

Accelerating implementation of Adolescent Friendly Health Services (AFHS) in the South-East Asia Region

Report of the Meeting of the National
Adolescent Health Programme Managers in
Member Countries of the South-East Asia Region
Bali, Indonesia, 12-15 February 2008



**World Health
Organization**

Regional Office for South-East Asia

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Contents

1.	Introduction	1
2.	Objectives of the meeting	2
3.	Inaugural session	3
4.	Global perspective	5
5.	Regional perspective	8
6.	Mapping adolescent programming and measurement	12
7.	Strategy to strengthen health sector response to adolescent health ...	15
7.1	Strategic information	16
7.2	Supportive, evidence based-policy (National Strategy)	21
7.3	Services and commodities	25
7.4	Strengthening other sectors	30
8.	Systematic approach to scaling up	35
8.1	Situation assessment	35
8.2	Developing National Standards	39
8.3	Implementing national standards on adolescent/youth friendly health services (AFHS/YFHS)	44
8.4	Monitoring the implementation of approved national quality standards	49
9.	Visioning	57

10.	Available/emerging methods and tools	58
11.	Review of draft Regional Strategic Directions for Improving Adolescent Health in South-East Asia Region	62
12.	Conclusions and recommendations	66

Annex

1.	List of participants	70
2.	Message from Dr Samlee Plianbangchang, Regional Director, WHO South-East Asia Region	74
3.	Programme	77
4.	Country vision and plans until December 2009	81
5.	Group work on regional strategic directions	90

Introduction

Adolescence, the second decade of life, between the ages of 10 and 19 years is a phase, rather than a fixed time period in a person's life, during which enormous physical and psychological changes occur, as do changes in social perceptions and expectations.

Adolescents acquire new capacities and are faced with many new situations that create not only opportunities for progress, but also risk to health and well-being. The health sector has a vital role in helping adolescents stay healthy and successfully complete their journey to adulthood. Although significant progress has been made in recent years to address the diverse needs of adolescent health and development, expanded and sustainable actions remain a priority. WHO is working to strengthen and accelerate country-level health sector response in this area. The 4 "S" strategic approach is being used to facilitate achieving goals of adolescent health and development. The 4 "Ss" are: Strategic information; services and supplies; supportive evidence-based policies; and strengthening other sectors. The objective is to enable the health sector along with a range of other key stakeholders to maximize their contribution in this area.

In this context a meeting of National Adolescent Health Programme Managers in Member countries of the South- East Asia (SEA) Region was organized from 12-15 February 2008, at Bali, Indonesia, by the Regional Office. The participants included National Adolescent Health Programme Managers, focal points from school health programmes from ministries of health, ministries of education, WHO staff from headquarters, Regional Office and staff from four country offices; the United Nations Population Fund (UNFPA) representatives from two countries and consultants on adolescent health and development (Annex 1: List of Participants).

2

Objectives of the meeting

The objectives of this meeting were enumerated by Dr Neena Raina, Regional Adviser, Adolescent Health and Development (AHD), WHO/SEARO.

General objective

To strengthen implementation of the Adolescent Health Programme in Member countries of the SEA Region.

Specific objectives

- (1) To share experiences in implementation of adolescent health activities in SEAR Member countries of the SEA Region;
- (2) To provide technical updates on evidence-based interventions, new tools and guidelines;
- (3) To obtain inputs from Member countries for the draft regional strategic directions; and
- (4) To discuss the implementation of workplans for the 2008–2009 biennium.

Inaugural session

On behalf of the Regional Director, the meeting was inaugurated by Dr Subhash Salunke, WR Indonesia, who read out the Regional Director's address (Annex 2). There are an estimated 350 million adolescents (10–19 years of age) in Member countries of WHO's SEA Region. Available data from the Region indicate that adolescents are facing a range of health and social challenges. Early marriage and childbearing is common, thereby increasing the risks of maternal mortality and morbidity. Anaemia, undernutrition, stunting, obesity and substance abuse are common among adolescents in some countries and are a cause for concern. Early initiation of sexual activity and lack of adequate knowledge and skills to avoid risky behaviour are placing adolescents at a higher risk of unwanted pregnancy, unsafe abortion and sexually transmitted infections including human immunodeficiency virus (HIV)/Acquired Immunodeficiency syndrome (AIDS). In addition, inadequate availability and access to adolescent-friendly health information and services, along with environmental challenges related to poverty and cultural prejudices have significant adverse health impacts. Violence, coercion and sexual abuse also pose a serious challenge to their health.

Though the challenges are numerous, policy and strategy support for adolescent health and development remains insufficient. There is a strong need for advocacy to augment the weak political commitment that is partly related to the nonavailability of accurate national data on adolescents. To promote adolescent health programming, a number of activities have been initiated by WHO. For example, with the help of Member countries factsheets on "Adolescent Health" and "HIV in Young People" have been prepared and published. Efforts are also being made to analyse the available data according to age and sex on relevant health indicators.

Another area of concern is the low utilization of health services by adolescents. WHO has organized numerous consultations on these issues and several countries have taken steps to provide adolescent-friendly health services. National strategies on adolescent health have been developed and national capacity in Member countries has been strengthened to improve skills of health workers. To ensure good quality of services, national standards have been developed and are being implemented in many countries. WHO has also been engaged in developing and sustaining partnerships with UN agencies and other relevant partners to move forward the agenda of adolescent health and development and help the countries to realize the Millennium Development Goals. (Annex 2: Speech of the Regional Director).

The representative from the Ministry of Health, Indonesia, read out the remarks from Dr Sri Astuti Suparmanto, Director-General of Community Health, Ministry of Health, Republic of Indonesia. In her inaugural address, she shared some of the problems faced by adolescents and the ongoing work on adolescent health programme in Indonesia. There are an estimated 40 million adolescents in Indonesia. A significant proportion of this population comprises school dropouts and street adolescents. Currently the problems faced by adolescents are HIV/AIDS, Sexually Transmitted Infections (STIs), drug and substance abuse, unwanted pregnancy, risk abortions and iron-deficiency anaemia. Some of the risk behaviours highlighted were smoking, needle-sharing and unsafe sex. Life-style changes, inadequate information on sexual and reproductive health along with insufficient quality health services for adolescents in Indonesia are making them more vulnerable to health risks.

A number of programmes have been implemented in Indonesia to address these problems. A School Health Programme was initiated in 1983 with health centres and is now functioning in all health centres of the country at the elementary school level. For high schools, the programme is in the process of development using the Adolescent Friendly Health Services (AFHS) approach. Being implemented since 2003, there are now around 782 AFHS health centres in Indonesia. The services have been integrated into the School Health Programme. Extensive training of trainers for AFHS health providers are being conducted in provinces. In order to reach out to street and out-of-school adolescents, peer counsellors are being trained. This achievement is a combined effort of the Ministry of Health, Ministry of National Education, Ministry of Religious Affairs, development partners and nongovernmental organisations (NGOs) (Annex 3 – Agenda).

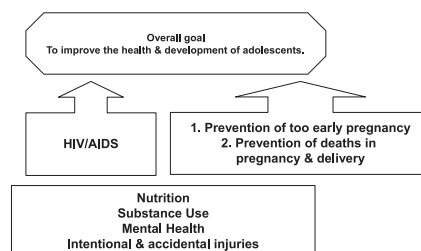
Global perspective

Where does the health of adolescents figure in the global public health agenda ?



- International Development goals relevant to adolescent health
- High profile publications
- Multi-country initiatives
- International organizations positioning themselves to support country action

Using strategic entry points, to move the wider adolescent health agenda.



Dr Chandra-Mouli Venkatraman, WHO/HQ, began his presentation by quoting David Brower's often acknowledged phrase "Think globally, act locally" in the context of the health of adolescents the world over. Giving a global perspective, he highlighted that there were more adolescents than at any time in history and then represented one fifth of the world's population (around 1.2 billion). In today's fast-changing world, adolescents face a range of health and social challenges. Some adolescents have greater access to education and information and a growing ability to make well-informed choices about their lives, while on the other hand social and economic deprivation for many other adolescents means malnourishment, lack of education, unemployment and inability to develop and live to their full potential. Religious intolerance, civil strife and war also influence adolescent health and development adversely. Many adolescents make the transition to adulthood in good health while many others do not do so. They face problems of sexual and reproductive health, undernutrition and overnutrition and endemic diseases like tuberculosis and malaria. Injuries resulting from

accidents and violence, problems of mental health and substance use are also common. Some of these health problems affect the individual during adolescence while others affect the individual later in life.

The health of adolescents is now included in the global public health agenda. Adolescent health now figures in a number of international commitments, high profile publications, multi-country initiatives and donor support. International organizations are positioning themselves to guide public health action in countries. National governments all over the world are also in the process of putting national youth policies and strategies in place.

However many obstacles still exist and need to be overcome. There is very little sound epidemiologic data, inadequate access to the available evidence on the effectiveness of public health action, lack of agreement on indicators to assess the process and outcomes of public health action, lack of cost estimates to plan public health action, inadequate resources and weak coordination and collaboration. In addition there are inhibitions in dealing with issues of sexuality, substance use, violence and mental health in relation to adolescents. The implications are that even if adolescents are identified as an important population segment to address, national programmes on AIDS, reproductive health and nutrition, do not meaningfully include adolescents in their portfolios. Actions in the following six areas are needed at global and national levels:

- (1) Strengthen the epidemiologic basis for public health action;
- (2) Strengthen the evidence base for public health action;
- (3) Develop sound cost estimates for key components of public health action;
- (4) Build consensus on indicators and methods to assess the effectiveness of public health action;
- (5) Advocate for investment in public health action for adolescents; and
- (6) Improve coordination and collaboration

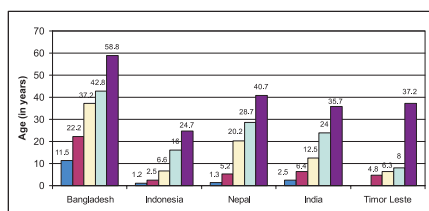
Ministries of health need to play a leadership role to ensure that adolescents grow and develop in good health. However, when they fail to do so other government institutions, NGOs and civil bodies try to fill this space that is inadequate in terms of impact and coverage. However, over a period of time a growing number of governments are planning, implementing and monitoring programmes aimed at promoting the health and development of adolescents, with a particular focus on sexual and reproductive health. This provides an entry point to address the other health problems facing adolescents.

Sharing the example of “Geracao biz” programme in Mozambique, Africa, Dr Chandra-Mouli highlighted how the strong commitment of the Ministry of Health towards sexual and reproductive health had provided a good basis for it to address this issue in adolescents. Starting with Maputo, the programme now covered almost the whole country. The example revealed that strong links needed to exist between three different sectors – health, education and youth – to enable a comprehensive strategy to be put in place. Strong coordination and action is required at national, provincial and local levels to enable all adolescents to grow and develop as healthy adults.

5

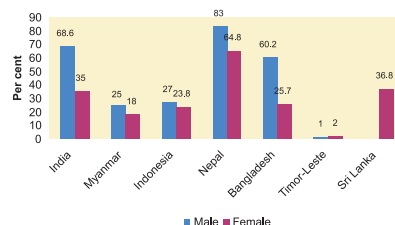
Regional perspective

Per cent of women ages 15-19 who have begun child bearing



Sources: Bangladesh DHS 2004, India NFHS-3, Indonesia DHS 2002-03, Nepal DHS 2006, Timor-Leste DHS 2003

Knowledge of two or more methods of prevention of HIV/AIDS among Youth.



Sources: Bangladesh: DHS 2007 (15-24 years); India: NFHS-3 (15-24); Indonesia: DHS 2003 (for 20-24 years); Myanmar: Behavioural Surveillance Survey 2003 (for 15-24 years); Nepal: DHS 2006 (15-24); Timor-Leste: DHS 2003 (for 20-24 years); Sri Lanka: DHS 2000

Dr Neena Raina presented a situation analysis of adolescents in the SEA Region. Highlighting the demographic and health indicators, knowledge, perception and behaviour of adolescents, she called attention to the diversity and commonalities of adolescent health and development problems among countries. A sizable proportion of population (15-26%) in all countries of the SEA Region comprised adolescents. A large proportion of young people are uneducated in Bangladesh, India and Nepal with huge gender gaps. Early marriage and childbearing is common in some countries like Bangladesh, India, Nepal, while age at marriage is high in countries like Sri Lanka and Thailand. Age-specific fertility rate among the 15-19-year-olds ranges from 23 (Myanmar) to 136 (Bangladesh). Other countries with high adolescent fertility are Bhutan, Nepal, India and Timor-Leste.

The main health problems include high prevalence of anaemia, low body mass index (BMI), obesity, problems relating to early pregnancy and childbearing, STIs and HIV/AIDS. Adolescent mothers experience more pregnancy complications, high maternal mortality and morbidity and high neonatal and

infant mortality as compared to older women. Institutional delivery is low for most countries except Sri Lanka (96%). It ranges from 7% -30% in Bangladesh, India, Indonesia, Nepal and Timor-Leste. Contraceptive use among married adolescent women (15-19 years) ranges from 5.8 to 75% being high in Sri Lanka and Thailand and low in India, Nepal and Timor-Leste for both 15-19 and 20-24-year-old women. Unmet needs for family planning especially for spacing are high among adolescents. Selected studies from India, Nepal and Thailand reveal that a large percentage of young women go in for abortion often in unsafe conditions. More than 1.6 million young people are living with HIV/AIDS in the Region and there is an increasing prevalence of HIV among injecting drug users (IDUs) and sex workers in countries like India, Indonesia, Myanmar, Nepal and Thailand. STIs are also increasing among young people. Trends from Sri Lanka and Thailand reveal a high proportion of young people reporting STIs.

Available behavioural data on young people in the Region show that though a large number of young people have heard about HIV/AIDS their knowledge on methods of transmission and prevention is low. In almost all countries except Nepal less than 50% young women have comprehensive knowledge on HIV/AIDS. Studies on the felt needs of adolescents show that they are more concerned about height and weight, sexual health, academic matters, boyfriend/ girlfriend issues, career and conflict with parents as compared to general health. Rural and urban perceptions also differ. Most adolescents have no source of information on puberty and related physical changes. Common sources of information are peers and media as compared to schools and parents. Adolescents also have a negative perception about health-care providers, both in rural and urban areas. Some of the behaviours that make adolescents more vulnerable are early sexual debut, premarital sexual activity with high-risk partners and low contraceptive and condom use. Less than 50% youth used condoms at last high risk sex in Bangladesh, India, Nepal, Sri Lanka (2000). The utilization of voluntary confidential counselling and testing services is low. In Myanmar for example, though 68% expressed the desire for HIV testing, only 5% had the HIV testing done. There is a huge gap between young people's understanding and their behaviour due to lack of services and enabling environment. There is no specific place where adolescents can seek health services.

Summarizing the progress made so far in the Region, Dr Raina highlighted the various initiatives which had been taken until then. For strengthening strategic information, factsheets on HIV and AHD for all 11 Member countries of the SEA Region had been printed. A regional factsheet on the situation of AHD was also being developed. Country profiles of Bhutan and Nepal had been published. Bangladesh, Sri Lanka and Thailand are in the process of finalizing these profiles.

A compendium of institutions working on adolescent sexual and reproductive health (ASRH), HIV and Young People (HIV/YP) in Bangladesh, India, Nepal and Sri Lanka has been published. Sub-set analysis of national surveys – Demographic Health Survey (DHS) and Behaviour Surveillance Survey (BSS) – and HIV/AIDS had been completed in Bangladesh, India, Indonesia, Sri Lanka and Nepal. Access and coverage factsheets on HIV and ASRH in India and Sri Lanka had also been developed.

Numerous consultations and meetings have been held for positioning AFHS in countries of the Region. In 2004 the first meeting on AFHS was organized in Bali, Indonesia. A declaration was adopted outlining the roadmap for future initiatives for AFHS. Regional consultants were trained on the orientation programme (OP) package and capacity-building workshops for HIV/AIDS and AHD programme managers was held in Chiang Mai, Thailand focusing on mapping adolescent health and measurement (MAPM) and WHO's 4 "S" strategy. A capacity-building exercise of UN country teams from Bangladesh, India, Nepal and Sri Lanka was undertaken in March 2006.

Assistance has been provided to countries to develop national standards for AFHS and to implement them. National standards have been developed in Bangladesh, India and Sri Lanka. The orientation programme package has been adapted by countries like Bangladesh, India, Indonesia and Sri Lanka in accordance with their local contexts. WHO and UNFPA are supporting a regional course on programming for ASRH, HIV/YP at Institute of Health Management Research (IHM), Jaipur, India. Tools for quality, coverage and cost are also being developed to be tested at three sites in India.

Several steps are also being taken for advocacy and facilitating supportive policy environment for adolescents in the Region. A meeting on consent and confidentiality was organized in New Delhi (2007). Advocacy booklets on AHD and HIV/YP are being finalized. Countries like Bangladesh and India now have national strategies for AHD. Others like Bhutan, Thailand and Myanmar are in the process of doing so. Regional strategic frameworks on HIV/YP and regional strategic directions on AHD are also being developed.

Initiatives have also been taken to strengthen collaboration with other sectors. Collaboration with United Nations Children's Fund (UNICEF) initiated a regional overview on life-skills-based education. Other country-based initiatives include the Bhutan School Health Coordinators, Training Package and school Health Programme of Sri Lanka in collaboration with the education sector.

Several challenges still exist. Inadequate information on adolescents still prevents them from being identified as a priority group within public health

programmes. There is lack of convergence within ministries of health, low resource allocation, limited capacities at country level, hindrances in scaling up and lack of mechanisms for collaboration with other sectors. However, there are numerous opportunities as well. Advocacy has increased commitment of countries for greater resource allocation for adolescents. Several development partners are addressing the needs of adolescents and young people. The Global Fund to fight HIV/AIDS, TB and Malaria (GFATM) is also providing resources for HIV/AIDS prevention and control among young people. National strategy available in many countries provides a good chance for resource mobilization.

