthood Federation (IPPF). It was for the first time that several international organizations had participated in a consultation on consent and confidentiality in adolescents.

Each country team had a nominee from IPA and IPPF/FPA, as well as from national and international NGOs. WHO (HQ, regional and country offices) staff comprised the resource team. UNFPA and UNICEF invitees could not participate due to concurrent official meetings.



## Opening session

The consultation was inaugurated by Dr Myint Htwe, Director, Programme Management WHO Regional Office for South-East Asia on behalf of the Regional Director, Dr Samlee Plianbangchang. In his address, the Regional Director outlined the various sexual and reproductive problems of adolescents in the South-East Asia Region (SEAR) who represent 22-25% of the population. WHO was committed to achieving the global development goals relating to adolescents (for example, HIV and maternal mortality) through partnership with UN organizations, nongovernmental organizations and many other agencies and associations.

Health-care providers need to be clear about the rights of adolescents, including informed consent and recognize the importance of confidentiality and privacy. Access to information and reproductive health services in Member countries is influenced by traditional, cultural and religious norms and values. These factors should not hinder access to reproductive health services including STIs and HIV/AIDS prevention, treatment and care.

There was a need to advocate policy and programme development with all stakeholders, including adolescents, parents and communities, who need to be involved in the planning, monitoring and evaluation of these services. In order to do this, it may first be necessary to inform policymakers, lawmakers and other stakeholders about the special needs of adolescents, the Regional Director stated.

Reproductive health services for adolescents are likely to be successful, if they are linked to general health services. The challenge is to ensure that existing services are able to respond to the specific needs of adolescents, to provide a range of "adolescent-friendly" services under one umbrella. This will help reduce the stigma associated with many diseases, the Regional Director said.

The Regional Director was pleased to note that this consultation had been organized with the involvement of UN agencies, the International Pediatrics Association (IPA), the International Planned Parenthood Federation (IPPF) and the International Association of Adolescent Health (IAAH). The combined strength of the technical expertise and experiences

would lead to achieving the objective of this consultation and pave the way in reaching the long-term goal of providing effective health services to adolescents.

Dr Adenike Grange, president IPA, highlighted the role of pediatricians and various national pediatrics associations in addressing the needs of adolescents. She promised to disseminate the recommendations of this meeting to all the 146 Member countries of IPA. Clarity on consent and confidentiality for adolescents, was important for ensuring access to services. Application of such understanding had wider implications, for example trials and subsequent programming for Human Papilloma Virus (HPV) and microbicides. She was very encouraged to see that a nominee from IPA was representing each of the five countries.

Dr Doortje Braeken, president IPPF, emphasized that adolescents across the world want confidentiality, but that sometimes the moral values of providers came in the way of delivering professional services to adolescents. This was especially a problem when dealing with sensitive issues such as adolescent sexual and reproductive health. She was happy that a nominee from IPPF/FPA was representing each of the five countries.

Dr Ueli Buelhmann, president IAAH, stated that the issues and complexities associated with consent and confidentiality were similar in all parts of the world, although there would be some differences depending on local cultures and community norms. He reiterated support from IAAH which was relatively a new organization as compared to IPA, but was directly involved with adolescent care.

## **General objectives**

The general objective of the consultation was to develop guidance for service providers and programme managers, using the document prepared by HIV and CAH units of WHO/HQ as background material.

## **Specific objectives**

- To provide an overview of existing laws and current policy and practices relating to consent and confidentiality for adolescents in selected countries in South-East Asia Region.
- To identify strengths, weaknesses and gaps with current policies and practice, from the perspective of the providers and users of health services.

- To identify priorities for action, at national, organizational and facility levels, to improve policies and practices regarding consent and confidentiality for adolescents.
- To develop draft guidelines for service providers and mid-level managers to better respond to the consent and confidentiality needs of adolescents.
- To develop plans for using the guidelines developed by selected countries participating in the consultation.

### **Expected outcome**

Guidelines for service providers and mid-level managers to assist them to respond more effectively to the specific needs of adolescents in relation to consent and confidentiality for a range of services relating to the prevention and care of HIV and adolescent sexual and reproductive health.

Participating countries prepare plans for introducing consent and confidentiality in programmes relating to ASRH and prevention and control of HIV/AIDS.

WHO and partners to use the consultation experience to organize similar consultations in other regions of WHO.

### **Participants expectations**

The agenda and proposed method of work during the consultation were approved by the participants. The participants were keen to better understand the meaning of consent and confidentiality, the factors that hinder informed consent and understand the human rights framework to improve access of services to adolescents. They wanted to share experiences of other countries and learn from the constraints and opportunities. They were keen to have guidelines on consent and confidentiality and use them to help health workers provide services for sexual and reproductive health including prevention and control of HIV/AIDS while working within the framework of the national policy. They would like to enhance the provision and utilization of services for adolescents in their best interests while not breaching the law and traditional cultural values of the respective countries.

## **Access to health services, rights, consent and confidentiality: an overview**

Adolescence is a period of rapid physical and psychosocial development: no longer small children, and not yet adults. There are changing roles and expectations, which pose challenges for the adolescents themselves and for the societies in which they live. Adolescents have many common characteristics, but they are also different. (age, sex, marital status, parental support, etc.). All adolescents are vulnerable, but some are more vulnerable than others.

If the goal of universal access to prevention, treatment and care for HIV is to be achieved, it would be important to focus on adolescents and young people as they remain at the centre of the HIV epidemic in terms of transmission, vulnerability and impact. Many young people are already infected but the vast majority are unaware of their HIV status.

Societies tend to have different expectations of adolescents depending on: individual characteristics (e.g. marital status), behaviors (sexual activity), roles (e.g. family tasks, marriage), and responsibilities (e.g. criminal responsibility, conscription). Adolescents may be able to do all of the above and yet not be able to give informed consent for medical procedures. Adolescents are capable of understanding information, appreciating risks, and making informed decisions. However, all adolescents do not develop at the same pace: age is therefore only one factor that needs to be taken into consideration when assessing an adolescent. Depending upon their stage of development, adolescents need: information and skills; health services and counseling; and a safe and supportive environment. It is vital to ensure that young people have access to prevention and treatment, and testing is an important entry point in this regard.

Governments recognize that adolescents need health services. This has been reaffirmed by their participation and acceptance of the convention on the rights of the child, ICPD, ICPD+5, UNGASS and AIDS+5. They are committed to the clauses in these conventions related to the rights of adolescents for consent and confidentiality etc.

Key issues that need to be addressed by health care providers, managers and policy makers include informed consent; competence of adolescents; best interests of adolescents; confidentiality; privacy; parental support; adolescent participation; community participation and interests of adolescents in special situations.

Voluntary Counselling and Testing (VCT) as an intervention for HIV prevention was used as an example to highlight the relevance of issues relating to policy and legislation, standards and guidelines, service provision and monitoring of policies. These are equally relevant to other problems faced by adolescents.

## **Developing consensus about a glossary of terms**

International human rights norms and standards, as stipulated in various UN and regional human rights treaties, can provide a useful legal and normative basis for addressing issues related to securing consent and confidentiality for adolescents. Key principles provide the foundation for a well-balanced and forward-looking response, taking fully into account the rights of adolescents' norms and standards to be used and the rights and duties of those caring for them. The terminology relevant to consent and confidentiality for adolescents was discussed in group work and plenary sessions.

