

SEA-MCH-225
Distribution: Limited

Adolescent-friendly Health Services in the South-East Asia Region

*Report of a Regional Consultation
9-14 February 2004, Bali, Indonesia*

WHO Project: ICP CAH 010



World Health Organization
Regional Office for South-East Asia
New Delhi
August 2004

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EXECUTIVE SUMMARY

Adolescents (10-19 years) constitute 18-25% of the population in countries of the South-East Asia (SEA) Region. Though adolescents are considered to be healthy, they face dual health problems that include undernutrition, early marriage and early childbearing in the deprived, and obesity, substance abuse, violence, injuries and suicide among the more progressive segments of the population. The existing policies and services are unable to meet the diverse needs of adolescent health and development. The available evidence suggests that when in need, many adolescents do not seek care from the available public health services and that the services are often not geared to respond to the special needs of adolescents. The strategy to respond to the health needs of adolescents is provision of Adolescent-friendly Health Services (AFHS).

The Child and Adolescent Health strategy of WHO calls for supporting national capacity- building and development of norms and standards for AFHS. The global consultation on AFHS in March 2001 focused on development of a shared understanding in the area of health and development needs and problems, and on the contribution that health services could make towards their health. Progress in development of tools to support AFHS, experience with quality assurance, initiation of pilot projects and AFHS provided impetus to hold a consultation for orientation of Programme Managers on AFHS in the SEA Region. Therefore a regional consultation on Adolescent-friendly Health Services in SEA Region was organized in Bali, Indonesia from 9-14 February 2004. The consultation was held to review the situation relating to adolescent health and development, identify the present contributions of the partners, develop strategies for AFHS by incorporating the quality assurance and quality improvement through the adoption of a public health approach to improve adolescent health and development. Participants from 8 Member countries, national and international NGOs, WHO (HQ, regional and country offices), and UNFPA attended the consultation. A number of interactive training techniques were used during the consultation. These included group discussions, roving plenaries, fish-bone analysis, VIPP, case studies and field visit.

During the consultation examples were presented from Bangladesh, India, and Thailand indicating the changing policy environment that favoured adolescent health and development. Different public health priorities were identified and importance of including Adolescent Health as an integral component of public health programming was discussed. Other issues that were discussed were: the existing barriers to access and utilization of services by adolescents including poor access, availability, affordability and acceptability of the services. The basic package of services to be provided to adolescents according to the needs and capacity of the health system to deliver services may vary in countries. Provision of good quality health services to adolescents can be achieved through a favourable policy environment, improved clinical and communication skills of providers and their supportive attitude, and the access to medicines and supplies. Different initiatives on AFHS were shared from Bangladesh, India, Indonesia and Thailand. There is no 'single or perfect model' of providing services to adolescents. Therefore while planning AFHS, there should be the choice from mix of services to adolescents. Quality of care is a useful framework to improve the effectiveness and responsiveness of health services to adolescents. Quality assurance and quality improvement for AFHS presented and illustrated by a country experience (South Africa) highlighted that to be comprehensive, quality assurance includes structure, process and outcomes. To be effective, it has to be a continuous process applied at all levels of health services and its success depends on the choice of the right method-mix based on the cost, time available and feasibility.

The consultation adopted the Bali declaration on adolescent health and development. It recommended enunciation of policy and strategy with a shared understanding among partners who can contribute to adolescent health and development. It is important to improve the scale and quality of AFHS using the public health approach. The rights of adolescents, equity, incorporation of gender concerns and human resource development should be an integral part of adolescent health and development in countries of the SEA Region. Member countries should build on existing experiences, fill the existing gaps and expand quality assurance and quality improvements at all levels of health care. The detailed conclusions and recommendations are included in the report.

Follow-up actions by WHO

- (1) Provide technical support to organize workshops at country level to discuss national-level programme issues for implementing AFHS. **(Action: WHO/HQ, RO, CO)**
- (2) The WHO country office (CO)'s capacity on the use of AFHS tools and guidelines needs to be strengthened. Opportunities at global, regional and country levels will be used to build WHO-CO capacity in provision of technical support. **(Action: WHO/HQ, RO)**
- (3) Regional capacity-building workshop on Orientation Programme on Adolescent Health will be organized to develop a pool of experts at regional level to support country-level action. **(Action: WHO/HQ, RO)**
- (4) Collaborate with UN agencies (UNFPA, UNICEF), donors, and bilateral and other partners to move the common agenda of adolescent health and development forward. **(Action: WHO/RO,CO)**