Discussion

- Adolescents are not only a challenge but also an important part of the solution; they should be involved in all stages – from conceptualization, design, implementation, feedback, and follow-up.
- Programmes should be designed keeping in mind the needs of adolescents.
- There is still resistance towards providing reproductive and sexual education to adolescents. It was discussed that a beginning could be made through a narrow focus and then by integrating issues related to sexual and reproductive health taking into account acceptance in community.
- Bangladesh has used HIV/AIDS as an entry point to provide AFHS services using the funds from GFATM (US \$ 19 million). The package of services was developed through a consensus with stakeholders. It covers HIV and problems like reproductive tract infection (RTI) and sexually transmitted infections (STI) and postnatal care including issues of body image. In India ARSH is the entry point. A point emerged in the discussion that no matter what entry point a country used, it was important to evolve a comprehensive package that responded to the diverse needs of adolescents.
- It is crucial to keep in mind the contextual situation of adolescents. Demographic and social patterns of adolescents differ by country and region. Interventions need to be tailored to address the diverse needs and contexts of adolescents' lives. Making existing services adolescent-friendly would ensure that services reach adolescents and they grow up to their full potential.
- Stakeholders and decision-makers need to be involved at all levels. Funds and resources need to be identified to work on focus areas.

6

Mapping adolescent programming and measurement

Which Interventions affect selected determinants			
Interventions	Determinants	Behavioural Outcomes	H & D Outcomes
Information provision to adolescents & YP on condoms & their availability	YP's beliefs/norms about condoms	Increased condom use among YP	To reduce STIs/ HIV infections in young people,
Information & Training for Health care providers	Knowledge and skills of health care providers		
Develop & implement standards	Clinic standards & policy on YFHS		

Dr Krishna Bose, WHO/HQ, introduced the concept of mapping adolescent health and Measurement (MAPM) – a tool for strengthening and rationalizing programme design, implementation and monitoring. MAPM provides the framework to evaluate how interventions lead to outcomes. The framework recognizes that behaviours depend on multiple determinants, including “protective

factors” that promote healthy behaviour and “risk factors” that can have a negative impact on health and development.

Steps for using MAPM are:

- Step 1: establish what the desired health outcome is.
- Step 2: identify and select important behaviours to change/encourage
- Step 3: identify and select determinants (risk and protective factors) for each of the behaviours.
- Step 4: identify intervention(s) to change/strengthen the selected determinant.

The concept of MAPM was explained with the example of reduction of STI/HIV infections among young people. The first step is to choose the specific health outcome the programme wants to achieve, for example – to reduce

STIs/HIV infections in young people. Secondly, behaviours that will contribute to this health outcome are identified, e.g. increased condom use among young people. The third step is to identify the key risk and protective factors that determine the behaviours of young people and can be changed by interventions. In this case the determinants can be identified as young people's beliefs/norms about condoms; knowledge and skills of health-care providers and clinic standards and policy on YFHS. Step four is to design programme interventions that will help to change behaviours. These interventions must also ensure that they must first change determinants, in order to affect behaviours and, ultimately the desired health outcomes. For the above health outcome, interventions like providing information to young people; sensitizing and training health-care providers; and developing and implementing standards can be used.

The MAPM framework is filled in by working from right to left so that it begins with the outcomes and after completion it is read from left to right so that it can be ensured that there is a logical connection between the interventions planned and the desired outcome through the columns of determinants and behaviour.

Along with providing guidance for designing programmes, the MAPM framework helps in developing monitoring and evaluation tools for programmes. It provides guidance to know whether the designed interventions are being implemented properly and have had a desirable effect on determinants which in turn have an effect on behaviours leading to impacting the selected health outcome. Programme activities (interventions) can be measured in terms of their quality, coverage and cost. Many programmes are able to measure the change in determinants while only some are able to measure change in behaviours because they take a long time. Very few programmes are able to measure health outcomes because these may take very long.

The benefits of using MAPM are that it can assist with defining desired results and provides a rational step-wise basis for selecting interventions to implement. It also makes explicit the importance of determinants in mediating behaviour change. It reduces pressure on achieving the outcomes. For monitoring and evaluation it assists with identifying and classifying indicators to monitor and helps to identify gaps in the available information for either developing an effective programme or reviewing existing programmes.

Discussion

- Application of the MAPM framework allows programme managers to specify which behaviour and its determinants they are currently addressing or intend to address through intervention activities. The ministry of health has to take a leadership role and coordinate and concretise action at country level.
- Advocacy is critical in efforts to improve adolescent reproductive health. It helps ensure that programmes for youth are enacted, funded, implemented and sustained by building support with ministry of health, ministry of education and other relevant ministries, religious bodies, parents, civil society, NGOs and donors.

Strategy to strengthen health sector response to adolescent health

Introduction

The health sector has a vital role to play in providing a range of effective, evidence-based interventions for adolescent health and development. It includes a number of players contributing to this goal. This includes government bodies, for-profit and not-for-profit non-government organizations (NGOs) and civil society organizations. Within this, the particular focus is on the stewardship role of the ministry of health.

The health sector roles

- **S**trategic Information
- **S**upportive evidence-informed policies
- **S**ervices and commodities
- **S**trengthening other sectors

The components of the health sector response are:

- Strategic information
- Supportive, evidence-based policies
- Services and commodities
- Strengthening other sectors.

Strategic information: Collect, collate, analyse and use data for advocacy and to inform policies and programmes. Such data include epidemiologic data and programme implementation data. To obtain these data routine reporting, sentinel surveillance, existing population-based surveys and special studies to address the gaps in existing information and monitoring, evaluation and operational research studies are required.

Supportive and evidence-based policies: Develop/revise (strengthen) policies and strategies through an inclusive process and that are:

- (1) effective in contributing to addressing determinants and influencing desirable behaviours and health outcomes;
- (2) feasible and sustainable in the social, cultural and economic contexts and
- (3) coherent.

These evidence-based policies will build on existing policies and see the overlaps in related policies like national population policy, reproductive health policy, HIV/AIDS policy and help in guiding public health action. For example, all adolescents should be able to obtain health services they need or by training and supporting health workers to be adolescent-friendly and making existing public health services adolescent-friendly.

Services and commodities: Provide adolescents with health services and commodities in appropriate settings and according to their need to achieve defined health outcomes; making health workers and support staff adolescent-friendly, making service-delivery points appealing and user-friendly, promoting adolescent demand for health services and commodities they need; and providing community support for their provision.

Strengthening other sectors: Engage and support other sectors to maximize their contribution to adolescent health and development through pooling of resources and their effective utilization based on a shared understanding of adolescent issues. For example, supporting the education sector in providing skills-based education; and supporting civil society organizations in building the capacity of parents to improve the health of their adolescents.

7.1 Strategic information

Country presentations

India: Dr Rajesh Mehta, National Professional Officer (NPO-AHD), WHO Country Office, India

On behalf of the Ministry of Health, Government of India, Dr Mehta gave a brief description of the sources of strategic information within the existing MIS framework in India. For planning and monitoring of the National Reproductive and Child Health (RCH) programme different surveys have been undertaken

Existing MIS for National Reproductive and Child Health (RCH) Programme

- **Routine MIS: Monitoring of RCH programme**
- **Periodic National Surveys: Tracking improvement in health (RCH) status**
 - National Family Health Survey (NFHS): National and State level data
 - District Level Health Survey (DLHS): District level data
- **Special Surveys**

Limitations

- There is a limited age and sex disaggregated RCH data available related to the adolescents and young people
- Such strategic information is indispensable for advocacy, formulating policies, and developing rational programmes for adolescent health and development
- Paucity of data comes in the way of developing specific strategies for special groups among this rather heterogeneous section of population

by the Ministry of Health and Family Welfare. These include: Periodic National Surveys for tracking improvement in health (RCH) status, National Family Health Survey (NFHS) for national-and state-level data; District Level Health Survey (DLHS) collecting district-level data and Special Surveys.

Over a period of time some of the key limitations and gaps within these surveys have been identified. These include lack of age and sex disaggregated data, non-inclusion of unmarried men and women in samples at national, state and district levels, lack of data on 10-14-year olds and on special groups of adolescents and youth. However, with sustained advocacy efforts to bring to the forefront the emerging health issues of adolescents and young people, changes are taking place. The latest edition of the NHFS-3 has incorporated several new areas. Important among these is the space devoted to adolescent reproductive health and testing for HIV and high-risk sexual behaviour among young people. The sample includes both married and unmarried men and women. Other new areas include perinatal mortality, male involvement in family welfare, family life education, safe injections, tuberculosis, malaria and testing for anaemia in both men and women. In addition, the Ministry of Health has also initiated a secondary analysis of existing data on selected indicators with regard to adolescent sexual reproductive issues with technical support from WHO. The objective is to obtain age disaggregated data on sexual and reproductive health issues for the age group 15-24 years and to provide an insight into the trends over the years.

A youth population-based study – The Youth in India Study (2006-2007) covering the states of Maharashtra, Jharkhand, Tamil Nadu, Andhra Pradesh, Bihar and Rajasthan has also been initiated. It focuses on the situation of the youth, and will identify the key factors underlying their sexual and reproductive health choices. It will provide separate estimates for rural and urban areas, male and female population and married and unmarried population. The main objective of the study is to advocate for evidence-based programming for young people. Some of the data emerging from the first phase of the study were

shared. For example, findings in the states of Jharkhand and Maharashtra revealed that young people have limited in-depth knowledge on HIV/STI and other sexual and reproductive health issues. The gender differentials are large with women scoring much lower than men. The main sources of their information on these issues are their peers and the media rather than their parents.

Sharing the next steps in the process of strengthening strategic information with regard to adolescent health and development, Dr Mehta identified three main areas of focus. These were:

- analysis of the adolescent module of NFHS- 3;
- incorporation of selected indicators on sexual and reproductive health like use of sanitary napkins, emergency contraceptive pills and coverage indicators for young people for example, HIV test – within past one year in the third round of DLHS;
- incorporation of selected ARSH indicators in routine MIS for RCH and inclusion of boys and men in survey samples.

Timor-Leste: *Mr Carlitos Correia Freitas, Head of Health Promotion Department, Ministry of Health (MoH), Timor-Leste*

Mr Freitas summarized the key activities and achievements in the area of policy and strategy development in Timor-Leste. The National Family Planning Policy (2003) and the National Reproductive Health Strategy (2004) have been

developed. Some of the key activities undertaken by the Ministry of Health include providing testing and referral points for STI and HIV; capacity building for STI Syndromic Case Management and training of clinical nurses. Information, education and communication material on health issues have been developed. Consultative meetings with key stakeholders on the issues of adolescent health and development

Strategic information

- Provided testing/referral for syphilis and voluntary HIV testing and management
- IEC materials
- Health curriculum in junior and high school
- Life skills modules
- Training of prevention and education for teachers
- Workshop on AHDS among key stakeholders
- Advocacy
- Development of the new AHDS guidelines
- Survey on knowledge and awareness of HIV/AIDS, 2002
- Campaign for HIV/AIDS prevention, 2007
- Survey training for local staff

have resulted in the development of new adolescent health strategy guidelines. The ministry has introduced lifeskill modules and health curriculum in junior and high schools of the country. Training has been initiated to sensitize teachers to the special needs of young people.

To strengthen strategic information on young people, the Ministry of Health conducted a survey on knowledge and awareness of HIV/AIDS among youth in 2002. Findings of the survey enabled the ministry to strategize and run a campaign on HIV/AIDS prevention across the country during 2007. Mr Freitas also highlighted a number of activities which were being planned for future. These included:

- conducting a national baseline survey on youth fertility and sexuality behaviour;
- Peer education for young people in school and out of school in 13 districts and training of members of seven NGOs to implement peer education;
- Media advocacy;
- Advocacy on reproductive health at regional level;
- Development of national guidelines for youth-friendly service and training; and
- Strengthening supervision, monitoring and evaluation.

Discussion

- There is lack of sex and age disaggregated data relating to adolescents and young people; data on 10-14-year olds is particularly lacking.
- The target indicators covered only reflect reproductive and child health but there is need to incorporate other key indicators such as those relating to mental health, nutrition, injuries and substance abuse, etc.
- As adolescents are heterogeneous, paucity of data comes in the way of developing specific strategies for special groups.
- There is a lack of interdepartmental and inter-ministerial coordination and convergence. Common pools of data analysis to address key concerns are required.
- More baseline surveys addressing specific gaps in the database are needed.
- Young countries like Timor- Leste have the advantage of learning and incorporating the best practices from other countries and have shown a good example of mapping the adolescent population which will lead to better planning and programming.

Group work

Participants were divided into country groups. They were asked to write down two key messages from the session which they would like to take back with them. One was to bring out the two things each group learnt from shared country experiences and the other was to identify one thing that they learnt not to do. The facilitators with the help of participants then collated and synthesized the outcome. The presentation was followed by discussion and the outcome was presented in visualisation in participatory process (VIPPP) cards in two different colours.

The key issues that emerged from group the work on strategic Information were:

- The purpose of strategic information is to aid advocacy and to inform policies and programmes.
- There is a need for systematic collection and analysis of data.
- The data would be of two types:
 - (1) epidemiological data, and
 - (2) programme data.

The MoH to coordinate and collaborate with stakeholders to:

- (1) Access and analyse all relevant existing data with reference to age and sex disaggregation - the groups felt that this must be the starting point before undertaking any ambitious surveys. This will include the routine MIS, existing national population-based surveys and sentinel surveillance.
- (2) Identify the gaps in information and adolescent-specific components to be included in periodic national surveys like DHS and DLHS, etc. and sex and age desegregation to be introduced in the routine MIS.
- (3) Undertake additional survey/special studies for specific information on adolescent issues like nutrition, behaviour determinants or for marginalized adolescents like in the garments and mining sectors and migrants, etc. Also, undertake evaluative studies for cost-effective and cost-benefit analysis of various strategies used.

- In summary, the groups felt that
 - (1) Systems-generated data will be first analysed and where relevant age and sex desegregation will be done;
 - (2) Population-based national surveys will be analysed around adolescent-specific issues, and components will be introduced specific to adolescent health and development; and
 - (3) periodic additional surveys to be conducted to generate information in critical areas that cannot be addressed through the above two methods.

7.2 Supportive, evidence based-policy (National Strategy)

Country presentations

Bangladesh: *Dr S.M. Abul Khayer Miah, Deputy Director, Primary Health Care and Programme Manager, Directorate General of Health Services.*

Dr Miah gave a summary of the National Adolescent Reproductive Health Strategy of Bangladesh and the process of its formulation. Giving the background that led to the formulation of the national strategy, Dr Miah briefly described the situation of adolescents in the country. One fourth of the population of Bangladesh comprises adolescents. Early marriage and childbearing is common. Almost 11% girls aged 10-14 years and 46% girls aged 15-19 years are married. Among them one third are already mothers in the 15-19 year-age group. Less than half of married women use any kind of contraception. Maternal mortality is high. Dr Miah stated that the government was committed to develop an adolescent reproductive health (ARH) strategy to improve the well-being of adolescents. The focus was on reduction of adolescent pregnancy, prevention of STIs and HIV, reduction of sexual abuse and violence. Increasing reproductive health awareness was also identified as an important component. The goal of the strategy is to ensure that by 2010,

Background of National Strategy

Milestones:

Sensitization Workshop, 2002
 Formation of Inter-ministerial committee, 2003
 Formation of Drafting Committee, 2004
 ARH Strategy Development Workshop, July 2006
 Draft ARH strategy developed, Aug – Sep 2005
 Review and consultation, Oct – Nov 2005
 Draft submitted to MOH&FW, Dec, 2005
 MOH&FW approved the ARH strategy, March 2006
 ARH Strategy Disseminated, Sep, 2006

“all adolescents will have easy access to information, education and services required to achieve a fulfilling reproductive life in a socially secure and enabling environment”.

The process of developing the national strategy started in 2002 with a sensitization workshop of key stakeholders. This was followed by the formation of an inter-ministerial committee in 2003 and a drafting committee in 2004. After a series of workshops and reviews, the draft strategy was submitted to the Ministry of Health and Family Welfare. The strategy was approved and disseminated in 2006. The suggested actions in the ARH strategy include:

- Improving adolescents’ knowledge on reproductive health;
- Creating a positive change in the behaviour of adolescents;
- Reducing the incidence of early marriage and pregnancy;
- Reducing the incidence of STIs and HIV/AIDS;
- Provision of easy access to ARH and services; and
- Creating favourable conditions that discourage risk-taking behaviours among adolescents.

The tools used to develop the strategy included review of the existing health strategy and workshops and collection of evidence-based information. The technical inputs were provided by the government, NGOs and development partners like WHO, UNAIDS, UNFPA, UNICEF, CIDA and Save the Children (USA).

It was suggested that in the process of strategy development it was useful to collect information from different sources. Political commitment and collaborative efforts of ministries were needed. Cultural sensitivities should be respected and communities should be involved in decision-making.

Myanmar: *Dr Myint Myint Than, Deputy Director / Project Manager, Women and Child Health Development, Department of Health, Ministry of Health.*

Young people (10-24 years) constitute 30% of Myanmar’s population (2004). Though there is no separate policy in the country for adolescent health, different policies like the draft National Population Policy (1992), National Health Policy (1993), National Policy for Reproductive Health (2002) and National AIDS Strategic Plan (2006-2010) recognize the need for providing services for adolescent health and development. For example the National Policy for Reproductive Health (2002), mandates that “reproductive health

<p>National strategic plan on adolescent health and development(2008-2012)</p> <p>Goal</p> <ul style="list-style-type: none"> • To improve knowledge, attitudes, and skills of young people, thereby encouraging adoption of healthy lifestyles, and to increase adolescent access to appropriate health services 	<p>Four priorities areas</p> <ul style="list-style-type: none"> • Reproductive health and HIV/AIDS • Nutrition • Substance abuse (e.g. tobacco, alcohol) • Injuries.
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services must be accessible, acceptable and affordable to all women and men, especially to underserved groups including adolescents and the elderly. Similarly, the National AIDS strategic Plan (2006-10) clearly articulates the strategic direction for reducing HIV-related risk, vulnerability and impact among young people.

In her presentation Dr Than highlighted the new National Strategic Plan on Adolescent Health and Development (2008-2012). The goal of the national plan is “to improve knowledge, attitudes and skills of young people, thereby encouraging adoption of healthy lifestyles, and to increase adolescents’ access to appropriate health services”. The objectives are:

- To promote the health and development of young people by providing accurate and culture-specific information through appropriate channels of communication;
- To reduce morbidity and mortality among young people by introducing and expanding access to youth-friendly health services; and
- To reduce the morbidity and mortality in adulthood resulting from preventable conditions or behaviours during adolescence.

The four priority areas that have been identified are reproductive health; HIV; nutrition; and substance abuse and injuries. A number of interventions have been planned under three strategic directions. Under the strategic direction for creating a supportive and enabling environment it is planned that national-level initiatives will be adopted to strengthen policy and programme. National- and township-level communication activities will be developed. The school environment will also focus on healthy physical development of students. For improving access of adolescents to information and skills, collaboration with the education sector is being planned. Information package for adolescents will be developed. For out-of-school adolescents, health education and skill-

building activities will be provided. For improving adolescents' access to and use of services development, reorientation of existing primary health-care services with the introduction of adolescent-friendly standardized service package is being planned.