Norms and standards covered by the Convention on the Right of Children (CRC), also help in placing adolescents at the centre of decision-making processes affecting their well-being. The principles to guide action include non-discrimination; best interest of the child; evolving capacities of the child; and respect for the views of the child.

**Non-discrimination**, as provided in the CRC, means that no child or adolescent should be prohibited from enjoying his or her rights based on the child's or adolescent's, or his or her parents' or legal guardian's race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status.

Article 3, paragraph 1, of the CRC states that **the best interest of the child** should be "a primary consideration in all actions concerning the child, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies".

**Evolving capacities of the child acknowledges** that children's and adolescents' development towards independent adulthood must be respected and promoted throughout childhood and adolescence. Respecting and promoting the evolving capacities of children and adolescents allows for recognition of growing maturity and exercise of autonomy, and thereby an increasingly independent exercise of rights. Under the CRC, governments are required to "respect the responsibilities, rights and duties of parents or, where applicable, the members of the extended family or community as provided for by local custom, legal

guardians or other persons legally responsible for the child, to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of the rights recognized in the present Convention".

**Respect the views of the child.** Recognition and acceptance of children and adolescents as subjects of rights and not only as recipients of protection, and with evolving capacities leading to increased maturity and understanding, must take into account their opinions. Respect for their views does not automatically translate into endorsement of said opinions, but provides children and adolescents the possibility of understanding the reasons for a different decision being taken, and will allow them to become active partners, with appropriate skills to participate in programme, conceptualization, design, implementation, coordination, monitoring and review.

The CRC calls upon governments to "assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child".

**Key terms.** Key terms in the context of consent and confidentiality include: Informed Consent, Competence, Assent, and Privacy & Confidentiality. These were explored and discussed by the participants.

Participants felt that **Informed consent** can best be described as a decision based on facts, pros and cons, and competence as the ability to understand facts, pros and cons to make a decision. Most participants were not familiar with the term, assent.

**According to participants, privacy** is a concept creating an environment which helps individuals to share information and experience with a chosen confidant/provider, while **confidentiality** is to have the information confined between the client and confidant/provider.

The definitions of informed consent, assent, and privacy and confidentiality are included in the annexure.

## Understanding the issues: country perspectives

Five countries, Bangladesh, India, Nepal, Sri Lanka and Thailand presented policies and practices relating to consent and confidentiality in relation to adolescent sexual and reproductive health and HIV/AIDS. The country

presentations were organized in the form of responses to core questions that had been shared with the countries prior to the consultation.

## **Bangladesh**

An adolescent is considered to be a person between 10 -19 years and a child between 0-18 years. There is no legal definition of a minor. The age of legal consent for sexual intercourse is similar in males and females (18 years). The legal age of marriage for girls is 18 years and boys is 21 years. The legal age for alcohol consumption is above 18 years.

There is no law restricting access of contraceptives to unmarried adolescents below 18 years. Emergency contraceptives are available without medical prescription as over-the-counter (OTC) drugs at a nominal price (Taka 10.00). Married adolescents under 18 years have access to contraceptives. In the national policy, married adolescents are mentioned but there is no specific mention of age. Health care providers from all sectors – private, public, government and NGOs – are distributing contraceptives to unmarried and married adolescents under 18 years. There is no national data regarding emergency contraceptive (EC) use by married and unmarried adolescents.

Abortion/Medical Termination of Pregnancy (MTP) is not legal, but menstrual regulation (MR) is legal since 1974. There is no national policy supportive of any special provision for MTP in special situations. There is no national data on safe and unsafe abortions and its complications which is disaggregated by age and marital status. There are no regulatory mechanisms for monitoring abortions and post-abortion complications in the unorganized and private sector. Training is provided to all levels of health care providers on MR and management of post-MR complications.

The National Strategic Plan for HIV/AIDS 2004-2010 includes STI treatment for all. There is no national data on STIs disaggregated by age and marital status. WHO's RTI/STI syndromic management for all is followed. There is a training component for special issues in adolescent STIs management for medical officers, nurses, voluntary health care worker etc. Training on VCT is also included.

There is no definite law regarding substance abuse. Harm reduction for Injectable Drug Users (IDUs) is included in the national policy on HIV/AIDS control. A needle exchange programme is provided by all sectors: private, government and NGOs. There is a strategic plan to provide support and services to drug users.

## India

A minor is defined as a person below 18 years. An adolescent is considered as a person between 10 -18 years and a child is between 0-10 years. The age of legal consent for sexual intercourse in girls is 16 years. It is 15 years if they are married. There is no age identified for boys. The legal age of marriage for girls is 18 years and boys 21 years. The legal age for alcohol consumption is 25 years.

There is no law restricting access to contraceptives (condom, OC pills etc.) by unmarried adolescents under 18 years. There is a supportive policy but no law. In the national policy, married adolescents are referred to repeatedly, but there is no specific mention of age. Emergency contraception (EC) are distributed free of cost to couples i.e. married adolescents regardless of age and have been included in the national family planning programme since 2002. Emergency contraceptives are available without medical prescription as OTC. Health providers from all sectors – private, public, government and NGOs – are distributing contraceptives to both unmarried and married adolescents under 18 years. There is no national data regarding use by married and unmarried adolescents.

There is a law legalizing abortion (Medical Termination of Pregnancy (MTP) ACT 1971). There is no difference in the law for unmarried and married adolescents under 18 years, but signed consent is required for a parent or guardian. There is special provision for MTP in special situations like: rape, incest, mental illness of the mother, physical illness of the mother, life saving situation for mother and failure of contraceptive. There is a policy, since 1971, to provide training to health care workers regarding safe abortions and management of post-abortion complications. There is no national data on safe and unsafe abortions and its complications that is disaggregated by age and marital status. There are no regulatory mechanisms for monitoring abortions and post-abortion complications in the unorganized and private sectors.

The national policy is supportive of providing of treatment for STIs to all regardless of age or marital status. There is a training component for special issues in adolescent STIs management for health care providers at all levels.

Informed consent for HIV testing of minors, the law gives paramount importance to the best interests of the child. In the context of HIV/AIDS, the best interests of the child are served by promoting access to information and services including VCT. Whenever possible, minors are encouraged to

involve their parents/guardians in supervising their health care. However, unwillingness to inform parents/guardians should not interfere with the minor's access to information and services.

## **Nepal**

A minor is considered a child under 16 years age and adolescent as a person between 10-19 years. A child is considered as below 18 years (Nepal abides by the Convention of the Rights of the Child). There is no law for age of legal consent for sexual intercourse but sex with a minor girl (under 16 years) is considered 'rape'. For boys there is no explicit age. Age of legal consent for marriage is 18 years with parental consent and 20 years without parental consent for both boys and girls. There is no legally-specified age for alcohol consumption, however, children under 18 years cannot be used by adults for procurement or sale of alcohol. Children and orphans living in child protection centres are forbidden to consume alcohol, drugs and to smoke cigarettes (source: Child Act 2048 B.S. and Regulation of Child Act 2051 B.S.).