1. INTRODUCTION

A Regional Consultation on Adolescent-friendly Health Services (AFHS) was organized from 9-14 February 2004 at Bali, Indonesia by the Regional Office. The participants included Adolescent Health focal persons from ministries of Health (MoH), and selected NGOs from eight countries of the Region, WHO staff from HQ, the Regional office and staff from two country offices, UNFPA, and staff representing institutions implementing projects on adolescent-friendly health services (AFHS) in India and Thailand, and staff from international NGOs in Bangladesh (Save the Child-UK, Marie Stopes International etc.).

1.1 Inauguration

The consultation was inaugurated on 8 February 2004. Dr Georg Peterson, WHO Representative, Indonesia read out the address of the Regional Director. According to the Regional Director, adolescence is a period of rapid transition because of physical, psychological, sexual and behavioural changes. It is considered to be a healthy period but in reality a large proportion of adolescents face the risks associated with undernutrition, early marriage and childbearing- and lifestyle -related health problems, like HIV/AIDS, STIs, obesity, substance abuse, (including the use of tobacco and alcohol) violence and injuries. Despite these risks, adolescent health has not received adequate attention. In the countries of the Region, the currently available maternal and child health programmes, school health services or reproductive health services are unable to meet the diverse needs of adolescent health and development. Adolescents and their parents may not appreciate the importance of seeking timely treatment or guidance and may delay seeking help. It is clear that health care services or health care providers alone cannot meet their diverse and varied needs. Sustainable, intersectoral partnerships are needed to meet these needs adequately. Adolescents need a range of health services, that are accessible and are provided in a supportive environment. There is a need for maintaining privacy and confidentiality. To complement and extend the coverage of government-run health facilities, provision of services should be explored through community or youth centres,

marketplaces and other suitable channels. Since there is no single solution, each country should develop its own package, based on existing policy and needs. Four countries in the Region – India, Indonesia, Nepal and Thailand have initiated pilot projects to introduce AFHS. In some Member countries, there are programmes which address problems relating to substance abuse, street adolescents, HIV/AIDS, school health and reproductive health. These programmes should be expanded. He hoped that participants will have the opportunity to share country experiences and get familiarized with tools, guidelines and techniques that will help countries in the Region to expand AFHS.

Dr Azrul Azwar, Director-General, Public Health, Ministry of Health, Republic of Indonesia in his address highlighted the numerous challenges that adolescents faced. These included: the role model to follow; dealing with religion; peer pressure; anger; loneliness, and helping the adolescents see themselves in life. Adolescents often try to experiment with behaviours that parents and society may not approve of. To help adolescents to respond to these challenges, programmes need to increase the capacity of adolescents by providing them updated health-related information. They need support through non-judgmental counselling skills, confidentiality and privacy, and to be supplied with commodities and medicines. Health services should be accessible and affordable. Greater coordination and cooperation are needed with other sectors. Dr Azwar then formally inaugurated the consultation.

1.2 Expectations from the Consultation

Participants were asked what they proposed to 'give' during the consultation and what they would like to 'take' with them. Participants said that they would describe their experiences with health services, enumerate the contributions from other sectors, discuss the contributions from partners and stakeholders and identify the support needed from WHO.

The participants expected that the consultation would help in developing strategy for introducing AFHS, advocating for it, establishing and sustaining AFHS, incorporating quality assurance and quality improvements and integrating good quality AFHS in public health. The consultation should also help concretize intersectoral collaboration in providing AFHS.

2. OVERVIEW

2.1 Global Perspective

Dr V. Chandramouli, WHO/HQ identified the age groups for adolescence (10-19 years); youth (15-24 years), and young people (10-24 years). In the strategy for child and adolescent health, 'WHO's vision is a world in which children and adolescents enjoy the highest attainable standard of health and development, a world that meets their needs, and respects, protects and fulfils their rights, enabling them to live to their full potential.'