Discussion

- It is vital to involve gatekeepers, parents and guardians and adolescents themselves at all levels of planning and programming. Bangladesh has achieved tremendous success in the health field in terms of health outcomes like reduction in maternal mortality rates and improvement in adolescent health.
- An adolescent sexual and reproductive strategy was launched in India in May 2006. The National Rural Health Mission launched by the Government of India was a positive development. It has a high potential to improve health systems and outcomes in the country, particularly in enabling adolescent health programming.

Group work

The key issues that emerged from group work on supportive and evidence-based policies and strategies were:

- The groups felt that the process of developing policies to address the needs of adolescents has to be inclusive and that the involvement of adolescents themselves is critical for ownership of the policy.
- Policy development has to be embedded in a spirit of convergence and has to be realized as both a technical and a political process.
- Policies and strategies need to be developed based on current experience and have to be rooted in the social, cultural and economic contexts of the country to be sustainable.
- These policies and strategies have to be effective in order to contribute to the desired determinants, behaviours and health outcomes the country determines for its adolescents based on supportive evidence.
- Policies also need to be developed on the basis of what is available and hence should work out the continuum of services using existing service and linkages.

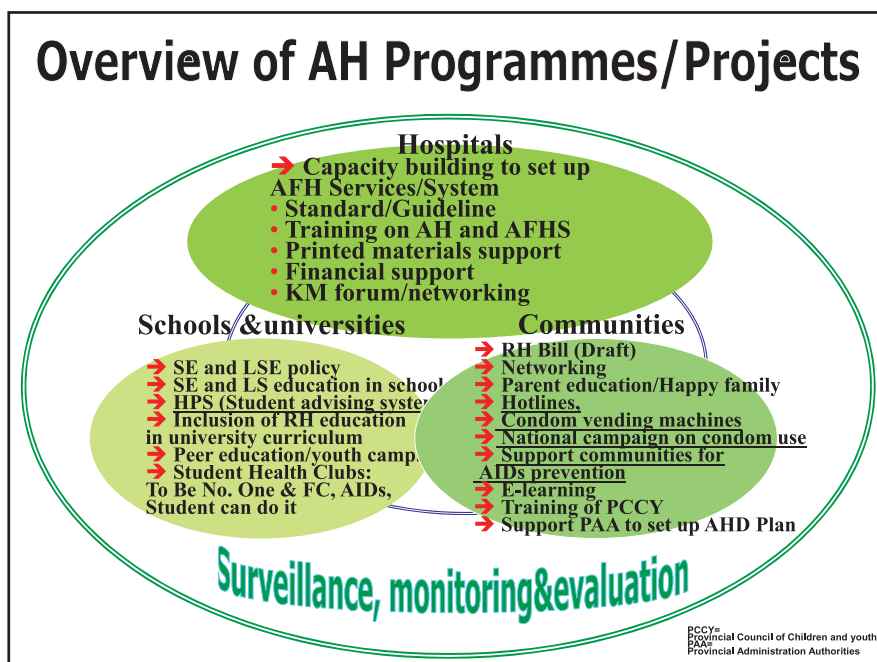
- Duplication of policies should be avoided; rather they should build on existing policies by avoiding the overlaps in related policies like National Population Policy, Reproductive Health Policy and HIV/AIDS policy, etc.
- However, while building on related policies the adolescent-specific policy should ensure facilitation of public health action e.g. all adolescents should be able to obtain the health services they need.
- The policy should guide public health action e.g. by training and supporting health workers to be adolescent-friendly and by making existing public health services adolescent-friendly.

7.3 Services and commodities

Country presentations

Thailand: Ms Yupa Poonkhum, Senior Public Health Technical Officer, Reproductive Health Division, Department of Health.

A number of key initiatives undertaken by the Ministry of Public Health for provision of health services and supplies to adolescents were shared. Ms Poonkhum highlighted some of the strategies for adolescent health





AFHS programme/Project

“Wai Roon Sod Sai Anamai Dee Dee” (Bright and healthy adolescents)

➔ **Capacity building to set up AFH Services/System**

- **Standard/Guideline**
- **Training on AH and AFHS**
- **Printed materials support**
- **Financial support**
- **KM forum/network meeting**

Hospitals

development. These included providing safe and supportive environment to adolescents; information and skills; health services and counselling; and ensuring youth and community participation. By keeping a close surveillance of prevalence and incidence of pregnancy, STI and HIV among young people, risk behaviours/factors for adolescents, can be reduced.

Efforts have been made to achieve the goal of reducing risk behaviours/factors in the school system. Sex education and lifeskill education, Health Promotion School programme together with advising system for students have been implemented continuously. Another initiative aims to include reproductive health education in university curriculum. In order to reach out to more youth, training of peer educators, holding of youth camps and starting student health clubs were mentioned as examples.

To build community support parents are being sensitized to support adolescent health issues. In addition, to increase access to information and supplies hotlines and condom vending machines have been installed. The mass media has been involved to promote condom use. Funds were also allocated for AIDS prevention in communities. In addition, the government supported the majority of Provincial Councils of Children and Youth to implement outreach RH education in schools and communities.

Regarding health facilities, efforts have been made to build capacity of health providers to provide adolescent-friendly health services. Standard guidelines and training materials for health workers have been developed and training of health workers has been initiated. All these efforts have led to increased investments by the National Health Security Office in adolescent health programmes and the coverage in schools and hospitals has increased. This initiative has been named as “bright and healthy adolescent” and is receiving technical support from the Royal Thai College of Obstetricians and Gynecologists, medical schools, Department of Health, Department of Disease Control, Department of Mental Health, Department of Medical Services and WHO.

Based on the experience of Thailand it was suggested that adolescent clinics should not be located near the outpatient department in hospitals. It was also suggested that AFHS should be linked to school-and community-based programmes to increase demand generation for health services. Some of the other issues highlighted included supportive supervision; forum for learning and sharing; and accreditation of health facilities.

Indonesia: *Dr Rinni Yudhi Pratiwi Toeloes, Chief, Subdirector of Adolescent Health, Directorate of Child Health, Director General, Community Health.*

Dr Rinni outlined the process that Indonesia had adopted to reach the goal of developing adolescent-friendly health services (AFHS) in all health centres of the country. Conducted in a phased manner, extensive scale-up in Indonesia

WHAT ACTUALLY DID

1. Developing Strategy and Policy
2. Socialization to all Provincial and District/ Municipality Health Offices
3. Multi tier Capacity building for AFHS
4. Technical and funding support to District when they develop AFHS

WHAT HAS ACHIEVED

- Socializing AFHS at almost all 33 provinces
- Training of trainers on AFHS at almost all 33 provinces, except : West Irian Jaya
- Totally around 782 of health centers providing AFHS (out of 7442 Health centers at sub districts, 2006)

was possible as health centres were available in every sub district and accessible to adolescents. Doctors and staff of these centres are well versed with problems relating to adolescent health and have the required skills to handle them. A back-up of guidelines, rules and regulation further helps the centres to provide special services to adolescents.

A number of factors facilitated the mainstreaming of this process. Among these was the development of a policy and strategy with regard to adolescent health. Orientation meetings were held with all provincial and district/municipality health offices. Capacity building for AFHS at different levels was initiated and technical and funding support were provided to districts as and when they developed AFHS. The effort was multisectoral, both at the central and provincial level. At the central level it included the government, nongovernmental organizations, community associations, donor agencies, development partners, professional associations and referral hospitals. At the provincial level, in addition to the above players, the local government was involved along with the local development planning board and local institutions. Other factors that helped was the awareness of the local decision-makers on the importance of adolescent health for future development of the country. Some of the challenges which were faced was lack of adolescent health focal points in most provincial health offices and district health offices. Lack of adolescent health data at district level also hampered advocacy efforts.

Around 782 health centres were providing adolescent-friendly health services in Indonesia in 2006. Almost 33 provinces had completed training of trainers.

Based on Indonesia's experience it was highlighted that comprehensive information on adolescent health problems should be used and efforts should be made to demonstrate that the AFHS programme can make a difference. It was also suggested that AFHS should not be started before sensitizing people on the magnitude of the problem. Local wisdom of the community and health providers should not be ignored.

Discussion

- The success of AFHS in Thailand was attributed to policy commitments of the MoPH and MoE; coordination and collaboration among relevant departments and NGOs; information (reporting system, surveillance system, school survey/national survey, and child watch/provincial survey) and mobilization of financial resources from local organizations (provincial/sub-district administrative authorities, budget of National Health Security Office (NHSO)). However Thailand needs national strategy to deal with ASRH problem. There are youth programmes and projects based at different settings like hospitals, schools, universities and communities. There is need to strengthen the monitoring and evaluation system to demonstrate results. A number of success stories like "friend's corners" need to be evaluated to understand their

working. Country could strengthen linkages of AFHS with projects in schools and the community.

- The importance of inter-and intra-sectoral convergence for success was reiterated. For example in Thailand common strategies were identified by different ministries and departments and then operationalized.
- Issues regarding monitoring were raised for Indonesia since the country has initiated scaling-up activities in this area. It was pointed out that monitoring had been started, though not nationwide.
- As countries like India and Indonesia have large adolescent populations living in rural areas, issues regarding coverage of rural areas were also discussed.

Group work

The key issues that emerged from group work on services and commodities were:

- Programmes for adolescents should provide them with health services and commodities they need to achieve clearly-defined health outcomes.
- Political commitment along with commitment from all key stakeholders involved in adolescent health and development is imperative.
- In order for adolescents to be successful in schools, the community has to be linked to various health service facilities.
- Focus needs to be established on specific settings to reach vulnerable adolescents, such as the workplace and factories.
- The settings will vary according to the specific adolescent population to be reached e.g. health-centre based; school-based, workplace-based and community-based.
- The involvement of adolescents themselves in determining the organizational aspect of these health services is crucial for their success.
- All efforts should be made to make service-delivery points appealing and user-friendly.
- The package of health services should be based on epidemiological data and evidence.

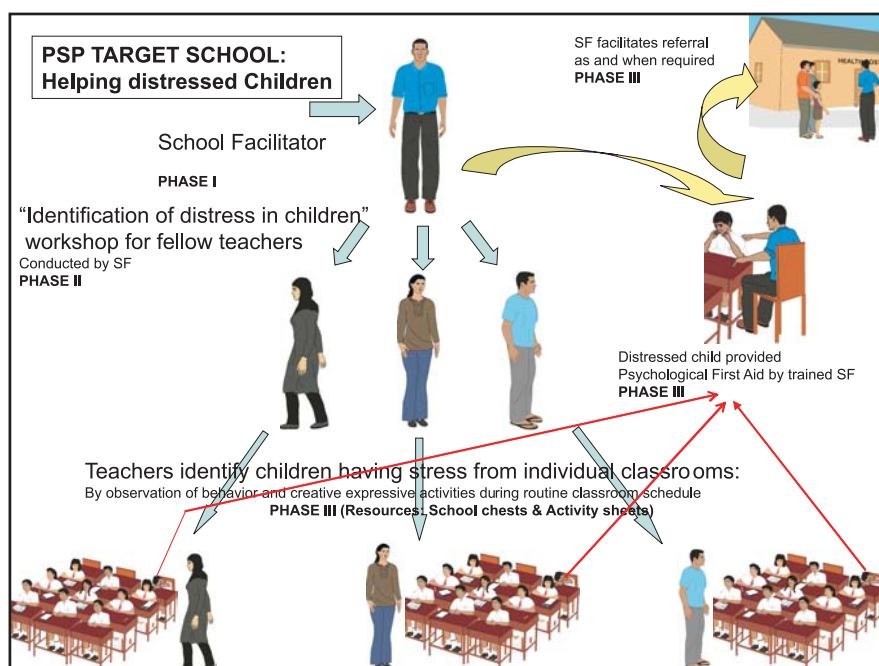
- Build capacity of health workers and support staff to make them sensitive to the needs of adolescents.
- Promote adolescent demand for health services and commodities they need and community support for their provision
- Monitoring the quality of services will have to be built into the programme to inform it and make necessary adjustments as required.
- Cultural sensitivity should not be ignored.

7.4 Strengthening other sectors

Country presentations

Maldives: Ms Nizma Hawwa, Project Officer, Department of Public Health, Ministry of Health.

Ms Hawwa summarized the contribution and collaboration of the health sector along with the other sectors in the promotion of adolescent health through the Adolescent Sexual and Reproductive Health (ASRH) Project in Maldives. Adolescents and the youth comprise almost 40% population of Maldives.



Adolescent health problems such as smoking and substance abuse are rising. It is estimated that 13% smokers start smoking during the ages of 13-17 years, while more than 10% youth are involved in substance abuse. Early marriages, unwanted pregnancies and increasing incidence of STIs also are areas of concern. Statistics show that the current period is crucial for policy intervention and strengthened programmes that meet the needs of adolescents and the youth in Maldives are needed.

INVOLVED ORGANIZATIONS AND DEPARTMENTS

- Ministry of Health
- Department of Public Health
- Ministry of Education
- Ministry of Justice
- Ministry of Youth and Sports
- National Narcotics control Board
- NGOs such as “Journey” for recovering drug addicts and “SHE” for youth counseling
- WHO, UNICEF, UNFPA, UNDP and other UN agencies

The ASRH project was developed to increase awareness of health among young people. Under the project different sectors were assigned different activities for promoting adolescent health. The ministries/departments and organizations involved were- the Ministry of Health, Department of Public Health, Ministry of Education, Ministry of Justice, Ministry of Youth and Sports, National Narcotics Control Board, NGOs and UN agencies. Some of the initiatives that involved these sectors were:

- National campaign for drug users- “Wake up” initiated by the Ministry of Youth in collaboration with UNICEF.
- Development and implementation of lifeskill packages in schools.
- Training of 226 lifeskill facilitators from 2006 to 2007.
- Training of 31 peer educators – they reached out to 1114 youths within six months of their training.
- Establishment of pre-marital thematic sessions under the guidance of the Ministry of Justice.
- Establishment of an adolescent health clinic in the Indira Gandhi Memorial Hospital.
- Measles and Rubella (MR) vaccine and Tetanus Toxide (TT) vaccine programmes were conducted for adolescents.

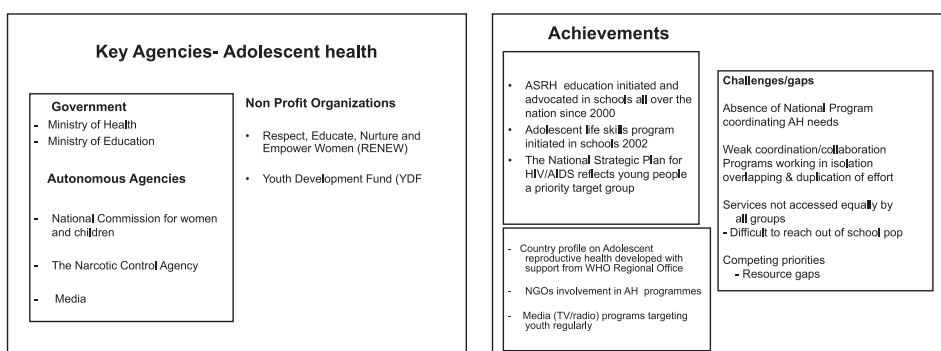
The Ministry of Education gave high priority to adolescent health through its “Maldives Health Promoting Schools Initiative”. Ms Hawwa informed the participants how these schools help distressed children. Phase one constitutes training of the school facilitator. In the second phase workshops for fellow teachers are conducted to help them identify distressed children. In phase three

teachers identify children suffering from stress in their classrooms by observing their behaviour and activities. The distressed child is then provided psychological first aid by the school facilitator. He/she also facilitates referral as and when required.

The presentation concluded with the suggestion that working together with other sectors leads to better and broader range of activities. Technical and financial support is easily available when activities are conducted in collaboration.

Bhutan: *Dr Sonam Ugen, Joint Director, Department of Public Health, Ministry of Health*

Dr Ugen outlined the activities of key agencies involved in adolescent health and development in Bhutan. Primarily comprising rural-based population, Bhutan has more than 60% young people. Emerging health challenges among adolescents include drug and alcohol abuse, teenage pregnancies and STD/HIV/AIDS. Other problems like juvenile delinquency and prostitution are also increasing. The government is the sole provider of health services and basic



health care is free of cost for all citizens. Currently there is no national adolescent policy/strategy or specific programme comprehensively addressing adolescent health needs. However, a number of programmes directly or indirectly address adolescent needs of health and development. The focus areas for adolescents include health, education, livelihood, law, sports, culture, family and community, etc.

Development activities for young people are undertaken by the Government of Bhutan and donor agencies. Within the government, the Ministry of Health and the Ministry of Education have programmes addressing adolescent health. The Department of Public Health has initiated a number of activities for

adolescents by collaborating with UN agencies for financial and technical support. Collaborations with NGOs have been initiated for implementation. Some of the programmes are: Comprehensive School Health Programme; Mental Health Programme; HIV/AIDS programme and Reproductive Health programme. The Ministry of Education through its collaboration with the Ministry of Youth and Sports is providing education, awareness and training in relevant areas. For out-of-school youth, a non-formal education programme is running in 646 centres in rural Bhutan. Autonomous agencies like the National Commission for Women and Children are working for the rights of women and children. As drug abuse is a growing problem, the Narcotics Control Agency is providing services such as counselling and detoxification programmes for adolescents. NGOs like Youth Development Fund and RENEW (Respect, Educate, Nurture and Empower Women) are also providing counselling and rehabilitation services to marginalized adolescents.

Dr Ugen shared some of the achievements of these collaborative efforts. Advocacy for adolescent sexual and reproductive health issues resulted in the initiation of ASRH education in schools in 2000. In 2002 adolescent lifeskills programmes were also introduced in schools. A country profile on adolescent reproductive health was developed with support from the WHO Regional Office. The National Strategic Plan for HIV/AIDS reflects young people as a priority target group. Over a period of time involvement of NGOs has also increased in adolescent health programmes. Mass mediums like TV and radio now have regular programmes targeting the youth.

In conclusion some of the challenges and gaps were identified. The foremost is the absence of a national programme for adolescents. Another limitation is the weak coordination/collaboration among ministries and agencies. A number of programmes are working in isolation resulting in overlapping and duplication of efforts. Services are not accessed equally by all groups of adolescents, especially the difficult-to-reach and the out-of-school populations.