There is no law restricting access to VCT by unmarried adolescents under 18 years. The national policy is neither supportive nor restrictive. The national policy is supportive of access as per the Family Planning National Guidelines (Revised 2000). Healthcare providers (private, public, the government sector and NGOs) are distributing contraceptives to unmarried and married adolescents under 18 years. The new National Guidelines for Family Planning Service 2006 specifically spells out contraceptive services for adolescents, youth, and newly-married couples. This document is being printed. EC are included in the National Family Planning Programme (2055 B.S.) EC are distributed free of cost to couples i.e. married adolescents regardless of age. They are not available nationwide but as a pilot programme certain NGOs (FPAN) provide ECs free. The market price for EC is Rs 40 (0.50 US \$).

There is a National Safe Abortion Policy since 2002 and Safe Abortion Service Procedure since 2003. There is no difference in the law for unmarried and married adolescents under 18 years except that minors (under 16 years) require the presence of a guardian during abortion. The national policy is supportive of special provision for MTP in special situations like: rape, incest, mental illness of the mother and physical illness of the mother. Training is given to obstetricians and gynaecologists for conducting safe abortions and for management of post-abortion

complications. There is a Technical committee (TCIC) which monitors safe abortion services and there is a National Family Health programme (NFHP) for monitoring post-abortion complications.

The national policy supports provision of treatment for STIs to both unmarried and married adolescents under 18 years since 2004. The data is available from sentinel surveillance surveys, antenatal care (ANC) clients, family planning (FP) attendees, IDU's, females sex workers (FSWs), truckers, migrants and other high risk groups. STIs management is included in training of health care providers including medical officers, nurses, voluntary health care workers etc. but there is no training component for special issues among adolescents.

There is no law restricting access to VCT for unmarried adolescents under 18 years. The consent of parent/legal guardian is not mandatory. There is a policy of providing training on VCT to health care workers but not with the specific focus on the special needs of adolescents.

There is a law regarding substance abuse/IDU (Substance Abuse Control Act 2033 B.S.). There is a difference in the law for children, adolescents and adults. No punishment is provided for children under 14 years (except she/he will be warned), 50% punishment is provided for children aged between 14 years and under 16 years and full punishment for children aged 16 years and above.

Harm reduction for IDUs is included in the national policy on HIV/AIDS control programme: National HIV/AIDS Strategy 2002-2006 of MoHP. Harm reduction services (needle exchange programmes) are provided by the government sector (Institute of Medicine, Kathmandu), and NGOs.

## **Sri Lanka**

A minor is generally considered as below 18 years and an adolescent between 13–19 years. A child goes by the international definition of below 18 years. The age of legal consent for sexual intercourse for both boys and girls is 18 years. The legal age of marriage for girl is 16 years and 18 years for boys. However, the legal age for marriage for Muslim girls is 12 years. This is proposed to be increased to 16 years. The legal age for alcohol consumption is 21 years.

There is no national policy restricting or supporting access to contraceptives. Married adolescents have access regardless of age. Health

care providers (private, public, government sector and NGOs) distribute contraceptives to unmarried adolescents under 18 years on request. The Family Planning Association actively promotes the use of condoms. In addition, condoms can be purchased from shops. Emergency contraceptives are available through the Family Planning Association. But they are issued by the organization and they are not “over the counter” drugs. EC are distributed free of cost to couples i.e. married adolescents regardless of age, if it is through the Government Hospital Family Planning Clinics. It is free if distributed from the Family Planning Association centres. There is no national data regarding EC use by married and unmarried adolescents. The national policy on HIV/AIDS implies support for condoms but there is no active promotion of the use of condoms.

Abortion is illegal in Sri Lanka except under special conditions to safeguard the life of the mother. There is no difference in the law for unmarried and married adolescents under 18 years. The national policy is not supportive of any special provision for MTP in special situations like: rape and incest, mental or physical illness of the mother or failure of contraception. It is only allowed as an exception to save the life of the mother. The Sri Lankan Penal Code makes both the recipient and the performer liable for legal action but it is extremely difficult to implement. There is no policy of providing training to health care workers regarding safe abortions and management of post-abortion complications. No national data are available on safe and unsafe abortions and its complications which are disaggregated by age and marital status. There are some statistics available but they are quite inaccurate as many abortions are performed outside the National Health Service.

The treatment for STD is given to all regardless of age or marital status under the provision of free health care for all that is enshrined in the National Constitution. There is training for STIs management for health care providers including medical officers, nurses, voluntary health care workers etc. but there is no component for special issues in adolescent.

**VCT in HIV/AIDS** There is no law restricting access to VCT for unmarried adolescents under 18 years. Consent of parents/legal guardian is not mandatory. There is no policy of providing training regarding VCT to health care workers.

There is a law regarding substance abuse/IDU “Dangerous Drugs Act”. There is no difference in the law for children, adolescents and adults apart from rehabilitation during or following a jail sentence. Harm reduction

programmes for IDUs are not included in the national policy on HIV/AIDS control.

## **Thailand**

The legal definition of a minor is a person below 20 years. Adolescents/Youth are between 18-25 years and a child is between 0-18 years. The age of legal consent for sexual intercourse for both boys and girls is 18 years. The legal age of marriage for both boys and girls is 18 years, the same as alcohol consumption.

There is no law restricting access to services to unmarried adolescents under 18 years. The national policy on HIV/AIDS or family planning implemented since 1992 is supportive of access to condoms to married adolescents under 18 years. Health care providers from the private, public and government sectors as well as NGOs distribute contraceptives to unmarried and married adolescents under 18 years. Emergency contraceptive are available without medical prescription as OTC. It is not distributed free of cost to couples i.e. married adolescents, regardless of age.

There is no law legalizing abortion. The national policy is supportive of MTP in special situations like: rape, incest, mental illness of the mother, physical illness of the mother, life-saving situation for the mother, but not for failure of contraceptive. There is no policy of providing training to health care workers regarding method of conducting safe abortions and management of post-abortion complications. There are no national data on safe and unsafe abortions and its complications disaggregated by age and marital status. There are no regulatory mechanisms for monitoring abortions and post-abortion complications in the unorganized and private sectors.

The national policy is supportive of provision of treatment for STIs to both unmarried and married adolescents under 18 years. There is a training component for special issues in adolescent STIs management for health care providers including: medical officers, nurses, voluntary health care workers etc.

There is no law restricting access to VCT for unmarried adolescents under 18 years. Consent of parents/legal guardian is not mandatory. There is no policy of providing training on VCT to health care workers with specific focus on the special needs of adolescents.

Harm reduction for IDUs is included in the national policy on HIV/AIDS control. Needle exchange programmes are run by the government and NGOs but not by the private sector.

## **Synthesizing experiences from countries in the Region: similarities, differences, lessons learnt**

The participants were divided into four groups. Each group selected a moderator and a rapporteur to discuss the similarities and differences between countries in the Region in policies and legislation relating to consent and confidentiality for adolescents to access health services; and with regard to specific groups of adolescents who are generally not able to give consent to access services. Younger adolescents, unmarried adolescents; specific health services interventions for which adolescents are less likely to be able to give consent themselves e.g. HIV testing, abortion; important gaps between policies/legislation and practice e.g. legislation supportive but provider attitudes are unsupportive.