The public health approach for adolescents focuses on health conditions that represent the greatest health burden to the population (caused by their contributions to mortality and morbidity), helps to ensure that public health programmes are effective in addressing these conditions i.e. they employ safe and cost-effective interventions. Besides the health sector, adolescent health and development also come within the domain of education, social welfare, youth affairs, women's welfare and rural development etc. It is also covered to some extent by commercial and charitable organizations. At the global level, it is supported by UN agencies, and their international organizations. These are not exclusively addressing the numerous health, social, and psychological problems faced by adolescents. A public health approach to adolescents should identify the target groups, define the health outcomes to be achieved, determine contributions that health services can make, assess the existing inputs of health sector, examine the context of legal provisions and protections, and incorporate the needs and expectations of inputs on adolescent health.

For AFHS, the adolescents are at the centre. Parents, siblings and other family members are in the immediate contact of adolescents to be able to influence their behaviour. Teachers, religious leaders and others can contribute to adolescent health since adolescents are in regular contact with them. Politicians, bureaucrats and other decision-makers influence adolescent health and development policy and commit resources. Health services have the responsibility of providing health care directly and influence other partners to make the contribution they need.

The goals of programming adolescents' health are to promote their healthy development, prevent and respond to health problems when they are well and when they are ill. To be effective, this requires organization and provision of AFHS.

2.2 Regional Perspective

The regional presentation highlighted the numerous problems faced by adolescents in the countries of the Region. Their nutritional status is poor and prevalence of anemia is high. Adolescent childbearing is common, especially in Bangladesh, Bhutan, India and Nepal (above 100/1000 women in 15-19 years age). This is related to early marriage, low contraceptive use and early childbearing. The risk of acquiring HIV infections is high with more than 50% of new infections occurring in young people during 2002. Injuries cause about 10% of all deaths and 13% disabilities in adolescents. The habits of tobacco and substance abuse have their roots during adolescence. The rates of suicide in India, Nepal and Sri Lanka are high. On adolescent health status, there is a paucity of data that is nationally representative. Dr Neena Raina stressed the need for improving database to produce a convincing argument for decision-makers.

Many Member countries are yet to develop comprehensive national AHD policies or strategies. Furthermore, the Health Ministry is not the nodal ministry for issues pertaining to adolescents and youth in some countries. The MoH may not have dedicated staff for AHD and priority public health issues may need to be identified. Dr Neena Raina summarized the programme of work and the thrust areas of WHO. A five-year strategic plan for Myanmar has been developed. The process has been initiated in Bangladesh and India. Furthermore, AFHS has been initiated as a pilot in India, Indonesia, Nepal and Thailand.

The regional perspective on HIV and Young People (YP) was presented by Dr P.D. Nayar. The period of adolescence between 13-19 years provides a window of opportunity to deal with HIV pandemic. UNAIDS has estimated that nearly 1.2 million YP are living with HIV in the Region. The age at sexual debut has been coming down in the Region. Most YP lack accurate information and services and thus are more vulnerable. It makes good strategic and tactical sense to utilize the HIV epidemic as an 'entry point' to advocate for AFHS in the countries. Improved coordination between HIV and AHD programme and among various sectors should be the starting point to effectively deal with the problem of HIV among young people.

During the discussions the need for developing a core package of health services for adolescents was highlighted by participants. The package should

be need-based and focus on the expected health outcomes. Depending on the characteristics of health services/providers, different components of the package could be provided by different service providers.

There is paucity of nationally representative data and evidence to decide strategies on AFHS and influence decision-makers for greater commitment, although this should not hamper the initiation of implementation of interventions.

The HIV/AIDS programme should have a greater focus on the young people component and AFHS should include HIV/AIDS in its strategy.

3. POLICY ENVIRONMENT FOR ADOLESCENT HEALTH AND DEVELOPMENT

In Member countries of the Region, the policy environment is changing favourably for adolescent health and development. Three examples were presented to describe experiences from Bangladesh, India and Thailand to illustrate the differences in the approach used in the policy. In India, the National Population Policy (2000) refers to adolescents as an under-addressed group and includes HIV/AIDS as a priority. In 2003, the National Youth policy was approved. The Planning Commission has identified the Ministry of Youth Affairs and Sports as the nodal ministry for adolescent health and development. While this was happening, the MoH initiated pilot AFHS clinics in 10 sites with support from WHO. It also supported a district model of AHD integration in the public health system through UNFPA and UNICEF. In the national Reproductive and Child Health II (RCH II) programme, AHD has been included with a focus on provision of AFHS.