Discussion

- Collaboration with many partners does not always lead to success. At times, working with one partner can lead to concrete results. For example in Maldives collaboration between Ministries of Health and Education has resulted in the Ministry of Education developing a life skills package.
- For developing a strategic plan for adolescent health it is important to bring together key stakeholders.

- In Bhutan and Maldives there is a focus on spirituality. Spiritual and religious organizations may have a unique contribution to adolescent health outcomes.
- Commitment is needed to reach out to adolescents who are in poverty or in conflict situations or are living without parents.
- Initiative is needed to disaggregate data by age and sex to generate evidence for policies and programmes and move from “words to action.”
- In India strengthening of National Service Scheme and Nehru Yuva Kendras has received emphasis. However, there is need to utilize their services for generation of community awareness and education programmes.

Group work

The key issues that emerged from group work on strengthening and supporting other sectors were:

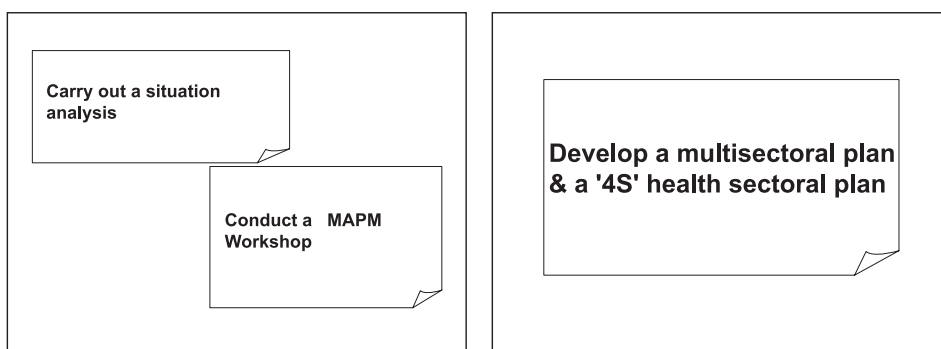
- The groups felt that the guiding principle will be “thinking comprehensively but acting selectively” in choosing partners and sectors. The purpose will be to engage and support other sectors to maximize their contribution to adolescent health and development.
- Certain settings to reach adolescents like schools will require stewardship role from education departments but health sector can support in providing skills-based health education.
- Supporting community-based organizations and local self-government in building the capacity of parents and community leaders to improve adolescent health and development.
- Pooling of resources and their effective utilization based on a shared understanding of adolescent issues. Health sector should play the advocacy role.
- The group underscored the need for strengthening and supporting other sectors realizing its own limited sphere where it has control and influence and spheres where it does have influence but no control and yet larger spheres where it has neither influence nor control.

Systematic approach to scaling up

8.1 Situation assessment

Introduction

Situation analysis is the first step for systematic scaling up. This involves reviewing the available data and identifying gaps. Often the existing data are not organized in a way that can point to public health action. Consequently they are not used for advocacy or planning for public health action. On the basis of situation assessment, the MAPM framework can be used to design interventions. The subsequent development of a multisectoral plan is imperative, along with a '4S' health sectoral plan.



Country presentation

Sri Lanka: Dr Ayesha Lokubalasooriya, Consultant Community Physician

Dr Lokubalasooriya summarized the situation of adolescents in Sri Lanka. Young people of the age group of 10-24 years constitute 28% of Sri Lanka's population

How do we assess?

- Routine data from School Health Programme
- Morbidity & mortality data from hospitals
- Special surveys and studies
- Census

Knowledge on Reproductive health

- 70% of 10-13 year olds not aware of physiological changes
- 14-19 year olds < 50%
- Knowledge on the risk of conception and signs of pregnancy < 25%
- Out of school – had a better level of knowledge than school children. More aware of contraceptive methods

Knowledge and attitudes on STI/HIV/AIDS

Only 57% aware on existence of STI among school children
Out of school less than 50%

Sexual Behavior

14-19 year olds ; 6% heterosexual
10% homosexual

Prevalence of hetero sexual experience: Boys 10%
Girls 2%

of which 19.7% are adolescents (10-19 years). It is projected that the adolescent population of Sri Lanka will hover around three million during the next two decades.

Numerous factors make adolescents in Sri Lanka more vulnerable to health risks. The extended conflict situation in the country over the past two decades has led to large number of internally displaced adolescents. Poverty and lack of livelihood in the country has forced many women to migrate to West Asian countries for employment, consequently leading many adolescents to grow up in single-parent families. Large-scale urban migration has also increased the number of adolescents staying in urban slums in poor conditions. Media exposure and changing lifestyles have led to the emergence of problems such as alcoholism, prostitution and violence. Another large group of vulnerable adolescents are those who have been orphaned by the tsunami. Out-of-school and street adolescents also face higher health risks.

For a situation analysis of adolescents in Sri Lanka, information from different sources was collected and studied. These included data from the School Health Programme, morbidity and mortality data from hospitals, special surveys and studies and the census report. Adolescent health problems were identified in the areas of sexual and reproductive health, substance abuse, nutritional problems, mental health disorders and other common health problems. Some of the reproductive health issues highlighted were the declining age of menarche (13 years) and the rising average age of marriage for girls (28 years) which has led to an increase in the fertile period before marriage. Sexual initiation is early for both boys and girls, at 15.3 years and 14.4 years respectively. About 2%-3% of girls and 10%-14% of boys in the 14-16-year age group reported having sexual experience. Teenage pregnancy varies from 2%-20% in different districts of the country. Problems of maternal mortality and morbidity, low birth weight babies and infant mortality also exist. About 20% of maternal mortality is due to abortions (2005). Social stigma attached to accessing contraceptives before

marriage acts as a major deterrent for young people. The incidence of substance abuse is also increasing, with 18% of boys and 6% of girls reported having used tobacco, 23% boys and 10% girls having alcohol and 3% of both having consumed other narcotic drugs. Other problems include anaemia (22%), under-nutrition (30-50%) and obesity (2%). Mental disorders such as depression are also common.

Dr Lokubalasooriya also shared some key findings of a UNICEF study (2004) on in-school and out-of-school adolescents. The study revealed that adolescents live with considerable pressure from their families to achieve in the academic sphere. Almost 40% of adolescents said they found it stressful to cope with this academic pressure to perform. Poor life skills and factors such as unemployment affect the well-being of adolescents. The family and social environment also gave rise to causes of stress for adolescents. Thirteen per-cent of all school-going adolescents felt some sense of insecurity at home while 23% felt insecure about their living environment. The study showed that almost 70% of younger adolescents (10-13 years) and 50% of older adolescents were not aware of the physiological changes that take place during this stage of their life. Less than 25% had any knowledge of the risks of conception and signs of pregnancy. In comparison, out-of-school adolescents had a higher level of awareness on these issues. Knowledge of STIs was low in both the groups. Adolescents reported both heterosexual and homosexual experiences. A higher percentage of boys (10%) reported both kinds of experiences as compared to girls (2%). Almost 10%-14% of adolescents reported being sexually abused and the study revealed that the perpetrators in most cases were family members. Sixty five per-cent of younger adolescents and 38% of older adolescents reported some family member as the abuser.

A brief on adolescent health services in Sri Lanka was also shared. There are 16 centres for Youth Friendly Health Services and some youth services are also run by NGOs. There are special projects on HIV/AIDS, dengue, other common diseases, mental health, etc. There are few small-scale projects for adolescents in conflict-affected areas. The state and the private sector hospitals provide health care for basic illnesses.

Seventy percent of adolescents in Sri Lanka are enrolled in school and the School Health Programme operates in 9700 public schools. A new School Health Programme has been introduced (December 2007) and is a joint activity of the Ministry of Health and the Ministry of Education. As part of this programme all state schools will be evaluated by a set of indicators on health and development issues. School health clubs will be strengthened to improve the participation of children in life skills education and health promotion activities.

Discussion

- The situation assessment in Sri Lanka revealed that AFHS centres which are not easily accessible are not utilized.
- The strategy to deal with psychosocial issues, mental health, etc. is by the training of teachers and medical officers so that they acquire the right communication skills to support stressed adolescents. Medical officers at the community level and teachers at the secondary school level are being trained to provide psychosocial support.
- Studies reveal that adolescents, especially younger adolescents, have very little knowledge on issues relating to reproductive and sexual health. Life skills education is needed to increase knowledge on RH issues.
- Special attention needs to be given to regional variations within the country. For example, some cultural pockets in Sri Lanka are not ready to accept certain modules and contents of programmes for adolescent health.
- Multisectoral plans need to be developed.
- An in-depth understanding of life's circumstances, concerns and the priorities of young people is required.
- Promote participation and ongoing involvement of adolescents.
- Findings from such assessment can contribute to modification of services and policies and developing community activities.

Group work

The key messages which emerged from the group work are:

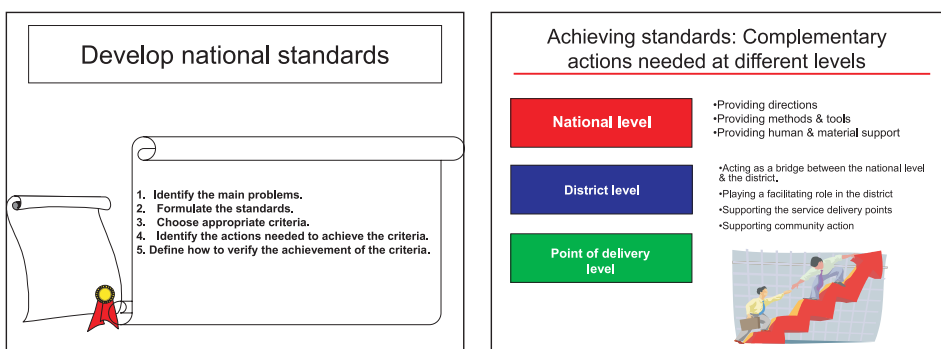
- The need to agree on a common framework for assessment and adaptation as per country need. MAPM can be used instead of using an adhoc framework.
- Data needs to be collected, analysed and used for advocacy and select relevant programmes on adolescent health issues. Available data, both national and regional, must be reviewed to identify gaps.
- Secondary analysis of data for specific indicators is needed.

- A steering committee could be established to lend expertise to the committee and guide data collection.
- Programmes must be reviewed to determine if the interventions in place may be expected to achieve the desired behavioural and health outcomes.
- The system must not be overloaded through the collection of unnecessary details.
- Multisectoral collaboration needs to be strengthened and data from different sources that affect the programme needs to be used for evidence base and advocacy.

8.2 Developing National Standards

Introduction

Certain prerequisite criteria have to be fulfilled to develop national standards. These include the identification of the main problem, which implies that it is necessary to establish the basis for the development of the standards based on policies and strategies; programmatic openings; country experiences in providing health services to young people; and experiences with quality improvement in public health. The second step is to formulate the draft standards. While formulating the standards it is important to define what needs to be done to achieve them. To achieve the desired draft standards, complementary actions are necessary from the national, state and district level. The next steps involved are to define how to verify that activities are proceeding as planned and determine whether adolescents are using the health services they need.



Country presentations

Bangladesh: Dr S.M. Abul Khayer Miah, Deputy Director, Primary Health Care, and Programme Manager, Directorate-General of Health Services

The developing process

Led by: MOH&FW, Govt. of Bangladesh
Supported by: WHO, Save the Children (USA) and National AIDS/STD Program
 Strategic workshop held on December 2004
 Workshop stimulated inter-agency collaboration
 National workshop on "Standard Development of Youth Friendly Health Services" April 2005
 Experiences of RHIYA-UNFPA projects
 Technical support from: WHO, USAID

Achievement

1. Formulation and dissemination of national standard
2. Organized:
 - AFHS workshop at district level involving health managers, supervisors, service providers and local elites
 - Orientation of health managers and service providers on national standard with special emphasis to need of young irrespective of gender, status and culture

Dr Miah summarized the process of developing national standards to improve the provision of health services and the utilization of services by young people in Bangladesh. The main reasons for developing national standards were identified to be:

- Health services not being truly youth friendly
- Recognition of the need to provide comprehensive YFHS I
- Inhibition of young people to discuss reproductive health issues
- Lack of privacy and confidentiality at health service delivery points

Furthermore, gate keepers were believed to be not sensitized to adolescent reproductive health issues and there was a perceptible lack of awareness among service-providers about YFHS.

The process of development of the national standards was led by the Ministry of Health and Family Welfare and supported by WHO, Save the Children (USA) and the National AIDS/STD Programme. The developing process included a strategic workshop held in December 2004 and a national workshop on "Standards Development of Youth-Friendly Health Services" held in April 2005. The experiences of the RHIYA-UNFPA projects were drawn from.

The national standards developed for YFHS are:

- Gate-keepers promote and support the use of YFHS by all young people.

- Young people must know where they can get YFHS.
- Young people must feel comfortable with surroundings and procedures of the HSDPs.
- All young people visiting HSDPs receive services that are provided in a respectable manner.
- All young people who visit HSDPs are dealt with in an equitable manner irrespective of their status.
- The privacy and confidentiality of all young people who visit HSDPs is maintained.
- Service-providers are motivated to provide health services to young people in a youth-friendly manner.
- HSPs provide appropriate services to all young people.
- HSDPs deliver effective services to young people.
- HSDPs collect, analyze and use data on young people to improve the YFHS.

Following the formulation and dissemination of the national standards, an AFHS workshop at the district level involving health managers, supervisors, service-providers and local decision-makers was organized. In addition an orientation of health managers and service providers on national standards with special emphasis on the needs of young people irrespective of gender, status and culture was also held.

Sri Lanka: *Dr Dula de Silva, Deputy Director-General, Public Health Services, Ministry of Health*

Dr Dula de Silva outlined the process of development of national standards and guidelines in Sri Lanka. YFHS was initiated in 2002 in Colombo South Hospital. By 2006 there were 11 YFHS centres. The state identified the need to develop standards and guidelines to address equity and fairness. A chronological overview of the milestones which facilitated the mainstreaming of the process was shared. Initially a Steering Committee was set up to develop guidelines. Consultations with key stakeholders were held in 2005 followed by consultation with young people in March 2006. After all stakeholders had arrived at a consensus, a Drafting Committee was formulated to finalize the standards. The five YHFS standards are:

- **Facility:** The facility is accessible and acceptable to young people. It is well managed and has the required equipment to provide YFHS.

Five YFHS Standards

I. FACILITY

The facility is accessible and acceptable to young people. It is well managed and has the required equipment to provide YFHS.

II. SERVICE PROVIDERS AND SUPPORT STAFF

Service providers and support staff have the required competencies and positive attitudes to handle young people effectively.

III. SERVICE PACKAGE

The basic health service package is provided in an effective manner.

IV. INFORMATION SYSTEM.

YFHS centers gather, analyze, maintain records and use data to improve service provision.

V. DEMAND GENERATION ACTIVITIES

Publicity, outreach and community participation activities

Physical environment

- Name board-with YFS logo and directions
- If SP proves that YP get adequate audiovisual privacy. (arrangement)
- IEC resource corner with other reading materials.
- Display- notice board
- Equipment/ models, chairs, book rack, height measuring tape/device, weighing scale
- suggestion box and happy sad box
- Times open- No of hours open (minimum of 2 hrs/per week)
- First aid box
- Access to toilets and clean water

- Service-providers and support staff: Service-providers and support staff have the required competencies and positive attitudes to handle young people effectively.
- Service package: The basic health service package is provided in an effective manner.
- Information system: YFHS centres gather, analyze, maintain records and use data to improve service provision.
- Demand generation activities: Publicity, outreach and community participation activities

Dr Dula further described in detail the requirements for the YFHS standards. For example, the health facility should display the YFS logo and direction prominently. The services provider at the facility ensures that the young client gets adequate audiovisual privacy. The physical ambience should be pleasant with facilities such as clean toilets and running water. Display notice board, suggestion boxes, reading material, equipment/models, chairs, bookrack, height measuring tape/device, weighing scale, etc. should be available. The centre should be open for a minimum of two hours per week. At least one service-provider should be specially trained on youth-friendly services and reproductive health issues using the training module developed for YFS. They should have a positive attitude towards young people and possess good communication skills. The basic health services package should include relevant information, guidance counselling, clinical services, condoms, etc. The information system should maintain a database, records and a client information card (mentioning age and sex). The services are to be catered according to the suggestions offered by the clients. Quarterly review meetings should take place at the centres and self-evaluation practices should be initiated. Planning of awareness, advocacy and outreach programmes should be conducted for demand-generation activities.

A monitoring matrix was developed to evaluate the implementation of the standards. Activities are continuously being evaluated and monitored. A monthly audit takes place by using a mystery client on social or clinical issues.

Discussion

- In the absence of national standards, the initiatives which are undertaken remain inadequate in terms of quality and coverage of services.
- Plenty of emphasis needs to be laid on building consensus among influences, politicians and policy-makers. Meeting and involving adolescents is also important.
- Setting and implementing standards and criteria improves the quality of adolescent services in clinics.

Group work

The key messages which emerged from the group work were:

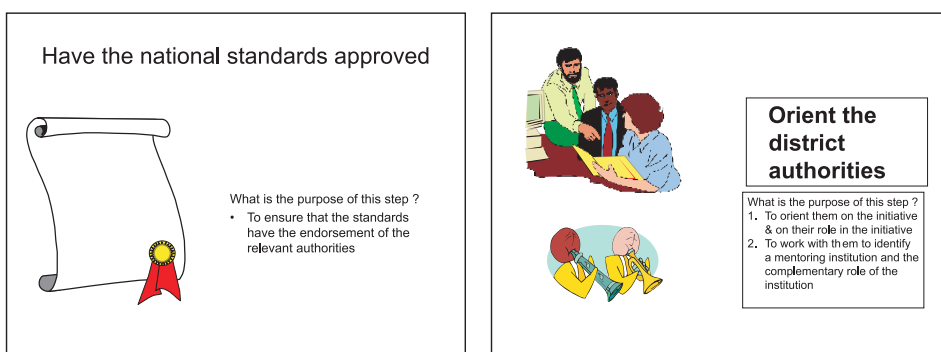
- Develop standards in the overall context of quality of services.
- Develop standards based on the implementation of existing services for adolescents and link it with the larger health development context.
- After the standards are developed one needs to ensure that these are applied and evaluated. Targets need to be time-bound and quantified.
- Involve all key stakeholders and develop consensus among key stakeholders in developing national standards for adolescent/ youth-friendly health services through a consultative process for ownership. Adolescents themselves should also be involved in developing standards.
- Countries should learn from each other and be open to adapting from best practices in other countries.
- Do not ignore social and cultural sensitivities.
- Raise awareness among the public and adolescents about the availability of standard driven services. Empower adolescents to use it. The community should be mobilized to generate a demand for the services.