The definitions of “child” and “adolescent” are similar in all countries. There are differences with regard to the definition of “minor” In some countries. In Sri Lanka, there is no legal definition of a minor. The age of consent for sexual intercourse and the legal age for marriage varies greatly. These two factors have a major impact on accessing reproductive health services by adolescents (married or unmarried). The formal age of consent for marriage varies from 16 years to 18 years. In practice, however, it depends on the setting, being much lower in some local traditional settings. For example, in Sri Lanka the age of consent for marriage is 12 years for Muslim girls.

The minimum age for alcohol consumption is between 18-21 years in all the countries except India where it is 25 years.

## **Contraception**

There is active promotion of condoms for family planning in Nepal and India. In Bangladesh commercial condoms are generally not affordable. The condom supply policy needs to be strengthened to improve access to unmarried young people. In India there is no law restricting unmarried adolescents to get contraceptives, except for Intra-Uterine Device (IUD).

There is no law or policy restricting the use of EC for unmarried adolescents in most countries, but these are only available over-the-counter (OTC) in India. EC are included in the family planning programmes of India and Nepal. They are available free of cost for married adolescents in India and in some pilot projects in Nepal. They are available for a price in Bangladesh and Thailand.

## **Abortion and MTP**

The laws regarding abortion/medical termination of pregnancy vary greatly, from being illegal in Sri Lanka to MTP being permitted in India through legislation that covers a large number of special situations that would allow MTP in adolescents. Consent by a parent/guardian is necessary for MTP in India for both married and unmarried adolescents under 18 years, while their presence during the procedure is compulsory in Nepal if the adolescent is less than 16 years old. Abortion is available in special situations in both Nepal and Thailand. Failure of contraception is accepted as a special situation only in India and Nepal. Only Menstrual Regulation is permitted in Bangladesh, under special situations. In Sri Lanka, abortion is only permitted in the exceptional situation of saving the life of the mother.

## **HIV/AIDS and VCT**

The national policy on HIV/AIDS in India, Nepal, and Thailand encourages the use of condoms for HIV prevention for all, regardless of age and marital status. In Sri Lanka, condoms are a part of contraception but not specifically for HIV prevention. In Bangladesh, there is a policy to supply contraceptives but not to unmarried adolescents. For unmarried adolescents under 18 years, the VCT consent of the legal parent/guardian is required in Bangladesh, India and Nepal but not in Thailand.

## **Drugs and Substance abuse**

India, Thailand and Nepal have drug control acts. However, the laws of many countries vary with regard to the recognized ages of majority and criminal responsibility (as low as seven years in some countries). The punishment varies widely as per age in different countries under the drug control act for illegal drugs.

## **Similarities**

In all countries, there is no law restricting access to contraception for unmarried adolescents less than 18 years. But most national policies actively support free access to contraception only for married adolescents (of any age). Married adolescents are registered as eligible couples and can freely attend family planning centres and avail reproductive health services. Unmarried adolescents do not access these services due to social stigma and the judgmental attitude of health providers in some countries in the public health facilities and family planning centres. The attitude of health providers is not supportive in providing contraceptives to unmarried adolescents. Though contraception is freely available at a price in the private and NGO sectors, regardless of age and marital status, most unmarried adolescents do not feel free to access these services as they are not adolescent friendly in terms of privacy and confidentiality.

In all countries treatment for STIs is provided regardless of age and marital status, free of cost in public facilities and at a cost in private facilities. However, unmarried adolescents have limited access to STI services due to stigma and discrimination.

In all countries there is no special component or focus on adolescent-specific issues when training for reproductive health is provided to health workers at all levels. However, in Bangladesh and India, an orientation programme for health providers for adolescent friendly health services has been initiated.

## **Individual characteristics that make it more difficult for adolescents to give consent**

Even where special adolescent health services are provided, their use is often limited. Service utilization by adolescents is influenced by many factors such as lack of privacy and confidentiality as well as the judgmental attitudes of service providers. Health professionals may refuse to see adolescents on their own under the age of 16 years and, in some countries, under 18 years, because of uncertainty about the ethical and legal rights and responsibilities. This is usually linked to a fear of incurring parental, community or pastoral wrath or even legal action.

Married adolescents under 18 years can freely access reproductive services as compared to unmarried adolescents who are not allowed access in public health family planning centres. Even in private facilities unmarried

adolescents need to have consent from parents or guardians for medical termination of pregnancy in those countries where it is legal. Consent from parent/guardian is also needed for HIV testing in most countries. Providers usually need procedural and/or practical guidance in relation to adolescents' competence to give consent for medical treatment, their right to confidentiality and their right to the provision of information.

### **Health service interventions for which it is less likely that adolescents will be able to give consent**

Termination of unwanted pregnancy, HIV testing, testing and treatment for sexually transmitted infections are situations where an adolescent will not want disclosure to parents/guardians and will not consent to the health care worker disclosing to them. Consent will also be an issue when adolescents are commercial sex workers or trafficked victims working in brothels, street children or other groups without parents or guardians. The consent of the institution head has to be taken in case of adolescents coming from orphanages, remand homes etc. Adolescents also will not consent to disclosure their sexual orientation.

### **Major gaps between policies/legislation and practice**

Scaling up vital SRH services for adolescents requires an understanding of the laws and/or policies that govern the issues of informed consent, competency, confidentiality and privacy. Unfortunately, the laws and policies in relation to adolescents and the services provided for them are not explicit, and the health care providers may not be fully aware of these laws and policies. Laws should take into account adolescents' emerging needs and maturity while responding to local social contexts and maintaining consistency with human rights, standards and norms. The development of policies and programmes directed at consent, competence, confidentiality and privacy for adolescents is affected by the extent to which adolescent human rights are respected and implemented. A range of sectors and stakeholders need to be involved in policy development.

Privacy is intimately connected with informed consent and confidentiality. Concerns by adolescents about privacy can prevent them from accessing health care, even if they are able to give their own consent for the services being provided. Such concerns also influence where

adolescents go for health services, and how and whether they will communicate openly with health care providers.

In situations where the law allows adolescents to give independent consent, adolescents and health care providers expect health care information to be treated as confidential. The language of the law in some countries supports this and does not allow disclosure without the adolescent or minor consenting to disclosure. Others leave disclosure to the discretion of the health care provider or are completely silent on the matter.

It can be particularly difficult to ensure privacy and confidentiality in respect of HIV testing for an adolescent with no parent or legal guardian. The law is often quite confusing and complicated as to who can consent on behalf of an adolescent in this situation: in some cases the legal guardian may be unknown, inaccessible or unacceptable to the adolescent. The law may also be very unrealistic, requiring, for instance, the consent of senior health officials or senior local council or administratively responsible individuals.

## Summary

Policies and health worker practices may restrict the provision and acceptability of health services for adolescents (although often in the Region, they are supportive rather than restrictive). For some groups and some health problems, if adolescents are not able to give informed consent on their own it may make it difficult for them to access the services that they need. It is very important that ministries of health and professional organizations are clear about the guidance that they are providing to health workers in relation to consent and confidentiality. This is already becoming an important issue for HIV testing, with more countries adopting provider-initiated approaches, in addition to existing client-initiated VCT.

## Consent and confidentiality: actions for improvement

A debate was carried out to discuss the topic, "***Except in exceptional circumstances, no minor should receive health services without parental consent***". During the debate, three main arguments were presented for the motion and three arguments against it. After the presentation of the arguments, there was a discussion on selected issues.

It is argued that minors are not mature to make decisions. However, maturity depends on age, and varies with different individuals. Some adolescents may be well informed and very mature to take decisions. Others may not. All parents may not take the right decisions especially if they are not well informed. Parents can take decisions based on their experience, but may not have prior experience in certain health-related issues.

Service providers are not legally protected to provide services to minors without parental consent. Married adolescents under 18 years may be able to make use of services but unmarried adolescents generally cannot do this without parental consent. In any event, adolescents do not come forward to seek health care without their parents especially adolescents below 16 years. The issues of consent are especially relevant to ASRH and HIV/AIDS.

Norms or social values are laid down by members of society and need to be respected. At the same time, values and norms have to be challenged occasionally as situations change and new problems have to be confronted.

The CRC and medical ethics support universal access to human rights. Though the legal situation is clear, it may not be well accepted in society.

As social norms change, attitudes and behaviors also change. In today's world if we want to reduce the incidence of unwanted teenage pregnancies and transmission of STDs we need to have appropriate services for adolescents/minors who are an important target group for these services. Consent and confidentiality issues should not become roadblocks in the timely utilization of services.

Taking a decision depends on the person's age, education and level of maturity. If parents are illiterate and uninformed, it is possible that the educated and well informed minor may be more competent to take a decision. Some groups of minors may be the only ones around to give consent, whatever their competence – street children or child labourers for example who have no parent or guardians. The situation may be difficult legally, but decisions need to be taken that are in the best interest of the adolescent, even if there are legal protection issues.

## Helping health workers make decisions about consent and confidentiality for adolescents

The session focused on discussion on case scenarios by different groups. Members in each group read the case scenarios and discussed what the health workers need to think related to consent and confidentiality when responding to the situation. This was done through role plays to illustrate how a health worker might be able to put consent and confidentiality into practice.

The role play showed how Manisha was skillfully convinced by the health worker to understand that her parents had to be informed about the situation, that their support was important, and they needed to give their consent for performing a medical termination in view of the existing laws. She was assured that the health care worker would help her to disclose to her parents and help to get their support. The subject of HIV testing was also raised for which parental consent would also be required. A good rapport and trust was established with Manisha so that she understood that confidentiality would be maintained. This is essential to ensure that she returns for a follow up and not go to a quack for a procedure that could lead to illness and death.

### Case scenario 1

Manisha, a 16-year-old unmarried girl from a poor urban area comes to your clinic. She is accompanied by her mother. She joins you in the consulting room alone, and is obviously upset. After some initial discussion she tells you that she is two months pregnant and wants a termination. She is doing well at school and is hoping to become a nurse. The baby was conceived when she was forced to have sex by the boy that she was going out with, but she has no intention of having a long-term relationship with him any more. If she has the baby her parents will throw her out of the house and she will be forced to leave school. She tells you that she has already found someone who will provide an abortion near where she lives, but she is scared to go there because a friend of hers recently went to this person for an abortion and became very sick afterwards, and died. (Note: termination of pregnancy is legal in the country, but unmarried girls under 18 years require parental consent).

Through a well-enacted role play, Rajesh was convinced that while he could consent to having his STI treated, it would be necessary to get parental consent for HIV testing because this was the law. Hence, the parents had to be on board. A good rapport and trust was built to ensure that confidentiality would be maintained so that Rajesh would return for follow up and not go to a quack for treatment. The health worker also explained the need for being tested for STIs and taking full treatment. He was also given information about STD and the risk of transmission risk through commercial sex workers. He was thus empowered to prevent future infections.

#### **Case scenario 2**

Rajesh, a 15-year-old boy, comes to your clinic with a urethral discharge. While taking the history he tells you that he lives at home with his parents, and has recently made some new friends: they dress cool, they drink alcohol, and they like to visit sex workers. As he is getting onto the examination couch he tells you that in addition to having his discharge treated he also wants an HIV test, because one of the sex workers looks very thin, and he has heard in the health education class at school that this is a sign of AIDS. He does not want his parents to know about any of this. (Note: HIV testing is widely available, but adolescents require parental consent)

During the role play, the importance of reporting was stressed to Anjeli since this was a case of sexual abuse. The parents would need to be informed and necessary steps taken to prevent further abuse. A complete examination and treatment for the STD would be undertaken.

#### **Case scenario 3**

Angeli is 14-year-old girl who is brought to your clinic by her mother who says that she has been complaining about lower abdominal pain for several months. The girl is sad and sullen, and when you examine her you find that she has vulval warts. You say nothing to the mother who is standing close by, but you ask the wise elderly nurse who is standing beside you to spend some time with Angeli and find out what has been going on. It turns out that an uncle who lives in the same house has been sexually abusing her for nearly a year. She has not said anything to her parents because she does not think that anyone would believe her and she heard her parents say that the uncle will be leaving soon. She told the nurse on condition that nothing was said to her mother. She just wants you to treat her for the problem.

This is a complex scenario because injecting drug use is a criminal activity in most of the countries in the Region. The fact that the parents are known to the health worker puts an added pressure on the health worker to disclose the situation to them. Dravid is likely to require parental support if he is to have treatment/rehabilitation for drug use. A detailed sexual activity history is required and he has to be checked for STD and HIV, which may need parental consent. He will also have to be given full information about drug abuse and STDs.

**Case scenario 4**

Dravid is a 17-year-old boy who comes to your clinic. He has recently left home and dropped out of school, and is hanging out with a group of boys who are known to be involved in petty crime. He presents with a persistent cough, and looks pale and thin. As you are examining him he mumbles something about wanting to have some syringes. When you ask him why, he tells you that his new friends sometimes inject drugs, and he overheard an outreach worker who was talking with them say that they should not share needles and syringes because they could spread diseases, including AIDS. You have known Dravid for many years, and have always felt that he was rather immature for his age. You also know his family, but he tells you that you should not say anything to them. Note: Needle exchange programmes are being established in the country)

## **Helping mid-level managers take decisions regarding consent and confidentiality for adolescents**

This session focused on the key issues that programme managers need to know and think about when considering consent and confidentiality for adolescents in relation to HIV and other ASRH health service interventions, and what needs to be in place for them to act on their decisions. The participants were divided into four groups and were instructed to read the scenario, discuss it in their group, and present the main actions to resolve the problems.

To give an initial response, the programme manager should review the existing laws, policies and practices related to adolescents specially relating to HIV testing, STD testing and treatment, contraception and medical termination of pregnancy for adolescents, specially for unmarried mothers. The strengths, gaps and weaknesses of the existing situation should be identified so that the needed changes in the laws, policies and practices can be recommended. Consultations with community workers, religious leaders, policy makers, lawyers, media and NGOs should be held to suggest changes which will meet parental and societal expectations and enable adolescents to access services without breaking the law. Consultations with other stakeholders are necessary but this cannot be rushed. The available literature relating to adolescents should be reviewed but this would take time.