- Service-providers should be motivated and have the requisite skills and expertise to deal with adolescents.
- Internal and external monitoring can lead to greater precision.

8.3 Implementing national standards on adolescent/youth friendly health services (AFHS/YFHS)

Introduction

Application of national standards requires that certain prerequisite actions be taken at the national and district levels. Approval and endorsement of standards at the national level by the relevant authorities is a must. To support the implementation, the influence, expertise and financial support of key stakeholders is vital. In order to ensure that the district health management teams and managers of health facilities are clear about the application of national standards, tracking implementation, and measuring quality, coverage and utilization, an operational manual needs to be developed. A set of training and self-learning materials and job aids should be adapted to build the capacity of health service-providers to respond to their adolescent patients effectively and with sensitivity.



The actions to be taken at the district level to apply the national standards include selecting a small number of districts with the potential to succeed in applying the standards successfully. For these, district authorities and the managers of service delivery points need to be oriented on the initiative and their role. Together with the centre they need to identify a mentoring institution and identify its role. Community leaders also need to be sensitized for their support. The district health management team and the mentoring organization

assists the manager of the service delivery point and their staff in assessing and improving quality on an ongoing basis. On the basis of the pilot assessment, it should be decided how to scale up services in a phased manner. Periodic reviewing of experiences and building on the lessons learned will show the way forward.

Country presentations

India: Mr Chaitanya Prasad, Director (IEC), Ministry of Health and Family Welfare

Mr Prasad outlined the institutional mechanism under which the adolescent programme was being implemented as a technical component of RCH II under the National Rural Health Mission. The strategy and key interventions were touched upon along with the backdrop in which the national standards were developed in India. Each standard was discussed in detail in the context of the

Launch of National Standards and Training Package

- Launched by Secretary, Health on 9 May 2006
- Dissemination to State programme managers, CBOs, NGOs, Professionals....



Implementation at district level

- Identification of districts for implementation in the first phase
- Orientation of district managers in state planning meetings
- Facilitation of developing district action plans to implement services under ARSH

operational mechanism and the level of implementation in the country. As far as the standard for service packages was concerned a detailed analysis of the strategy was adopted to expand the outreach of services through training workshops. This included outcome indicators to position the relevance of demand generation in the context of ARSH. The presentation also highlighted the standard for training package in the context of health providers and development of IEC material on adolescent issues. Along with the standard on monitoring and evaluation, the efforts of the government to incorporate ARSH in routine MIS was touched upon. Efforts are also being made in the direction of piloting tools for assessment of cost and quality of services. The initiative of the government to incorporate MIS indicators was also presented in the form of efforts undertaken with relation to national and sub-national surveys in the country.

The second section of the presentation described the initiative of the government in supporting the implementation of ARSH services at the district level. The strategy for a district-level training programme was highlighted along with the matrix for state ToTs. The case study of Haryana and West Bengal was presented to explain the implementation of approved standards at the district level where WHO provided technical and financial assistance. Two specific case studies for operationalizing AFHS using the ARSH implementation guide was given. The objective was to demonstrate the doability of operationalizing AFHS as per the implementation guide. The example of Haryana included a detailed account of the baseline assessment of health facilities, selected locations and the innovations adopted to increase utilization of services, and the kind of services provided.

Indonesia: *Dr Rinni Yudhi Pratiwi Toeloes, MPET, Chief, Sub-directorate of Adolescent Health, Directorate of Child Health, Directorate General of Community Health.*

Dr Rinni in her presentation on implementation of national guidelines of AFHS in health centres of Indonesia provided a chronological overview of the steps taken to augment capacity-building in the country since 2003. She then highlighted the planning process in administration to expand AFHS facilities in the country. Using the example of the East Bogor AFHS health centre she pointed out that the number of adolescent cases increased dramatically where previously no adolescent cases were reported since the implementation of AFHS guidelines. The impact of the introduction of standards was on services initiated and outreach enhancement for different critical segments such as training peer counsellors and teachers. For implementation of standards technical assistance was provided by WHO and financial support came from both the Central and the local government. Tools utilized were training modules and aids and supervisory tools.

IMPLEMENTATION OF NATIONAL GUIDELINES OF AFHS IN HEALTH CENTERS

Capacity Building

YEAR	ACTIVITY	TARGET AREA
2003	•Training for Master Trainers on AFHS •Training of Trainer of AFHS	National level 2 Provinces , 10 Districts, 50 HCs
2004	•Training of Trainer of AFHS	11 Province 12 District, 20 HCs
2005	•Training of Trainer of AFHS •Socialization AH Planning in districts	10 Provinces, 10 districts 6 provinces, 6 Districts
2006	•Training of Trainer on AFHS •Orientation of Planning Guidelines •Supervisory on AH Planning in districts	16 Provinces 7 provinces (multisectoral and program) 6 provinces, 6 Districts
2007	•Training of Trainer of AFHS •Training of Trainer of AFHS	8 provinces 9 provinces

Achievement

At Health Centers (example East Bogor AFHS HC)

- Previously no cases were reported, since the standard implemented, the following result
 - Population of age group 10 – 19 years : 12,047 out of 54,172 (22.24%)
 - Schools : 25 Elementary, 6 Junior High Schools, 10 Senior High Schools
 - Adolescent Visit to Health Center / month: 244 (7.4%)
- Services in HC:
 - ☞ 3days/ week – Tuesday, Thursday, Saturday (8 a.m – 1 p.m) and with appointment
 - ☞ Counselling, Basic treatment, Referral
- Outreach
 - ☞ Net program for junior and senior high school
 - ☞ Training for peer counselor in school and out of school (Youth movement and street children)
 - ☞ Training for guidance and counselling teacher
 - ☞ FGD, Small survey, interactive consultation through radio program, school orientation program, seminar etc

As a guidance note to other countries it was suggested that advocacy and socialization of the standards to obtain involvement of local stakeholders was important. Building supervisory and problem-solving capacity at the provincial and district level is also critical. For successful implementation generalization in implementing standards should be avoided and all the components of the standard should not be implemented at the same time.

Discussion

- Valuable lessons can be adopted from studies such as that conducted in Haryana (India).
- Pilot projects are important for testing feasibility.
- Some of the challenges discussed were with regard to sustaining training, capacity development and motivation of providers.
- Increased collaboration is required within the health sector – RCH, HIV/AIDS, nutrition – and intersectoral collaboration – education, women and child development, youth groups, village health and sanitation committees.
- There is a need to ensure uninterrupted adolescent-specific supplies.

Group work

The key messages which emerged from the group work are as follows:

- Standards: Make sure relevant standards are in place to ensure quality services, smoother transition and community participation.
- Exchanging experiences: Learnings from other countries, translate experiences from other countries.
- Getting started: Phased rollout with benchmarking; even in the absence of national standards AFHS can still be implemented.
- Partners and participation: Don't exclude partners; encourage community and adolescent participation.
- Scaling up: Scale-up in select areas according to needs, human resources and commitment; do not start with large-scale implementation; do not scale up without testing feasibility; select and use pilot projects to examine feasibility
- Monitoring: Do not expand without monitoring; periodic monitoring is important.

Capacity-building of programme managers for HIV/AIDS and reproductive health programming for young people in South and South-East Asia

Dr R.S. Goyal, Indian Institute of Health Management Research, Jaipur, India

Dr Goyal provided an overview of the programme managers' course titled "Capacity-building of Programme Managers for HIV/AIDS and Reproductive Health Programming for Young People in South and South-East Asia". The course was initiated keeping in view identified gaps in programming capabilities at the district and provincial levels. Capacity-building was particularly needed in the sphere of: programme planning, scaling up of interventions, programme implementation, monitoring and evaluation. Training modules were developed with the support of WHO/SEARO, UNFPA and others. As a part of these initiatives, IIHMR, Jaipur, organized a pilot training programme in December 2006 with support from UNFPA, WHO, CEDPA, Engender health, RCSHA, Child Development centre and other development partners. The objectives of the training programme were to strengthen management capabilities at the district and state levels for

Objectives

To strengthen management capabilities at district and state levels for programming for HIV/AIDS, sexual and reproductive health of young people including adolescents.

This course was designed to impart state-of-the-art knowledge and skills for designing and delivering efficient, equitable and financially sustainable HIV/AIDS and SRH interventions.

programming for HIV/AIDS and the sexual and reproductive health (SRH) of young people including adolescents. This course was designed to impart state-of-the-art knowledge and skills for designing and delivering efficient, equitable and financially sustainable HIV/AIDS and SRH interventions. The course was attended by 20 participants from Afghanistan, India, Nepal and Sri Lanka representing governments,

NGOs, UN bodies and technical institutions. Issues dealt with adolescent and reproductive health in the SEA Region, supportive evidence for policies, defining priorities for action, project cycle management (PCM), result-based management (RBM), management information system (MIS), operational management/implementation and monitoring and evaluation. The course was delivered by trainers from WHO, UNFPA, IIHMR, CDC and RCSHA.

A follow-up workshop was held in Trivandrum in July. 2007 to review the feedback and lessons learned. The course objectives were then redefined to focus on identifying and prioritizing HIV/AIDS and SRH issues; to design operational plans for addressing the HIV/AIDS and SRH needs of young people;

to develop programme management skills for implementing evidence-based strategies and for monitoring and evaluation of the programme. Accordingly, the course content was also modified. The emphasis was now more on evidence-based strategies and components of HIV/AIDS and SRH programming for young people and effective management. In programme planning the focus was on situation analysis, MAPM, resource planning, strategic communication, and monitoring and evaluation. Within capacity-building the focus was on needs assessment and planning where the training was needed and what the local needs were.

Dr Goyal also informed the participants about the next course which would be held during May 2008 at IIHMR, Jaipur. The focus would be on capacity-building of district and state-level programme managers. Case studies and real data would be used for enhancing skills. During the programme participants would be encouraged to develop strategies for implementation. He also invited all WHO representatives to facilitate the participation of programme personnel from their countries in this training.

8.4 Monitoring the implementation of approved national quality standards

Introduction

Planned activities should be carried out at the national, state and district level in terms of input, output and process criteria. It is critical that these activities lead to improvements in the quality of services at the local level and are utilized by adolescents. To take the adolescent health agenda ahead strategic entry points such as substance use, mental health, nutrition, intentional and accidental injuries, HIV/AIDS, prevention of early pregnancy, prevention of deaths during pregnancy and childbirth, can be used to improve the health and development of adolescents.

Country presentation

Bangladesh: *Dr S.M. Abul Khayer Miah, Bangladesh (MoH/SCF)*

Bangladesh has been successful in formulating and implementing a plan for monitoring the implementation of approved national quality standards for youth-friendly health services. In his presentation Dr Miah gave a description of what is being monitored and how it is being done. This process seeks to monitor whether young people of Bangladesh are aware of the availability of YFHS and

Monitoring is being done

Methods:

- Record Review
- Observation
- Individual Interview
- Spot check
- Focus group discussion
- MIS

where to access it. The comfort level of the young clients and the degree of privacy, confidentiality and equity maintained by the health providers while providing the services was monitored. The kind of services provided to young people in terms of prevention, treatment and care at the health service delivery points (HSDP) was also monitored. In addition, it was observed whether the key players in

the adolescent's life (gatekeepers) are aware of the availability of YFHS and whether they are supportive of the concept and are comfortable promoting it.

Methods used for monitoring were record review, observation, individual interview, spot check, focus group discussion and MIS. The HSDPs at the district level were monitored monthly and quarterly at the national level. Monitoring was carried out by the District Management Committee; the Ministry of Health and Family Welfare; HASAB consortium¹; partner NGOs and other private organizations. It was supported by WHO, Save the Children (USA) and USAID.

Prevention of HIV and AIDS among young people in Bangladesh

Dr Neena Raina, WHO/SEARO

Objectives of the process evaluation

- To understand the changes that occurred, the lessons learned, the challenges faced, the trouble shooting strategy employed
- To review the assessment of facilities, selection of health centres, training of service providers
- To document functional interlinks among facilities across layers with ACY (Accessing Condoms for Young People) & LSE (Life Skills Education)
- To document the processes executed at different levels & generate learning from the process documentation
- To assess the process indicators
- To compare between health facilities with special corner & no special corners

Dr Raina provided a review of the report of process evaluation of YFHS, which was carried out in June 2007 in collaboration with the National AIDS/STD Programme, Ministry of Health and Family Welfare and Save the Children, USA. She informed the participants that currently the project is in Phase 1 and covers 23 health facilities and that Phase 2, which will cover 100 health facilities, is to be

undertaken. The objectives of the process evaluation were:

- to understand the changes that occurred, the lessons learned, the challenges faced and strategy employed to overcome the hurdles;

¹ HIV/AIDS and STD Alliance Bangladesh (www.hasab.org)

- to review the assessment of facilities, selection of health centres, training of service-providers;
- to document functional interlinks among facilities across layers with ACY (Accessing Condoms for Young People) and LSE (Life Skills Education);
- to document the processes executed at different levels and generate learning from the process documentation;
- to assess the process indicators; and
- to compare between health facilities with special space for adolescents and those with no special space for adolescents.

Methods used for evaluation were document review, field visits and interviews with key informants. Field-testing settings were hospital, pharmacy, NGOs and private clinics.

The Bangladesh YFHS consisted of 10 standards. Taking the example of the standard on delivering effective services to young people by Health Service Delivery Points (HSDPs), Dr Raina highlighted what the input criteria were and what the assessment found. For example, for the input criteria: *Equipment, supplies and basic services needed to provide the specified health services are in place – Basic services (i.e. water, sanitation and electricity) are in place*; the assessment findings showed that though basic services were available in all HSDPs, a water filter was not found in many HSDPs. There was no examination light and not even a torch available in many places. There were no specific guidelines about minimum supplies or equipment. Certain recommendations were made on the basis of such findings. For example, it was recommended that a basic list of equipment and supplies should be provided. One of the main lessons learnt through this process was that a quality measurement criterion provides a clear basis for monitoring progress. Monitoring also points to the level at which actions have been taken and what corrective actions are required.

Measuring coverage: Access to health services for young people

Dr Krishna Bose, WHO/HQ

Dr Bose in her presentation highlighted the concept of coverage in the context of young people. Taking the example of the coverage of health services for HIV prevention for young people, she explained that such coverage would mean the number of young people (aged 15 to 24 years) for whom services are available/accessible/acceptable or being used by them, divided by the number

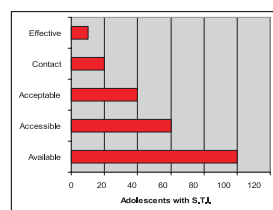
Definition of Coverage

COVERAGE of health services for HIV prevention for young people is

The number of young people (**aged 15 to 24 years**) for whom services are available/accessible/acceptable or being used by them

divided by the number of young people who need the services (**e.g. Young people aged 15 – 24 years who are sexually active**)

Tanahashi Conceptual Framework For Coverage



[1] Tanahashi, 1978, "Health service coverage and its evaluation," *Bulletin of the World Health Organization*, 56(2):295-303.

of young people who need the services (e.g. young people aged between 15 to 24 years who are sexually active). The Department of Child and Adolescent Health of WHO has adopted a framework for assessing coverage, based on the classic *WHO Bulletin* paper of Tanahashi² that provided a conceptual and operational definition of "coverage" for use in programme delivery and assessment. *Tanahashi* has defined "coverage" according to the availability, accessibility, acceptability and contact and effectiveness of health services with clients. For young people, the same classifications are being used to define their coverage by prevalent health services. The different ways of estimating coverage are:

- Availability coverage: The percentage of young people for whom the service is available.
- Accessibility coverage: The percentage of young people who can reach and use the service.
- Acceptability coverage: The percentage of young people who are willing to use the service.
- Contact coverage: The percentage of young people who actually use the service.

In her presentation, Dr Bose reiterated that increasing access to health services for young people is one of the UNGASS goals for HIV prevention. To take forward this objective it is necessary to measure the access (coverage) of health services for young people at the – global, national and sub-national level. She added that existing survey questionnaires, including MICS, DHS and BSS – do measure coverage as part of a larger KAPB survey. These are expensive

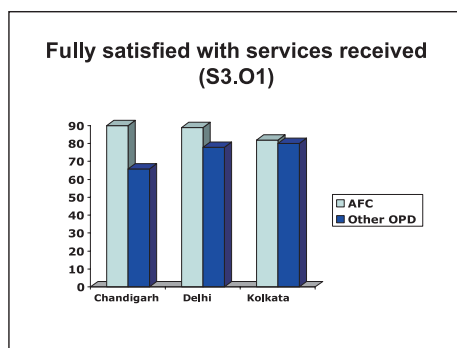
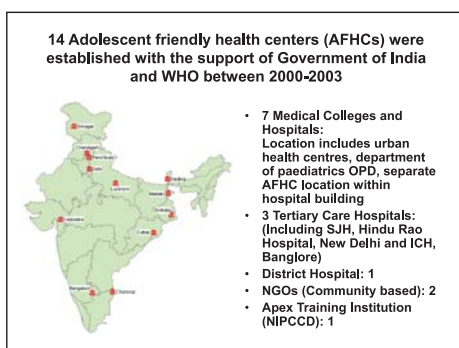
² Tanahashi, 1978. "Health service coverage and its evaluation" *Bulletin of the World Health Organization*, 56(2):295-303.

and infrequent, and are not likely to meet the needs of global monitoring for achievement of the UNGASS Goals and Millennium Development Goals (MDGs). She also informed participants that MDG 6 has possible revisions on reduction of maternal mortality target(s) with addition of indicators on adolescent fertility measure.

Piloting assessment of quality, coverage and cost of adolescent friendly health centres in India

Dr Rajesh Mehta, WHO India

India has identified adolescent reproductive and sexual health (ARSH) as a key strategy under the Reproductive and Child Health Programme Phase II (RCH II) and the National Rural Health Mission (NRHM). The Ministry of Health and Family Welfare has developed an “Implementation Guide” to help key resource persons at the state and district level in implementing the broad framework of the ARSH National Strategy. In his presentation, Dr Mehta highlighted the core attributes of ASRH services as accessible, equitable, acceptable and comprehensive. Based on these the Implementation Guide has outlined seven standards which will guide the effective implementation of the ARSH strategy.