**Case scenario 1**

You work in the Ministry of Health. One Friday afternoon your boss walks into your office and tells you that the Ministry is about to start a process to develop a new national policy on adolescent health and development. She wants you to give her a list of issues that need to be considered in the policy that deal with consent and confidentiality. The new policy needs to link with other national policies dealing with adolescents: there are many that do relate to adolescents' health and development, either directly or indirectly. She would like your initial thoughts by Monday morning. You had been planning a weekend away with the family.

The law is very explicit about the need to have parental consent before carrying out HIV testing on people under 18 years. The NGO has to protect itself and work within the legal system. The authorities will not be able to protect the NGO. At the same time, it is important to

**Case scenario 2**

You are a manager in a large national NGO providing a range of health services to adolescents. One afternoon you receive a phone call from the Manager of the National AIDS Control Programme: he sounds very irritated! "What are you people doing?" he shouts down the phone "...trying to make things worse rather than better? I have now had five reports of young people coming to your clinics to get their HIV test, being turned away because they do not have parental consent. Are you people crazy? We are doing our best to get people tested, and you spend your time sending them away! I know that the law says that minors need parental consent, and we are working to change it. In the meantime, why don't you just get your health workers to put down an older age in the records or something?" You put down the phone and try to regain your composure. It's impossible: one minute the Ministry people are shouting at you because your staff doesn't follow the rules, and the next minute they want you to break the rules...what to do?

work in the best interest of adolescents. An effort should be made to track those who have been turned away and explain that the NGO would assist in obtaining consent from the parents. The health worker and the senior staff should deal with the adolescents and the parents so that parental consent is obtained and the testing is done without losing the confidence of adolescents. A meeting of all the NGO staff was recommended to brief them about the law, and at the same time, protect the interest of the adolescents. The involvement of the parents, the community, lawyers, media, religious leaders, policy makers and other stakeholders was recommended.

As a programme manager, it is important to make the facility and the services "adolescent friendly". This means while staff must work within the legal framework, and, at the same time, protect interest of adolescents. They need counseling skills to help the adolescent disclose to their parents and obtain parental consent for accessing reproductive health services. For long-term action, programme managers must go beyond the hospital or clinic to reach out to the parents, community and religious leaders, policy makers and stakeholders. They should find allies among lawyers and media persons. A meeting of the entire staff, including any people who have undergone training for AFHS and C&C should be called. Explain in detail that turning away adolescent patients would result in them paying more for poor quality services, with some of them being denied any service because they cannot afford the cost, or because they are embarrassed to try elsewhere having been refused at one facility.

**Case scenario 3**

You manage a busy polyclinic that provides services to young people, among others. You are keen to increase the number of young people who use the clinic, and have recently sent some of your staff to a workshop that dealt with adolescent friendly health services, including a focus on consent and confidentiality. Ever since they returned, far from increasing the number of adolescents attending the clinic they seem to be sending them away because they don't have parental consent. It would be bad enough having to put up with all their new rights-talk, but seeing the numbers of patients dwindling is just too much, especially as you know that the young people who are being sent away are simply walking further down the road to the private practitioners where they have to pay much more and get inferior service! The staff is well intentioned, but clearly what they are doing is not in anyone's best interest, certainly not yours and certainly not the young people's ....what to do?

Reporting against the gynaecologist by the nurse certainly shows lack of harmony and team work in the hospital, which is a serious matter. This could have happened because of strong religious or moral beliefs of the nurse, personal animosity towards the surgeon, or worries on getting implicated if the event is reported. If the reporting is still in your jurisdiction, as programme manager you must call a staff meeting to sort out the matter so that in future such reporting is avoided.

#### Case scenario 4

You are a busy manager in a large hospital. You are just leaving your office at the end of another extremely busy day when one of your gynaecologists bursts into your office and says "OK I have had enough...I really can't cope with this nonsense any longer". She tells you that she has been reported to the authorities by one of the nurses for carrying out a termination of pregnancy on an adolescent girl without her parents' consent. "The parents of these girls are so conservative that they will never agree to their girls having an abortion, and either I do the termination, or they go to those back street quacks. What's more important, the girls' lives or the ridiculous laws"? You manage to calm her down, but as you are traveling home that evening you have to admit that she has a point...but what to do?

Ask the records department to help the surgeon prepare a report showing the number of young girls who have undergone abortion in the hospital in the past 1-3 years. Getting detailed statistics of the number of girls who have been admitted with post-abortion complications due to abortions done by quacks outside will be important. These details can be presented at the staff meeting to convince everybody that we cannot deny young girls abortion facility. It is important to discuss how parental consent can be obtained without hurting the interest of the client. Advocacy and education of the community and different stakeholders is an important step. The surgeon should know that she cannot break the law in her own interest and in the interest of the hospital. The interest of the girl who wishes to have the abortion has to be a priority. Involving the parents/guardian is necessary and all efforts have to be made to ensure that the girl is not forced to go to quacks and to prevent complications and large expenditures on abortion.

## Consent and confidentiality: developing draft guidelines

Country working groups discussed the development of guidelines on consent and confidentiality issues of ASRH and HIV/AIDS relating to

adolescents for guidance of health care workers (doctors and nurses). The key issues discussed were: topics to be included; structure of the guidelines; people who should be involved in developing the guidelines; and the plan for training of the health care providers.

The guidelines on consent and confidentiality should be developed in consultation with WHO, UNAIDS, IPA, IPPF, IAAH, UNFPA, and UNICEF. The audience should be health care workers and mid-level managers. The guidelines should help the programme managers and decision makers provide support to health workers in addressing consent and confidentiality while dealing with ASRH and HIV/AIDS problems in adolescents. While these guidelines should be generic, specific information relevant to the Region and the countries should be included. The guidelines can be used as stand-alone training material or incorporated into the existing training programmes on adolescent health. The contents and broad framework agreed is summarized in the annexure.

### **Checklist on consent and confidentiality for programme managers and policy makers**

The participants drafted the following checklist on consent and confidentiality for managers and policy makers. This was done in groups followed by a discussion in the plenary.

- (1) Situational analysis to include a description of the socio-cultural environment; a brief review of religious/ moral issues; parental attitudes to consent; background demographic information and statistics on adolescent ASRH and HIV; services available for adolescents; standards and procedures concerning consent and confidentiality; attitudes and perceptions of the health care providers; laws and policies and practices relating to consent and confidentiality; gaps and challenges in the existing policies; and services currently being rendered by NGOs and the private sector.
- (2) Short-term actions proposed included developing awareness, partnerships and plans; synthesizing key findings from the situation analysis, including the review of organizational and government policies/laws, for advocacy and use by allies and stakeholders; initiating research on key gaps identified, including the specific needs and concerns of adolescents; identifying allies (e.g. lawyers, media, professional associations, other providers of

services to adolescents) for support; involves young people and youth-serving organizations; identifying and involving other stakeholders (e.g. religious and community leaders, politicians); initiating dialogue at community level to generate community support ('AFHS' not perceived as threat to family/culture); and ensuring gender sensitivity in dialogue with community. This should be followed by developing an action plan in collaboration with the stakeholders. Standards and guidance on C&C should be developed. This should include clarifying roles and responsibilities; orienting and training mid-level managers, training health service provider's staff, including the integrating of C&C into existing training modules, integrate consent and confidentiality into existing efforts to make health services more responsive to the needs of adolescents, or use C&C as an entry point for advocating for AFHS (C&C may make an important contribution to creating a supportive environment, and increasing utilization).

- (3) Long-term actions included: revision of government and organizational policies/laws; lobbying for change in policies/laws with government (involve NGOs, young people and other allies/stakeholders); action plan to change, disseminate and implement new laws/policies; advocacy to change laws with policy makers/stakeholders; developing AFHS, including a focus on C&C; integration in national standards and quality assurance processes; integration into health worker training; integration into "adolescent-friendly" changes in facilities (e.g. opening hours, privacy, user-fees); integration into on-going efforts to generate demand and community support. Support should be strengthened by continuing to raise awareness with communities about C&C, legislation and services, developing partnerships/networks and establishing intersectoral coherence and linkages, involving young people and addressing stigma and discrimination.
- (4) Monitoring and evaluation - Develop frameworks/tools/processes to assist programme managers and service providers monitor C&C; undertake on-going review/documentation of laws and policies (government and organizational); monitor the policy-practice gap; monitor how health workers are "getting round" obstructive policies; develop intersectoral linkages for monitoring. Supportive supervision should be provided by

involving the youth and youth groups, and by monitoring implementation of the action plan. Indicators should include assessment of policies focusing on C&C, changes in attitude of managers/service providers; increases in number of adolescents using services; clinic data to assess use by adolescents of different HIV and ASRH services; and impact of training on health provider attitudes/practices (develop indicators based on the C&C booklet).

Methods: disaggregate health facility data and routinely collected statistics by age and sex, AFHS quality assurance methods, participatory evaluation methodologies, focus group discussions, case studies of attitudinal changes of service providers, documentation of good practices, surveys (of community members, young people, service providers), and periodic evaluation of the impact of training programmes.

## **Follow-up and next steps**

### **Plans for the next six months: global/regional and country priorities for action**

The participants worked in three groups to develop country-level, regional and global plans for the next six months addressing consent and confidentiality issues for ASRH and HIV/AIDS in young people. The plans were discussed in a plenary.

At the country level each country team would involve themselves in advocacy, awareness and sensitization efforts regarding consent and confidentiality issues in ASRH with policy makers, stakeholders, community leaders, parental and professional organizations. The team would review the strengths and gaps in the existing laws, policies and practices with inputs from lawyers, suggest the necessary changes and lobby for the same, as well as advocate to make health services adolescent friendly by organizing awareness and advocacy programmes. They would also initiate capacity building and training of health care workers in various facilities to become adolescent friendly, including a focus on issues of consent and confidentiality. As soon as the guidelines are ready they will initiate training programmes for health care workers on issues of consent and confidentiality related to adolescent health.

At the regional level, a review will be undertaken of the situation in other countries in the Region by sending them the questionnaires that were originally sent to the five countries participating in the meeting. The WHO Regional Office will initiate another regional workshop to involve the remaining countries in the Region. Once the guidelines are ready, national-level training workshops will be held in all countries of the Region.

At the global level, the preparation of the first draft of the guidelines will be the responsibility of WHO/HQ and WHO/SEARO. The draft will be sent to the representatives of IPA, IAAH and IPPF for their feedback before finalization. Once finalized more regional workshops will be held in other regions of WHO to test and use the guidelines. IPA, IAAH and IPPF will actively help WHO to widely disseminate the guidelines to all its members and provide additional assistance as needed.

## **Summary and conclusions**

Access to adolescent friendly health services and care of adolescents and young people with HIV/AIDS and adolescents in special situations is constrained due to numerous factors. These relate to key issues covering consent and confidentiality even though respective governments are committed to global resolutions adopted under the Convention of the Rights of the Child and articulated in different global fora.

The matrix prepared by the participating countries relating to consent and confidentiality issues was presented and reviewed. The key issues were synthesized, the lessons learned documented and similarities and differences because of local culture and societal norms identified.

A consensus was developed on the glossary of terms relating to evolving capacity of adolescents, informed consent, assent, confidentiality, privacy, non-discrimination, the best interest of the child, evolving capacity of the child, and respect for the views of the child.

Case studies were used for solving problems of health care providers and managers to address the numerous and complex issues relating to consent and confidentiality. The participants attempted to identify the best approach to address the problems in the prevailing context and milieu of specific countries.

The guidance developed by WHO/HQ on issues relating to consent and confidentiality in prevention and care of HIV/AIDS in adolescents and young people was reviewed. The structure and outline of guidelines was

prepared for further development and refinement by WHO/HQ in collaboration with SEARO.

The participating countries prepared a roadmap for the next six months to incorporate the guidelines in the provision of AFHS and prevention and care for HIV/AIDS. The implementation would involve contributions and support from WHO/HQ, Regional Office, and International Professional Associations. It would be implemented by the country teams in collaboration with the national programme managers.

Similar consultations were planned to cover the remaining countries in the SEA Region and in other regions of WHO.

## Annex 1

### **Address by Dr Samlee Plianbangchang, Regional Director, WHO South-East Asia Region**

Distinguished participants, colleagues, ladies and gentlemen,

It is my pleasure to extend a warm welcome to all the distinguished participants and observers.

I would also like to take this opportunity to convey the greetings of Dr Samlee Plianbangchang, Regional Director, WHO South-East Asia Region, to the distinguished participants of this consultation. The Regional Director regrets his inability to open the consultation due to another equally important commitment made earlier. I have the privilege, therefore, to deliver his address. And I quote:

Adolescence is recognized as a period of both great opportunities and risks. The journey from childhood to adulthood has tremendous implications for health outcomes including fertility, safe motherhood and sexually transmitted infections, particularly HIV/AIDS.

I would like to highlight a few scenarios which adolescents are facing in this part of the world. The problem of HIV/AIDS in young people is increasingly becoming serious with more than 50% of new cases occurring in young people alone.

New cases of HIV are more frequent amongst young females compared to young males. Women between 16-24 years of age are 1.6 times more likely to be HIV positive than men of the same age. Children are increasingly being orphaned by HIV/AIDS and many of these are adolescents. Adolescents are vulnerable to HIV and sexually transmitted infections because of numerous biological and socioeconomic factors.

There is now an increasing trend towards earlier sexual debut. The first sexual experience among many adolescents is often with commercial sex workers and is usually unsafe. Adolescents in developing countries often do not have easy access to condoms. Even with knowledge and easy access, many adolescents do not obtain condoms because of the stigma associated

with pre-marital sexual activity, judgmental attitude of the provider, privacy and confidentiality. Similar barriers hinder access to contraceptives and treatment for sexually transmitted diseases.

Despite the fact that every country has a legal minimum age of marriage, early marriage is still common in many nations. About 50%-60% of girls are married by the age of 18 in Bangladesh, India and Nepal. Due to lack of information and also lack of access to contraceptives, unwanted pregnancy among married and unmarried adolescents increases their risk of death due to unsafe abortion and delivery complications.