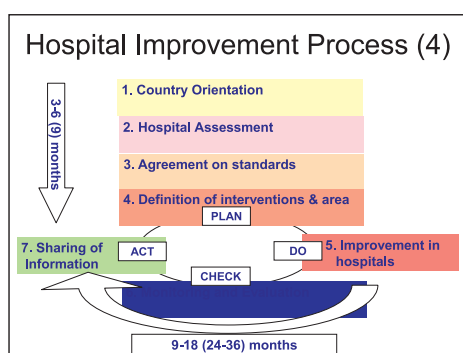


Dr Mehta detailed each standard with its related input, process and output criteria. To explain the concepts of quality, coverage and costs he gave the example of a pilot assessment of quality of services which was carried out in three Adolescent Friendly Clinics in Kolkata, Chandigarh and Delhi, India. The pilot study assessed: (1) whether the establishment of adolescent-friendly centres has increased the quality and access to health services; (2) the effects of school-based outreach activities on the school environment and access to adolescent-friendly health services; (3) and role of adolescent-friendly health services vis-à-vis RCH-II ARSH strategy and their feasibility and sustainability.

Three Adolescent Friendly Health Centres (AFHC) out of the 14 sites were selected on the basis of the criteria that they are tertiary-care hospitals located in medical colleges. These have been functional without interruption for the last three years or more and have established a centre with trained health-providers. They also had an outreach programme with schools. The assessment methodology included training of staff who were involved in the evaluation and pre-testing of study instruments. Data collection was monitored by trainers. Statistical analysis was conducted using SPSS³ 15th version. Tools which were used have been adapted from WHO quality assessment tools and an additional tool for parents was developed to obtain information from adults accompanying adolescents to the clinic. This was administered while the adolescent underwent the client exit interview. Study tools included client interview schedule, parent interview schedule, school student's questionnaire and staff questionnaire and facility checklist. Observations revealed that facilities had adequate manpower and independent consultation rooms. The general ambience was good and privacy was being maintained. Outreach sessions were organized regularly. Parents were aware about the functioning of the centres, their timings and location. They also had the information that all the services provided were free of cost. Some of the quality improvements highlighted were the increased degree of privacy during consultation with doctors in AFHCs and the higher percentage of client satisfaction with services at the centres as compared to the other outpatient departments. Dr Mehta concluded by highlighting the fact that though the national standards were developed after these sites became operational, yet certain input and process criteria related to Standards 2, 3, 4, 5 and 6 were found to be in place.

Quality improvement of hospital care for children

Dr Martin Weber, WHO/Indonesia



Dr Weber reiterated that quality improvement is a collaborative approach. It is important to bring people together periodically to exchange experiences and work on common problems. In his presentation he took the audience through the evolution of the quality improvement process of hospital care for children. The hospital improvement process includes planning, implementing the

³ Statistical Package for Social Sciences

plan, monitoring and evaluating it, and finally acting on the improvement. For planning purposes, identification and sensitization of the leadership and key stakeholders within the country is required. A situation assessment of the hospital will provide a clear picture of the quality of services provided. The next steps involved are the agreement of the standards and the adaptation of the materials for their implementation. The intervention areas are defined and the improvement process begins with the implementation of the standards, technical training, audit, etc. The processes are then monitored and evaluated and the assessment information is disseminated. The time period taken is approximately 24-36 months. On the basis of this assessment of improvement the intervention area is extended and scaling up takes place.

Discussion

- Monitoring and evaluation processes measure implementation, quality and impact of services using the identified input, output and process criteria.
- Bring stakeholders on board to identify criteria.
- Monitoring should be a cyclical process with planned activities at the national, district and local level to improve quality.
- Assessment and monitoring should be a combination of internal and external assessment.
- Improvement in quality lead to improvement in service utilization at the facility and the community, thus leading to improved coverage. Experiences from countries such as Sri Lanka and India reveal that improved quality improves the utilization of services, and that it is possible to improve quality in government facilities.
- In India, the quality assessment process is piloted in 3 facilities and the AFHS quality assurance manual for districts is under development. This will provide guidance on how to ask questions, plan visits and report back.
- Possibilities could be identified in countries to include ARSH services into the ongoing QA project.
- There is a need to change the age-old process of punitive supervision to supportive supervision. Supervision should be viewed as a learning experience. It can be a two-way learning process benefiting both the supervisor as well as the health-provider.

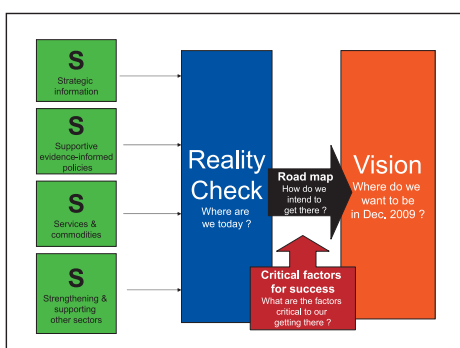
Group work

Key messages which emerged in relation to monitoring were:

- Identify a small number of indicators and provide training to collect and analyze data. Special skills are needed for monitoring and capacity-building is, therefore, required.
- Tools must be developed for AFHS monitoring. Checklists should be in place for effective monitoring.
- Staff should not be overburdened with monitoring and complicated tools should be avoided.
- Monitoring should be built into the implementation plan and have a clear timeframe. Responsibilities and action must be shared at every level. Monitoring helps in keeping track and taking corrective action.
- Identified indicators need to be in coherence with other efforts at quality improvement.
- Few standard/uniform indicators for global and regional country comparisons should be developed.
- The use of the latest communication technology for monitoring and submission through the internet should be encouraged.

Visioning

Introduction



Vision is the ability to see beyond our present reality, to create and invent what does not yet exist, to aspire for and become what we are not. It gives capacity to live out of our imagination instead of our memory.

Visioning exercise

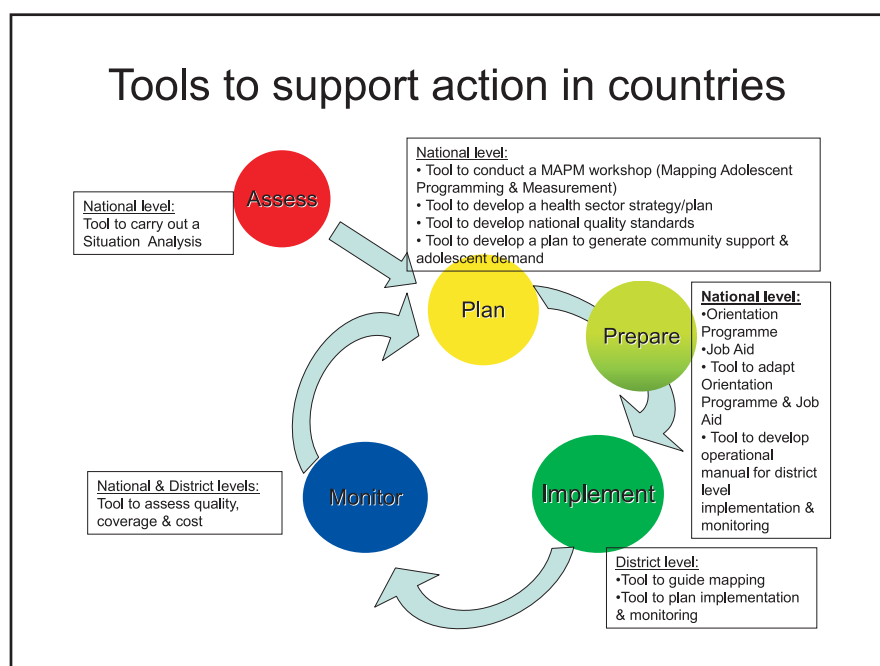
The participants were divided into country groups and asked to fill a matrix. The objective was to assess in terms of “4 S” – Strategic information, Supportive evidence-informed policies, Services and commodities and Strengthening other sectors – where countries are placed today, where they want to be in December 2009 and the factors that are critical to getting there (Annex 4).

10

Available/emerging methods and tools

Dr Chandra-mouli, WHO/HQ

The presentation by Dr Chandra-mouli brought out information on available relevant tools for programming. He pointed out that a systematic approach is required to scaling up health services. To do this at national level tools are required to carry out a situation analysis, to conduct a MAPM (Mapping Adolescent Programming and Measurement workshop), to develop a health sector strategy/plan, to develop national quality standards and to develop a



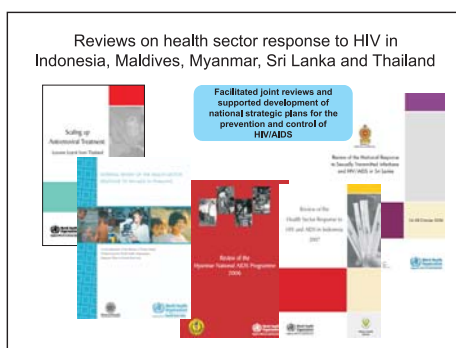
plan to generate community support and adolescent demand. Orientation programmes and job aids are required for the health worker to provide preventive and curative health services effectively and sensitively and spell out what the health worker needs to do if the patient is an adolescent. At the district level tools are required to guide mapping and to plan implementation and monitoring. Tools are required to assess quality, coverage and cost at both national and district levels.

WHO framework for global monitoring and reporting on the health sector's response to HIV/AIDS

Ms Laksami Suebsaeng WHO/SEARO

The presentation by Ms Laksami Suebsaeng took the audience through the United Nations General Assembly high-level meeting on HIV/AIDS in 2006, where countries committed to work towards the goal of “universal access to comprehensive prevention programmes, treatment, care and support” by 2010. The meeting led to the development of the global framework that includes a core set of indicators to monitor the scaling-up of priority health-sector interventions for HIV/AIDS prevention, care and treatment as well as policy and programmatic issues related to the national response.

- From 2008 onwards, WHO will provide an annual global update on the scale-up of a comprehensive range of priority health sector interventions for HIV prevention, care and treatment.



Priority interventions where the health sector must invest in order to progress towards universal access include:

- testing and counselling;
- prevention (PMTCT, prevention in the health-care setting, prevention of sexual HIV transmission and prevention of transmission through injecting drug use);
- treatment and care (ART, care, HIV/TB).

For each intervention, the framework measures three dimensions of progress, availability, coverage and outcome/impact. In addition, the framework measures progress in strengthening key components of the health system to support the scale-up of priority interventions.

To generate a standard set of core information to monitor and report on global progress towards universal access, a number of measurement tools are being used for data collection and reporting. These include national programme records and routine health information systems; population-based surveys; facility-based surveys; behavioural surveillance surveys; and special surveys. From 2008 onwards WHO will provide an annual global update on the scale-up of a comprehensive range of priority health sector interventions for HIV prevention, care and treatment. Reviews on the health sector response to HIV were conducted in Indonesia, Maldives, Myanmar, Sri Lanka and Thailand. Joint reviews facilitated support and development of national strategic plans for the prevention and control of HIV/AIDS. Guidelines for conducting a review of the health sector response to HIV/AIDS were also developed at the regional level. The challenges are weak, uncoordinated monitoring and evaluating systems, multiple data sources, and lack of human resources. As countries scale up health sector programmes there will be increasing need to invest in improving quality of data, monitoring new interventions (e.g. male circumcision), and measuring the quality of services and equity in access.

Information was also shared on Round 8 of the Global Fund and assistance that can be provided to countries in the development of proposals to be submitted to the Global Fund was discussed. The focus of this round will be on strengthening the ability of NGOs/CBOs to reach and provide services to people (e.g. home-based care, outreach prevention, orphan care, etc); partnerships with the private sector and gender equality issues. Participants were invited to participate in the proposal workshop to be held during 11-13 March 2008 in Jakarta, Indonesia

School health promotion

Dr Davidson Munodawafa, Regional Adviser, Health Promotion and Education, WHO/SEARO

Dr Davison presented guiding principles of health promoting schools (HPS) and shared its essential elements. The elements include healthy school policies, the school's physical AND social environment, individual health skills and action competencies, community links and the health services provided. In highlighting the challenges faced by HPS, he identified lack of policy and strategy coherence between the Ministry of Education and the Ministry of Health and others to be

a major impediment. In addition, curriculum overcrowding, limited capacity of schools to deliver content and lack of financial resources further impede the process. Several of the challenges relate to lack of evidence of the effectiveness of HPS on account of weak monitoring and evaluation. Cultural barriers and weak community links lead to limited involvement of students in school health activities. To

overcome these barriers it is critical to build a viable partnership between the education and health sectors, he pointed out. To overcome limited participation, health issues within the context of student and community should be explored. Teaching strategies that use the “whole school approach” should be adapted. He also stressed on the importance of providing capacity-building opportunities for teachers on a regular basis.

Essential Elements of HPS

- | | |
|---------------------------------|--|
| • Healthy school policies | • Individual health skills and action competencies |
| • School's physical environment | • Community links |
| • School's social environment | • Health services |
| | • Partnership: Alliance building and networks |

Discussions

- Tools and methods need to be jointly developed and countries can adapt it as per their needs.
- National HIV/IADS work plan such as Myanmar, Sri Lanka and Thailand must have adolescent focus.
- World Bank has earmarked funds for Bhutan for HIV/AIDS.
- Its useful to share resources for planning an implementation.
- Round 8 under global fund provides a wonderful opportunity to tap and use existing resources.
- Good progress has been made on collaborative work with HIV/AIDS and HPE unit.
- A weak monitoring and evaluation system is a challenge.

11

Review of draft Regional Strategic Directions for Improving Adolescent Health in South-East Asia Region

Dr N Raina WHO/SEARO

The presentation by Dr Neena Raina brought out the relevance of focusing on young people and provided the rationale for Regional Strategic Directions. The Regional Strategic Directions on Adolescents makes a case for the adoption of a public health approach within the health sector and identifies actions needed to involve stakeholders from other sectors to contribute to AFHS in a sustained manner. It identifies the challenges and opportunities in adolescents based on the health situation and risk profile of adolescents in Member States of SEA Region. Strategic directions underscore the need for value-added services for adolescents in the existing health systems and health programmes. It advocates for sustained political commitment, policy and legislation that is consistent with commitments made. It helps promote a rights-based approach with a focus on special groups. It also stresses on the need for strategic behaviour change to

The regional strategic directions

- Makes a case for adoption of a public health approach within the health sector and identifies actions needed to involve stakeholders from other sectors to contribute to AFHS in a sustained manner.
- Identifies the challenges and opportunities in adolescents based on the health situation and risks profile of adolescents in SEA member states.
- Underscores the need for value added services for the adolescents in the existing health systems and health programmes.

The regional strategic directions

- Advocates for sustained political commitment, policy and legislation that is consistent with the commitments made
- Promote a rights based approach with a focus on special groups.
- Stress the need for strategic behaviour change to empower the adolescents and improve their care seeking.
- Emphasize the complementarity of research and programme for successful expansion
- Recommend standards for quality as well as results based monitoring to assess progress achieved

empower adolescents and improve their care-seeking. It emphasizes the complementarity of research and programmes for successful expansion. It provides standards for quality as well as results-based monitoring to assess the progress achieved. The target audience for strategic directions is policy-makers, decision-makers and national programme managers in the Member countries of the South East Asia Region. The purpose is to support the national programme on AHD, and help scale up and sustain responses that meet the needs and rights of adolescents. The objectives of the Regional Strategic Directions are:

- Formulate/refine national policy and strategy in support of adolescent-friendly health services using a rights-based approach.
- Identify the role of the health sector in delivering services for adolescents that meet their needs.
- Strengthen and sustain partnership with related sectors to help adolescents optimize the achievement of their full potential and at the same time reduce the risks and vulnerabilities.
- Increase access to accurate knowledge and services through the adoption of an adolescent-friendly approach.

The impact objectives are:

- Early identification and management of adolescent pregnancy increased by 50%.
- Reduce the unmet needs of adolescents for contraceptives by 30% in the 15-19-year age group.
- Decrease the incidence of anaemia by 50% among the 10-19-year age group.
- Increase the rate of condom use by 50% in casual sex amongst the 15-24-year age group.
- Reduce the incidence of STIs and HIV by 20% in 15-24-year age group.

Strategic components include strategic information, services, supportive policy environment and advocacy and strengthening of collaboration with other sectors.

Strategic information: Comprises of collection, analysis and dissemination of information. This is essential for preparing evidence-based policies and programmes, building advocacy, and for partnerships with other sectors.

Strengthen services for adolescents: Comprises of increasing the awareness of adolescents and access to accurate information; providing adolescent-friendly health services and enhancing demand generation for services amongst adolescents.

Supportive policy environment includes evidence-based national policy; advocacy; sustained engagement of the politicians, decision-makers and academicians; partners for policy change; formulation of policies and legislation that are rights-based; and broad-based endorsement of the policies.

Strengthening of collaboration with other sectors implies that the health sector needs to help other sectors act in ways that strengthen and facilitate the interventions that are being provided through the health sector.

Discussion

There was a general consensus about the need for regional strategic directions for adolescents for effective adolescent health programming. The main comments involved the following issues :

- Include sections on dental health, mental health and gender-based violence.
- Some directions on covering children who are entering adolescence and are disabled.
- Address abortion as a cause of maternal mortality in many countries.
- Impact objectives need to be reviewed as they are over-ambitious.
- Consider specific quality and coverage indicators for the region.
- As policies are backed by authentic data, include directions on the implementation of a communication strategy for advocacy.
- Review of laws in countries that promote and hinder policy and guidance for health- care providers.

Group work

Participants were divided into five groups and each group was given one impact objective from the regional strategic direction. For every objective, the group had to identify interventions, expected outcomes, activities, responsible person/ groups, indicators and assumptions, and risks involved. A matrix of the same was provided to them. (Annex 5: Group work on regional strategic directions)

Issues of concern raised by participants

Over the period of three days of the meeting certain critical issues and concerns were raised by the participants. These were issues on adolescents in conflict area, adolescents with missing parents and those experiencing different kinds of violence.

Group work

The participants were divided in three groups each of which comprised participants from different countries. The participants discussed the following questions:

- In many countries adolescents are caught up in conflict situations/ have missing parent/experience violence. Is this true in your country? Provide a brief reflection.
- What could ministries of health do to respond to the above issues.

Key issues which emerged on how the ministries of health can respond

- Sensitize the information system to record adolescents' needs.
- Advocate at higher/central levels on adolescent health issues.
- Review laws and implementation guidelines to ensure appropriate attention to the problem.
- Special health services for adolescents in difficult situations.
- Increased access to health services.
- Strengthen the health system.
- Provide support to NGOs and the social welfare departments, who provide shelter and care for those suffering from general health and mental health problems.
- Strengthen collaboration with other sectors.