Irrespective of the fact that abortion is legal or illegal in countries, clandestine abortion is becoming common among unmarried adolescents. This is because pre-marital pregnancies are socially unacceptable in this part of the world.

The development of policy and programmes directed at consent, competence, confidentiality and privacy of adolescents is directly affected by the extent to which the rights of adolescents are respected and implemented. All Member countries in our Region have ratified the Convention on the Rights of the Child which recognizes the right of adolescents to access to information and health services. There are particular provisions relevant to consent and confidentiality for adolescents.

The 1994 International Conference on Population and Development Programme of Action noted that signatory countries should promote the rights of adolescents to reproductive health education, information and care.

In addition, Member States agreed to the Millennium Development Goals to reduce poverty which include young peoples' need for gender equality, education, safe pregnancy and reduction in STIs and HIV/AIDS. The Member States are committed to these goals.

WHO is also committed to achieve these goals through partnership with UN organizations, nongovernmental organizations and many other agencies and associations.

Provision of Adolescent Friendly Health Services by health providers and creating a supportive policy environment are essential prerequisites for promoting adolescent health and development. Increasing the use of available health services for prevention and treatment by adolescents still

remains a challenge. In order to overcome this, it is important that people working in the health system fully understand the rights and recognize the capacities of adolescents to take decisions about themselves.

The health-care providers should be clear about the issues relating to the rights of adolescents and those relating to confidentiality and consent. These factors should no longer be a roadblock in access to reproductive health services including STIs and HIV/AIDS prevention, treatment and care.

A number of questions challenge the health system and the health-care providers in the quest for increasing the access of adolescents to Voluntary Counselling and Testing and reproductive health services. These relate to informed consent and its importance, the best interests of adolescents, the assessment of competence of adolescents to make decisions, as well as the importance and relevance of confidentiality and privacy. Access to information and reproductive health services in Member countries are greatly influenced by traditional, cultural and religious norms and values.

There is a need to advocate policy and programme development with all stakeholders, including parents and communities. Policymakers, lawmakers and stakeholders are at times not adequately informed about the special needs of adolescents. We need to support countries with evidence-based interventions for implementation within the existing socio-cultural, religious and legal environment.

For reproductive health services to be successful among adolescents, linkages with adolescent-friendly health services and other general health services are essential. This approach is likely to provide a range of services under the same umbrella and will therefore reduce the stigma associated with many diseases.

The challenge of access to reproductive health services and general health services among adolescents can only be effectively addressed if parents, families and communities are involved in the planning, monitoring and evaluation of these services.

I am also very pleased to note that this consultation is being organized with the involvement of UN agencies, the International Paediatrics Association, the International Planned Parenthood Federation and the International Association of Adolescent Health.

I am sure that the combined strength of the technical expertise of these agencies, especially the experts who are present here, will lead not only to achieving the objective of this consultation but also pave the way in reaching the long-term goal of providing good health services to adolescents.

In conclusion, I wish you fruitful deliberations and a pleasant stay in Delhi. Thank you." Unquote.

I shall, of course, inform the Regional Director of your deliberations and the outcome of this important consultation. Thank you.

## Annex 2

# List of participants

### Bangladesh

#### IPA

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### Annex 3

## Programme

Day/ Time	Content	Process/ Responsible	Comment
Day 1 25.07.0 6	<b>Consent and confidentiality: Current Situation and Challenges</b>		
	<b>Moderator:</b> Swati Bhave <b>Rapporteur:</b> Rajesh Mehta		
0915 hrs	Participant expectations	Bruce Dick/ Neena Raina	
1000 hrs	Official opening of the consultation	Dr Myint Htwe	
1030 hrs	Group Photograph	All	
1115 hrs	Review of agenda, outputs, and working methods	Bruce Dick/ Neena Raina	
1130 hrs	Introductory remarks from the collaborating organizations: ➤ IPA ➤ IPPF ➤ IAAH	Adenike Grange Doortje Braeken Ueli Buehlmann	
1145 hrs	Adolescents: access to health services, rights, consent and confidentiality: an overview	Bruce Dick	Presentation of the background paper and discussion
1215 hrs	Developing consensus about a glossary of terms	Marcus Stahlhofer	

**Moderator:** Doortje  
Braeken

**Rapporteur:** Rvipa Vennakit

1400 hrs	Understanding the issues: country perspectives	Presentations from countries: 15 minutes per country: Bangladesh, India, Nepal, Sri Lanka, Thailand	Highlights from the preparatory assessments that were carried out by the country teams prior to the workshop
1600 hrs	Sharing experiences from countries in the region: similarities, differences, lessons learnt	Group Work Swati Bhawe/ Natasha Dawa	What are the commonalities and what are the differences in terms of countries approaches to consent and confidentiality for adolescents
1700 hrs	Synthesizing experiences from countries in the region	Plenary report back and synthesis	

**Day 2      Consent and Confidentiality: Actions for Improvement**

**26.07.0  
6**

**Moderator:** Ueli  
Buehlmann

**Rapporteur:** Samsad Jahan

0900 hrs	Flash Administrative Matters		
0920 hrs	Debate: no minor should receive health services without parental consent	Bruce Dick	
1010 hrs	Scenarios on consent and confidentiality: elements of good practice ( <b>service providers</b> )	Group Work	
1045 hrs	Discussion of scenarios (cont)		
1100 hrs	Feedback on scenarios	Plenary	Feedback presented as role plays/skits

**Moderator:** Adenike Grange  
**Rapporteur:** Anand Tamang

1400 hrs	Helping health workers make decisions about consent and confidentiality for adolescents: key issues for inclusion in a booklet	Group Work	What are the key issues that health workers need to know and think about when considering consent and confidentiality for adolescents in relation to HIV and other ASRH health service interventions
1445 hrs		Plenary discussion and synthesis	
1545 hrs	Structure/outline for a booklet for health workers to assist them with issues of consent and confidentiality	Group work, plenary presentation and synthesis	
1630 hrs	Developing a training programme to support the use of the booklet	Group work, plenary presentation and synthesis	

**Day 3 Consent and Confidentiality: Draft Guidance and Next Steps**

**Moderator:** Vijaya Manandhar  
**Rapporteur:** Mihiri Fernando

0900 hrs	Flash Administrative matters	Rajesh Mehta	
0920 hrs	Scenarios on consent and confidentiality: elements of good practice ( <b>managers</b> )	Group Work Plenary Discussion	
1045 hrs	A checklist for good practice for managers and policy makers: initial assessment and monitoring	Group Work Plenary Discussion	Helping mid-level managers make decisions about consent and confidentiality for adolescents. What are the key issues that programme managers need to know and think about when considering consent and confidentiality for adolescents in relation to HIV and other ASRH health service interventions

1130 hrs	Review the outline for the booklet for health workers	Group Work Plenary Discussion
1215 hrs	Entry points and opportunities for training on consent and confidentiality	Brainstorming
1400 hrs	Plans for the next 6 months: Global/Regional and Country priorities for action	Global, regional and country teams
1500 hrs	Evaluation	