12

Conclusions and recommendations

The meeting of the National Adolescent Health Programme Managers in member countries of the South East Asia Region, held at Bali, Indonesia, 12-15 February 2008 reaffirmed the need for a focus on adolescents since they make up around one-fifth of the total population in the Member countries of the South-East Asia Region. They are vulnerable and have differing needs due to differences in age, sex, marital status, environment (e.g. conflict, emergencies) and other factors. There are sound reasons for investing in the health and development of adolescents. Therefore, promoting and safeguarding the health of adolescents has been recognised as a priority.

Countries of the South-East Asia Region have made good progress in addressing the health of their adolescents. Many government departments – including health, education, youth and sport – as well as civil society are contributing to this. The efforts being made to gather and use information to guide policies and programmes were noted. The importance of policies and strategies for providing clear signals to facilitate, legitimize and guide action to improve the health of adolescents was recognized. The critical importance of involving adolescents in all stages of policy and programme development, implementation, monitoring and evaluation was acknowledged. This should be done in accordance with the prevailing norms in the member countries of the region. There are many government, private and NGO initiatives delivering health services and commodities to adolescents in order to prevent health problems and to respond to them when they arise.

While noting that important progress has been made in recent years, participants stressed the need for a systematic and sustainable approach to scaling up health services provision and recognized the need to take appropriate steps to convert the efforts from “project mode” to programme-based approach in order to improve coverage while maintaining the quality of health services.

There are several noteworthy examples of school health promotion initiatives in the SEA region. Ministries of Health and Education have collaborated in contributing to these initiatives. In this context, ministries of health have an important role in providing evidence-based, age-appropriate content for life skills education, nutrition education and health promotion activities to be delivered by the education sector through schools. The ministries of health have the responsibility of helping to ensure that evidence-based approaches are used by the education sector to deliver this content.

The efforts made by WHO SEARO to develop strategic directions to improve the health sector's response to adolescent health in the Region were appreciated and acknowledged in the meeting. The strategic directions document would provide a definite, doable menu of actions from which member countries may draw according to their specific needs. Regional indicators aligned with global indicators will assist countries to define national indicators.

Recommendations to member countries

- To promote a multi sectoral approach, health ministries should strengthen the role of the health sector by collating and disseminating strategic information; developing evidence-informed policies; improving the provision of health services; and forming sustainable partnerships with other sectors. A framework which highlights the links between health outcomes, behaviours, determinants and interventions should be prepared.
- Ensure that policies and strategies are based on sound evidence; are sensitive to the social and cultural milieu; and based on accurate and representative situation analyses, preferably not on small surveys and studies undertaken in a limited geographic area.
- Adolescents should be involved in all stages of policy and programme development, implementation, monitoring and evaluation in accordance with the prevailing norms in countries.
- Health ministries in member countries should increasingly take up a stewardship role to define national quality standards for the provision and utilization of health services for adolescents; provide guidance to improve the quality standards and coverage of health services through actions at the national, sub-national and local levels; strengthen systems of supervision in a manner that involves and empowers all parties, including health workers, community members and adolescents themselves; and monitor regularly using indicators based on the established national standards for quality and coverage.

- Efforts are needed to strengthen the national monitoring systems and integrate efforts to monitor adolescent-friendly health services within the national health management information systems.
- Alongside efforts to improve health service provision, complementary efforts are needed to generate demand for adolescent health services and community support for their provision.
- Ministries of health should provide evidence-based, age-appropriate content for life skills education, nutrition education and health promotion activities to be delivered by the education sector through schools. Partnerships with other sectors and with civil society are required in order to strengthen the complementary contributions that they can make to improve the health of adolescents (e.g. in providing information and education and in building supportive norms).
- High-level advocacy, effective communication between collaborating sectors, capacity-building for health workers, and initiatives to drive the demand for services should be undertaken by the member countries.
- The national governments may consider identification of doable actions according to their specific needs from the regional strategic directions produced by WHO/SEARO.
- Efforts should be mounted to strengthen data and information on adolescent health by undertaking secondary analyses of available national data from national surveys (e.g., DHS, Behaviour Surveys) and ensuring age-and-sex-disaggregation of data of future surveys. Data and information on health from other sectors should also be collated.

Recommendations to WHO

- Continue to strengthen advocacy for making adolescent health as an integral part of public health agenda. Efforts are needed to enhance the resources committed towards improving adolescent health for a public health impact.
- Step up its guidance and technical assistance to member countries to help scale up key interventions which would contribute to improved coverages of key indicators.

- Develop the capacity in the member countries on adolescent health and development through intercountry meetings, national TOTs, and expert consultations to develop tools and guidelines. WHO should also provide guidance and support for assessment of laws, regulations and policies in the context of adolescents' sexual and reproductive health and HIV/AIDS.
- Finalize the Regional strategic directions and provide support to the countries in developing their national strategies and operational plans.
- Continue to engage partners at global, regional and national levels to mobilize resources and support demand generation.
- Strengthen the capacity of the countries in monitoring and evaluation of coverage indicators that are consistent with the UNGASS goals and relevant MDGs 5 and 6 (maternal mortality and HIV prevention in young people).

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Annex 2

Message from Dr Samlee Plianbangchang, Regional Director, WHO South-East Asia Region (To be delivered by WR Indonesia)

Distinguished participants, colleagues, ladies and gentlemen, I have great pleasure in conveying the greetings of Dr Samlee Plianbangchang, Regional Director, WHO South-East Asia Region to all the distinguished participants.

The Regional Director regrets his inability to attend the meeting due to prior commitments. I have the privilege of delivering his message.

Quote:

Adolescence is a period of rapid growth and development that marks a change from childhood to adulthood. This transition involves numerous changes and creates many opportunities which can lead to risks to health and well-being.

There are an estimated 350 million adolescents (between 10-19 years of age) in Member countries of the WHO South-East Asia Region. The needs of adolescents are diverse and therefore should be addressed according to age, sex and other sectors.

According to available data, about 68% of the girls in Bangladesh, 47% in India and 51% in Nepal are married before the age of 18 years. Consequently, many adolescents face problems relating to early child-bearing. The maternal mortality rates are two to five times higher in girls aged 15-19 years as compared to older women. The problem of unwanted and unplanned pregnancy in adolescents is largely because of the unmet needs for contraception. Undernutrition, stunting and obesity are common among adolescents in some countries and are a cause for concern. Iron deficiency anaemia in some countries is about 50-70% among adolescent boys and

girls. For the above reasons, adolescents should form an important component of the national programmes.

Early initiation of sexual activity exposes adolescents to an increasing risk of STIs, HIV/AIDS and unwanted pregnancy. Lack of knowledge and lack of access to contraceptives including condoms increases the risk of unwanted pregnancy, clandestine abortion and sexually transmitted infections including HIV/AIDS. Some adolescents and young people resort to high-risk behaviours including injecting drug use, commercial sex work and men having sex with men. This together with intake of alcohol, violence, coercion and sexual abuse pose a serious challenge to their health.

Ladies and gentlemen,

Even though the challenges are numerous, policy and strategy support for adolescent health and development is inadequate because of weak political commitment. This is partly related to the non-availability of accurate national data which is often limited due to incomplete information. There is a lack of age and sex disaggregated data. WHO, with the help of Member countries, has prepared Factsheets on Adolescent Health and HIV in Young People. Efforts are also being made to analyse the available data according to age and sex. This strategic information is helping to advocate for adolescent health programming.

Another area of concern is that despite numerous problems and challenges, adolescents do not seek available health services due to lack of privacy, confidentiality and the judgmental behaviour of the health care providers. WHO has organized numerous consultations on these issues and several countries have taken steps to provide adolescent-friendly health services. The national capacity in Member countries has been strengthened to improve the skills of health workers. To ensure good quality of services, national standards have been developed and strengthened by many countries. It is important that partnerships are developed with the stakeholders and people who are 'influencers' for the adolescents, to empower them with knowledge and skills and generate demand for health services.

Ladies and gentlemen,

I am happy to note that WHO has been engaged in developing and sustaining partnerships with UN agencies and other relevant partners to move forward the agenda of adolescent health and development and help the countries to realize the Millennium Development Goals.

WHO has assisted Member countries to prepare national strategies on adolescent health. WHO/SEARO has produced draft strategic directions for improving adolescent health which will be discussed in this meeting. I look forward to your valuable inputs, which, I am sure, will enrich programme implementation.

Unquote:

I shall, of course, inform the Regional Director of your deliberations and the outcome of this important consultation. In conclusion, I wish you fruitful deliberations and a pleasant stay in Bali. Thank you."

Annex 3

Programme

Day/Time	Event	Presented by
Day 1	12 February 2008, Tuesday	
0830-0900	Registration	
0900-1130	Opening by WR Indonesia, on behalf of RD, WHO/SEARO	
	Chair: Dr Rinni Yudhi Pratiwi Toeloes	
	Co-Chair: Mr Hussain Rasheed Moosa	
	Global perspective	Dr Chandra-Mouli
	Regional perspective	Dr Neena Raina
	Introduction to Mapping Adolescent Programming and Management (MAPM)	Dr Krishna Bose
1130-1300	Session I	
	4 'S' strategy to strengthen health sector response to adolescent health	
	<ul style="list-style-type: none"> Presentation by countries on each 'S' <ul style="list-style-type: none"> Strategic information (Introductory presentation) <ul style="list-style-type: none"> India Dr Rajesh Mehta Timor-Leste (MoH Survey on Young People) Mr C.C. Freitas Services and commodities (Introductory presentation) <ul style="list-style-type: none"> Thailand (MoH) Ms Yupa Indonesia (MoH) Dr Rinni Toeloes 	

1400-1530	Chair: Dr Sonam Ugen Co-Chair: Mr Carlitos Correia Freitas <ul style="list-style-type: none"> • Supportive evidence-based policy (National strategy) (Introductory presentation) <ul style="list-style-type: none"> – Bangladesh (MoH) Dr S.M.A.K. Miah – Myanmar (MoH) Dr M.M. Than • Strengthening other sectors (Introductory presentation) <ul style="list-style-type: none"> – Maldives (MoH) Ms Nizma Hawwa – Bhutan (MoH) Dr Sonam Ugen
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1545-1730 Group work and feedback

Day 2: 13 February 2008, Wednesday

0900-1045	Session II Chair: Dr Dula de Silva Co-Chair: Mr Ravi K. Ramachandran Systematic approach to scaling-up <ol style="list-style-type: none"> 1. Situation assessment (Introductory presentation) <ul style="list-style-type: none"> • Sri Lanka (MoH) Dr Ayesha
1045-1300	<ol style="list-style-type: none"> 2. Developing national standards (Introductory presentation) <ul style="list-style-type: none"> • Bangladesh (MoH) Dr SMAK Miah • Sri Lanka (MoH) Dr Dula de Silva
1400-1530	Chair: Dr S.M. Abdul Khayer Miah Co-Chair: Dr Keshav Raj Bhurtel <ol style="list-style-type: none"> 3. Implementing national standards actions at national and district level (Introductory presentation) <ul style="list-style-type: none"> • Indian Institute of Health Management Research Dr R.S. Goyal • India (MoH) Mr Prasad • Indonesia Dr Rinni
1545-1730	Group work and feedback

Day 3 14 February 2008, Thursday

0830-1030	Session II continued	
	Chair: Dr Pensri Kramomtong	
	Co-Chair: Dr Ayesha Lokubalasooriya	
	<ul style="list-style-type: none"> • Group work on implementing national standards on youth friendly health services • Flash exercise • Feedback on the group work followed by discussion in plenary 	
1045-1130	4. Monitoring implementation (quality and coverage) (Introductory presentation)	
	<ul style="list-style-type: none"> • Dr S.M. Abul Khayer Miah, Bangladesh (MoH/SCF) • Mr Chaitanya Prasad, India (MoH) 	
1130-1230	Presentations, group work, plenary feedback and discussion on Monitoring the implementation of National Standards on Youth Friendly Health Services	Dr Chandra-Mouli Dr Krishna Bose Dr Rajesh Mehta Dr Martin Weber Dr Neena Raina Dr SMAK Miah
1330-1430	Session III	
	Group work on Implementing National standards on Youth Friendly Health Services	
	Looking ahead – Visioning exercise in country groups, followed by feedback and discussion in plenary	
	Group work and feedback on following issues;	
	<ul style="list-style-type: none"> • Key activities to be undertaken in 2 years • Areas of work which need strengthening • Support required – Financial and technical 	
1430-1530	Skills building session on communicating effectively	Ms Olivia Lawe-Davies
1545-1730	Methods and tools for country level actions	
	<ul style="list-style-type: none"> • Global, regional level methods, tools 	Dr Neena Raina
	<ul style="list-style-type: none"> • Global monitoring indicators on HIV/AIDS (HIV/AIDS-SEARO) 	Ms Suebsaeng
	<ul style="list-style-type: none"> • Global School Health Survey (HPE-SEARO) 	Dr Munodawafa
	<ul style="list-style-type: none"> • Panel presentations by WHO SEARO and WHO HQ on available/emerging methods and tools and resource mobilization followed by discussion in plenary 	

Day 4

15 February 2008, Friday

0900-1030

Session IV

Chair: Dr Myint Myint Than

Co-Chair: Ms Yupa Poonkhum

Skills building session on Communicating Effectively

Ms Lawe-Davies

1045-1300

Review of draft Regional Strategic Directions on AHD
Mini presentations and feedback from participants

Dr Neena Raina

1400-1530

Chair: Dr Mohamad Nasir

Co-Chair: Dr Sonam Peldon

Group work and discussion on Issues of concern raised
by participants on following :

- Missing Parent
- Conflict
- Violence

Feedback on Regional strategic Directions

1545-1700

Conclusions and recommendations

Country vision and plans until December 2009

	Where we are today	Where we want to be in 2009	How do we intend to get there	What are the factors critical for our getting there
BHUTAN				
Strategic information	<ul style="list-style-type: none"> – Paucity of information/data on adolescents – Multiple players for AH interventions – No lead agency coordinating program for adolescents – Gaps in service provision 	<ul style="list-style-type: none"> – to have evidence based Information – Have priority issues identified – Bridge service gaps – Improve multisectoral collaboration on issues concerning AH 	<ul style="list-style-type: none"> – Secondary data analysis of existing data with financial and Technical Assistance from agencies like WHO 	Collection and dissemination of Evidence based information as a tool for advocacy among political leaders
Supportive evidence based policies	Currently no National Strategy on AHD <ul style="list-style-type: none"> – National Health Policy – Individual program policies on (HIV/RH/Nutrition) – General policies on Tobacco Alcohol Drug abuse & others 	Moving towards a National Youth policy in collaboration with MoE leading	Sensitization of politicians & policy makers using evidence based information	Political commitment to AHD
Services and commodities	<ul style="list-style-type: none"> – General Health Services – CSHP (in school youth) – For Out of school youth – NGOs interventions 	<ul style="list-style-type: none"> – Ensure equity of services – Increase service delivery to schools through CSHP – Enhance services to Out of school youth using NGO support – Pilot at least 1 AFHS in the capital city 	<ul style="list-style-type: none"> – Capacity building of relevant stakeholders – Sensitise health workers on AFHS – Develop fact sheets – Guidelines and training plans for HCWs 	Technical and Financial assistance from WHO

	Where we are today	Where we want to be in 2009	How do we intend to get there	What are the factors critical for our getting there
Strengthening other sectors	Currently collaborating with Ministry of Education for CSHP	<ul style="list-style-type: none"> – Build sustainable partnership with key players in adolescent health – Identify roles and responsibilities of key stakeholders 	<ul style="list-style-type: none"> – Sensitization – Advocacy – Garner high level support with principal stakeholders 	<ul style="list-style-type: none"> – Cooperation and commitment of key stakeholders
INDIA				
Strategic information	<ul style="list-style-type: none"> – Gaps in data regarding key indicators of adolescent health – No data for 10-14 yrs old – Limited data on unmarried adolescents esp. boys 	<ul style="list-style-type: none"> – Propose to commission dedicated national survey on adolescent health (SRH, Mental Health, Nutrition, Injuries) – Key indicators would be identified and incorporated 	<ul style="list-style-type: none"> – Identify ARSH indicators to be incorporated in routine MIS – Secondary data analysis 	<ul style="list-style-type: none"> – Evidence based information for mainstreaming ARSH in the public health system.
Supportive evidence based policies	<ul style="list-style-type: none"> – Policy and strategy in place but implementation tools at state/districts levels inadequate – Gaps in adol specific guidelines like on consent, provision of contraceptives 	<ul style="list-style-type: none"> – Dissemination of the strategy and evidence of successful implementation at state level – Adolescent specific guidelines would be incorporated as per 'standards' 	<ul style="list-style-type: none"> – Incorporate the standards in the state programme – introduce standards guidelines in states depending upon their understanding of the implementation framework 	<ul style="list-style-type: none"> – Capacity of state system to absorb and implement ARSH services according to the implementation framework
Services and commodities	<ul style="list-style-type: none"> – Health outposts in districts have been identified – Trainings at both national and state level started for building capacity of medical professional to implement ARSH – Limited roll out of services in states – Communication package not yet ready for advocacy 	<ul style="list-style-type: none"> – Improved state plans – Trainings to be complete – Operationalize services in identified facilities as per guidelines – Communication package developed and disseminated – Monitoring mechanism for evidence based review 	<ul style="list-style-type: none"> – Build state capacity through appropriate technical assistance from WHO and other agencies – Building pool of ARSH professionals to train HWs at the state level through regular training and capacity building – Build capacity of states to monitor utilization of services 	<ul style="list-style-type: none"> – Willingness of policy makers at state level to introduce and implement appropriate ARSH services for young people

Where we are today	Where we want to be in 2009	How do we intend to get there	What are the factors critical for our getting there
Strengthening other sectors INDONESIA Strategic information	Intra- and Inter-departmental collaboration inadequate – Adolescent and reproductive health survey – Subset analysis of Basic Health Survey by MOH – Indonesia Adolescent Health Survey – Lack of AH data at district level – National strategy paper for AFHS	– Convergence with YP component of HIV program – Convergence with ICDS and Education in 2008 – Convergence with Deptt. of Youth in 2009 Have evidence based information on AH to be used for programming	– Commitment of policy makers to share ground on the common issues concerning young people Use evidence base information as tool for advocacy
Supportive evidence based policies Services and commodities	AFHS implemented in 782 HC in 15 provinces out of 7442 HCs (2006) Guideline and material for AFHS Draft checklist for monitoring facilitative supervision School health program Guideline for school health curricula Standard on adolescent health (sign by MOH, MOE, MORA)	Policy on AHD Developing AFHS in all health centres of the country. Implementation of guidelines on AFHS Increase coverage of school health program which is currently in 80% of elementary schools	High level political commitment Technical and funding support for activities related to AFHS. Involvement of the local government along with local development institutions. Collaboration and coordination with relevant partners. Resource mobilization For AFHS

	Where we are today	Where we want to be in 2009	How do we intend to get there	What are the factors critical for our getting there
Strengthening other sectors	Ministry of Education NGOs, community associations, development agencies	Build partnership with key players in adolescent health.	Intra and intersectoral collaboration and coordination especially with Ministry of Education	Collaboration between ministries Coordinated action and commitment by partners
MYANMAR				
Strategic information	Information on key indicators on adolescents available to some extent	Secondary analysis of existing data – Global School Survey, Global Youth Tobacco Survey – HIV surveillance Survey	Collaborate with related departments and sectors	Willingness of relevant departments to contribute towards building strategic information on adolescents for evidence based advocacy
Supportive evidence based policies	Draft National Strategic Plan for AHD 2008-2012	Finalize, Endorse, Launch National strategic plan for adolescent health – Resources to be mobilized for implementation of plan	Coordination within intra and inter-sectoral partners	Readiness to implement by key stakeholders identifying common milestones
Services and commodities	One AFHS pilot project Health Promoting Schools Tobacco-Free Schools	Develop national standards on AFHS – Commission 9 Pilot townships with AFHS Strengthen implementation Enforce guidelines and standards	Integrate AFHS within the existing health services	– Availability of resources – Capacity building for AFHS – Collaboration and coordination with MoE
Strengthening other sectors	Presently collaborating with Ministry of Education	Align other relevant stakeholders with national strategic plan for AHD	Advocate for AHD and provide resources for effective implementation	– Political commitment – collaborations with other key stakeholders

	Where we are today	Where we want to be in 2009	How do we intend to get there	What are the factors critical for our getting there
THAILAND				
Strategic information	<ul style="list-style-type: none"> – Age & sex disaggregated data available – Surveillance Data – Behavioural surveys 	<ul style="list-style-type: none"> – Use information/data for new programmatic interventions & scale up to lower incidence of teenage pregnancy, STIs and HIV. 	<ul style="list-style-type: none"> – Close surveillance and continuous data monitoring, review & up gradation for strengthening evidence base 	<ul style="list-style-type: none"> – Advocacy for policy makers and administrative authorities to invest in AHD.
Supportive evidence based policies	<ul style="list-style-type: none"> – National Family Planning Programme – National Youth & Development policy & Plan – Specific national plans to implement promotion and prevention programmes 	<p>Stronger policy & its implementation for the betterment of health SRH among adolescents</p> <ul style="list-style-type: none"> – To improve relevant programmes – Initiate new strategies and interventions to lower incidence of teenage pregnancy, STIs and HIV 	<ul style="list-style-type: none"> – Strengthening coordination and collaboration with concerned agencies- 	<p>Commitment of key stakeholders in civil society.</p> <ul style="list-style-type: none"> – Enhance participation of local administration
Services and commodities	<ul style="list-style-type: none"> – MOPH& universities providing technical support for hospitals to implement “Adolescent Friendly Health System” – AFHS models have been introduced to Faculties of Medicine, Provincial Hospitals, and Community Hospitals. – “AFHS” promoted in Health Promoting Hospitals. – NGOs providing SRH knowledge, and counseling services through Hotlines, and E-learning. 	<p>Improve targeted interventions with regard to key issues.</p> <p>Reduce risk behaviours/factors for adolescents.</p> <p>Improving quality of sex education and Life Skills Education</p> <p>Increasing coverage of AFHS</p>	<ul style="list-style-type: none"> – Advocacy for local administration authorities to invest in AHD – Advocacy for hospitals to invest in promotion and prevention with relation to AH. – Standard guidelines & training for health workers for improving quality of services – Strengthening surveillance, monitoring, and evaluation system. 	<ul style="list-style-type: none"> – Capacity building for relevant stakeholders – Using mass media to create new value of SRH in society. – Sensitization of parents and building community support for programmes on AHD – Ensuring youth and community participation

	Where we are today	Where we want to be in 2009	How do we intend to get there	What are the factors critical for our getting there
Strengthening other sectors	<p>The Ministry of Public Health (MOPH) is working with Ministry of Education (MOE).</p> <p>MOU between MOPH & MOE to promote Health Promoting Schools Programme on Student Advising System to screening and providing timely and appropriate care. – For university students, inclusion of S&RH as credit courses in bachelor programme.</p> <p>NGOs, and relevant agencies working with adolescents – NGOs also working for adolescents outside school system.</p> <p>Ministry of Social Development and Human Security, MOPH, and NGOs are working together to strengthen Thai family connectedness.</p> <p>Adolescent participation is also applied as strategy to approach target groups.</p> <p>The MOPH has a programme to build capacity of Provincial Council of Children and Youth to actively implement S&RH education activities in schools and communities.</p>	<p>Increase knowledge and skills of adolescents through the educational system to prevent risk behaviours and build capacity to take appropriate decisions.</p>	<p>Strengthening the educational system to understand the requirements of young people.</p>	<p>Increase coordination and collaboration between different educational systems.</p> <p>Participation of young people.</p> <p>Introducing monitor- able indicators in the education system to review ARSH related matters.</p>

	Where we are today	Where we want to be in 2009	How do we intend to get there	What are the factors critical for our getting there
TIMOR-LESTE Strategic information	Age & sex disaggregated data from Census 2004 Data collection activities relevant to young people ongoing, e.g. Baseline Behavioral Survey on HIV/AIDS Discussion for inclusion of ARH indicators in revised HMIS	Results of national survey analyzed, disseminated and used for ARH programme	National baseline survey on youth fertility and sexuality planned in 2008 (as part of the larger baseline survey for the National BCC Strategy; separate analysis and report on 15-24 year age group (15-19, 20-24); 15-24 year age group vs. 25-49 year age group Identify critical indicators for ARH programme, determine baselines and set targets	Intra- and inter-sectoral collaboration and coordination with MoH and National Statistics Directorate in the lead (required for national survey) Resource allocation/mobilization Meaningful involvement of key stakeholders at all levels at all stages: National/district level steering committees for the survey with key stakeholders involved including young people, parents, community and religious leaders
Supportive evidence based policies	Relevant health sector policies and National RH Strategy (2004), ARH is one of the four critical components (with SM, FP and General RH) – Draft Health Sector Strategic Plan 2008-2012, Basic Service Package 2007, National BCC Strategy, National HP Strategy, National FP Policy, National HIV/AIDS Strategic Plan	National standards and guidelines for youth-friendly services developed, approved, disseminated and used by health workers and other implementers National ARH Strategy to be developed.	Review of National RH Strategy planned in last quarter of 2008: opportunity to situate ARH programme in Timor-Leste in relation to RH Strategy and other relevant documents, including regional frameworks. Determine need to develop separate ARH policy/strategy based on review recommendations.	Intra- and inter-sectoral collaboration and coordination with MCH Department in the lead Advocacy at all levels (national, district, local and health facility) Meaningful involvement of key stakeholders at all levels at all stages

	Where we are today	Where we want to be in 2009	How do we intend to get there	What are the factors critical for our getting there
Services and commodities	Draft National Youth Policy (Secretariat of State for Youth & Sports)		Develop national standards and guidelines for youth-friendly services based on international best practice adapted to Timor-Leste context Develop training materials and job aids based on the standards and guidelines Conduct regional and district level advocacy workshops on ARH	
	No youth-friendly services in place Package of services for ARH identified in RH Strategy but not operationalized; needs to be harmonized with new HSSP, BSP	Youth-friendly services provided in x number of facilities, depending on availability of resources (human and financial) BCC interventions and IEC materials on ARH developed	Build capacity for ARH programming at national and district level Develop training/orientation programme for health workers on YFS provision based on international best practice adapted to Timor-Leste context Reorient existing health facilities to be youth-friendly in selected districts on pilot basis (i.e., operationalizing national standards) Develop training, monitoring and evaluation plan for ARH Inclusion of ARH programme in forecasting for RH commodities and supplies Build capacity for planning and managing BCC interventions at national and district level in coordination with HP Department Plan and manage BCC interventions	Intra- and inter-sectoral collaboration and coordination with Resource allocation/mobilization Meaningful involvement of young people South-South collaboration: partnership/networking with other countries, identification of training institution to assess, prepare and deliver training

	Where we are today	Where we want to be in 2009	How do we intend to get there	What are the factors critical for our getting there
Strengthening other sectors	<p>Ongoing HIV information and prevention initiatives with Ministry of Education: Extracurricular life skills-based modules on HIV prevention implemented on pilot basis</p> <p>Peer education: Implemented by local NGOs (FTH) in collaboration with Ministry of Education and UNICEF in selected border districts targeting most-at-risk groups for HIV prevention including young people</p> <p>School Health programme in collaboration with the Ministry of Education (primary school pre-testing, inception level)</p>	<p>ARH included in secondary school curriculum with modules, syllabus and teachers' guide developed, translated, printed and disseminated; implemented on pilot basis in 10 secondary schools in Dili</p> <p>Quality and coverage of peer education for ARH improved (possibly with GF support)</p>	<p>Develop modules, syllabus and teachers' manual on ARH (including population and gender) for inclusion in the secondary school curriculum</p> <p>Create linkages with School Health programme in secondary school level</p> <p>Identify other partners and tap their expertise for ARH</p> <p>Scale up peer education to increase coverage and quality and ensure standardization of messages</p>	<p>Intra- and inter-sectoral collaboration and coordination, particularly with Ministry of Education and Secretariat of Youth and Sports</p> <p>Resource allocation/mobilization</p> <p>Meaningful involvement of young people</p> <p>South-South collaboration</p> <p>Advocacy at all levels</p>

Annex 5

Group work on regional strategic directions

Objective: Increase the rate of condom use by 50% in casual sex amongst the 15-24 years age group

Interventions	Expected outcome/s	Activities	Responsible person/group/s	Indicators	Assumptions/risks
1. Redefinitions of indicators (Collect information on current condom use level in youth in countries)	Revised indicators	Expert groups to provide guidance in relevant indicator	Regional Advisers and experts in the region	The experts group has met and provided revised indicators	Non availability of national representative data of condom use among young people
2. Find out what are the laws in the countries for condom use.	Listing of laws and policies	Consultants to review all laws and policies document	Ministry of Health	Listing of laws and policies are documented	
3. Ensure the adoption of laws/policies/strategies.	Adopted laws/policies/strategies	Inter-ministerial meeting between MoH and Ministry of Law and Parliament Affairs	Ministry of Health		
4. Sensitize the policy makers, community particularly religious leaders in condom use among young people.					
5. Ensure adequate supplies of condom and reasonable cost in selected areas.					
6. Sensitize the providers at the delivery points on the provision of condom					
7. Increase the awareness of young people about where to get the condom and increase the skills of young people to get condom when they want one.					

Objective: Decrease the incidence of anaemia by 50% among 10-19 years age group

Proposed change: Decrease anaemia by 25% of current level, among 10-19 years age by 2015

Interventions	Expected outcome/s	Activities	Responsible person/group/s	Indicators	Assumptions/risks
1. Bench marking	Baseline data available	Survey Document review	<ul style="list-style-type: none"> Ministry of Health/ Education/ Youth 	Bench marking completed	<ul style="list-style-type: none"> Commitment budget resource
2. Education	Improved knowledge on balanced diet change in eating habits	Develop training material /IEC	<ul style="list-style-type: none"> Ministry of Health/ Education/ NGOs 	<ul style="list-style-type: none"> Improved knowledge modified eating habit 	<ul style="list-style-type: none"> risk resistance to change affordability availability
3. Supplementation of iron, folate	Increase haemoglobin	<ul style="list-style-type: none"> Procurement Distribution IEC 	District-health, education /NGOs/ private sector <ul style="list-style-type: none"> District-health, education /NGOs/ private sector 	supply are reaching <ul style="list-style-type: none"> compliance of adolescent 	<ul style="list-style-type: none"> lack of supply lack of compliance mis-conception
4. De-worming	reduction in prevalence of worm infection	<ul style="list-style-type: none"> Procurement Distribution IEC 	District-health, education /NGOs/ private sector <ul style="list-style-type: none"> District-health, education /NGOs/ private sector 	supply are reaching <ul style="list-style-type: none"> compliance of adolescents 	<ul style="list-style-type: none"> lack of supply lack of compliance mis-conception
5. Monitoring	-benchmarks are achieved	Data collection		<ul style="list-style-type: none"> information available for benchmark 	<ul style="list-style-type: none"> poor monitoring

Note: Determinants: supplementation of iron, folate; Improve eating habit; Improve knowledge education; Infection control

Objective: Early identification and management of pregnancy increased by 50% among adolescents

Interventions	Expected outcome/s	Activities	Responsible person/group/s	Indicators	Assumptions/risks
Assessment of the problem	Identification of target groups	Secondary data analysis	MOH	Completed data analysis	Availability of primary data and funds
	Awareness campaign	Information campaign on knowledge and access to services	Schools, families, health staff, NGOs	Knowledge to access to services and early pregnancy signs	Government take ownership
	Enhance outreach activity to register pregnancy and provide care	Early registration and ANC care	Health services provider	Number of ANC visit to outreach facilities	Recipients access outreach care and funds
	Training Health care workers and teachers and families on care of teenager	Training	Health care providers, families members		
	Teach adolescents mother on pregnancy and child care	Awareness campaign			
	Review legal and policy environment for advocacy propose				

Objective: Reduce the incidence of STIs and HIV by 20% among 15-24 years age group

Interventions	Expected outcome/s	Activities	Settings	Responsible person/group/s	Indicators	Assumptions/risks
Use the 4S strategy-	Reduce unsafe sex	Promote condom use	Health facilities	Ministry of Health	Percentage of schools having SRH programme	Policy for IDUs developed and implemented
Strategic Information Functional HMIS		Life-skills SRH education in schools BCC interventions/IEC campaigns	Schools	Ministry of Education	Percentage of health facilities providing condoms	Policies to facilitate access to condoms for young people are in place
Supportive evidence-based policies	Delay sexual initiation	Peer education/other outreach activities	Vocational training institutions	Ministry of Youth	Percentage of 15-24 year olds who can correctly identify three ways of HIV transmission	RH commodities and supplies are available
Services and commodities		Promote retention of young people in schools especially girls	Community	Civil society		Resources are available for implementation
Strengthening other sectors		Empowerment of girls and young women – promote access to training and income generation opportunities for vulnerable girls and young women	Special settings		Percentage of 15-24 year old who reported condom use during the last sexual encounter	Functional HMIS in place
Collaboration with other partners/sectors		Life-skills SRH education in schools BCC interventions/IEC campaigns Peer education/other outreach activities				

Interventions	Expected outcome/s	Activities	Settings	Responsible person/group/s	Indicators	Assumptions/risks
	Reduce injecting drug use (IDU) Improve quality and coverage of STI/HIV services	Laws and policies relating to drug use Harm reduction Life-skills SRH education in schools Peer education/other outreach activities Provide services in other settings including prisons Expansion of syndromic approach for diagnosis and management of STIs Expansion of quality VCT services Uninterrupted supply of drugs/ supplies/ commodities/reagents Reduction of social stigma for people living with STI/HIV			Percentage of 15-24 year olds who receive quality STI/HIV care Percentage of 15-24 year olds who know their HIV status Percentage of health facilities with uninterrupted supplies and reagents in the last 3 months Number of intervention sites offering harm reduction services Percentage of new HIV infections among 15-24 drug users Involvement of PLWHA in HIV prevention, treatment, care and support activities	

Objective: Reduce the unmet needs of adolescents for contraceptives by 30% in 15-19 years age group

Interventions	Expected outcome/s	Activities	Responsible person/group/s	Indicators	Assumptions/risks
1. Demand Creation (Increasing awareness among adolescents)	Increase in demand	<ul style="list-style-type: none"> – Mass communication – IPC – School Curriculum 	MOH, Education NGO/CBO	Increase in awareness among adolescents (compared to baseline)	Cultural barriers
2. Advocacy with stakeholders	Overcome cultural barrier	<ul style="list-style-type: none"> – Meeting with religious leaders – Families – Education department 	MOH CBO Community groups	Stakeholders have positive attitude towards adolescent use of contraceptives	Opposition from religious leaders
3. Increase availability (Adequate Supplies)	Increase availability	<ul style="list-style-type: none"> – Increase delivery sites – Ensure adequate and regular supplies 	MOH NGOs	Number of delivery sites with supplies available	Supply chain logistics
4. Supportive Policies	Policy support to provision of contraceptives to adolescents (unmarried)	Multi- sectoral consultations	MOH	Supportive policy exists	Lack of political support
5. Periodic collection of age and sex disaggregated data	Data available	Routine MIS / Surveys	MOH	Unmet needs of contraceptives for 15-19 years	Health system capacity and availability of resources



**Meeting of the National Adolescent Health Programme Managers
In Member Countries of South - East Asia Region
Bali , Indonesia , 12 - 15 February 2008**



Adolescence (10-19 years) is a period of transition from childhood to adulthood, during which enormous physical and psychological changes occur. Significant progress has been made in recent years in Member countries of the WHO South-East Asia Region in the response to specific health needs of adolescents, though sustainable and broad-based actions continue to remain a priority. In this context, a meeting of the National Adolescent Health Programme Managers of Member countries of the Region was organized at Bali, Indonesia, from 12-15 February 2008. The objectives of the meeting included the sharing of experiences with implementation; obtaining technical updates on evidence-based interventions; preparing new tools and guidelines; receiving inputs of Member countries in the draft regional strategic directions; and implementing the workplans for 2008-2009.

The 4 'S' strategic approach (Strategic information, Supportive evidence-based policies, Services and supplies, and Strengthening other sectors) suggested by WHO was accepted by Member countries and select country experiences were shared by programme managers for each component of the approach. Participants concluded that Member countries of the SEA Region have made commendable progress in addressing the health and other needs of adolescents. Access and coverage of health services is being implemented through the Adolescent Friendly Health Services (AFHS). Participants also recommended that while actively contributing to a multisectoral approach it is vital that health ministries of countries bolster the role of the health sector in collating and disseminating strategic information; developing evidence-informed policies; improving the provision of health services; and forming critical partnerships with other sectors.



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SEA-AHD-15