Thailand does not have an explicit national policy and plan on adolescent health, but it has been implementing AFHS with strong support from Director-General, Department of Health. Pilot projects have been initiated. Thailand has implemented different programmes in collaboration with Ministry of Public Health and Ministry of Education through a Memorandum of Understanding (MoU). A focal point of each ministry has been identified for continued exchange of information and collaborative work.

Bangladesh in its HNPS program has identified adolescents as an important segment whose health needs should be addressed. The posts of Programme Manager and Deputy Programme Manager have been established in the Directorate of Family Welfare. The Government of Bangladesh is supporting NGO efforts to implement different activities. National policy and strategy need to be articulated and current efforts incorporated in the policy.

Countries in the SEA Region are showing greater concern about adolescent health and development. Advocacy backed by evidence will be important in bringing about a change in the policy environment for adolescent health and development. This is important for sustaining the political will and to mobilize additional resources required for implementing AFHS.

3.1 Public Health Priorities in Adolescent Health

Public health priorities were identified and discussed through group work in the form of a roving plenary. Each country identified three public health priorities that are relevant to adolescent health and development. They were asked to select one that is being successfully addressed through a national programme.

Participants from Bangladesh identified (a) adolescent pregnancy; (b) under-nutrition, and (c) sexual and reproductive health, to be very relevant to adolescent health. They provided the rationale for this justification. The participants identified family planning to be a public health priority that has been successfully addressed through the national programme. The key elements contributing to this were: political commitment; a maternal reproductive health strategy; services focused on family planning, and contraception domiciliary services and campaigns to increase acceptance of contraception.

Participants from Maldives selected (a) substance abuse (b) sexual and reproductive health and (c) nutrition as their priority health concerns that are relevant to adolescent health. The problem of substance abuse has been successfully addressed through a national programme. This is attributable to high political commitment, the development of a national strategy and programme, establishing a rehabilitation centre, and initiation of life-skills programme and media campaign.

Bhutan, Nepal, Myanmar and Thailand identified (a) HIV/AIDS; (b) reproductive health; (c) hygiene and sanitation; (d) drugs and alcohol, and (e) school health. They provide the justification for their relevance to adolescent health. In Thailand, containment of HIV/AIDS is a success story. In Myanmar, leprosy has been eliminated through achievement of national targets. In Bhutan, IDD elimination is a successful programme.

Indonesia gave prominence to (a) adolescent pregnancy; (b) substance abuse, and (c) HIV/AIDS having relevance to adolescent health. The programme on vaccine- preventable diseases is a success story.

3.2 Discussion Points

Sexual and reproductive health with the focus on adolescent pregnancy, HIV/AIDS control, substance abuse, and adolescent nutrition, were considered as important public health issues that can impact on adolescent health and development. The common denominators for successful national programmes in Member countries are: (i) sustained political commitment; (ii) enunciation of policy and strategy; (iii) clear guidance on interventions to be used; (iv) surveillance; (v) community mobilization; (vi) media campaigns, and (vii) health sector reforms. Adolescent health can improve if there is a focus on programming and if it is made a public health priority. The health sector can contribute substantially through application of strategies based on lessons learnt in countries.

4. STATE OF PUBLIC HEALTH PROGRAMMING – IMPLICATIONS ON ADOLESCENT HEALTH

In the context of public health priorities selected by participants from Member countries, a roving plenary session was organized to discuss the state of public health programming to address the selected priorities. Actions taken on different elements of the programme at the district and national levels were discussed. The groups identified **where** the actions were being carried out, **by whom** were these actions carried out, and **where** were these being implemented.

Indonesia is implementing a policy on decentralization. At the district level, for adolescent pregnancies, health services are provided by the government, private sector, NGOs, public health midwives and Traditional Birth Attendants (TBAs). Counselling is provided through youth clubs, in schools, and by health care providers. Information is available from public and private health providers, schools, youth clubs and peers. Prevention of adolescent pregnancy through family planning is the responsibility of public health care providers. Public information and education is carried out by print and electronic media, through discussions in schools and by involving the peers. At the national level, the Ministry of Health provides regulation, standardization and services, Ministry of Education is responsible for school health programme, national NGOs co-ordinate provision of information and assistance, and undertake advocacy and organize services for the poor. The Ministry of Religious Affairs renders counselling and provides religious guidelines, while the Ministry of Internal Affairs supports local planning. Professional organizations support the programme through development of standards, training, and stimulating debate on legal considerations and ethical codes. The National Parliament approves the budget and gives approval for policy. Technical support and funding are undertaken by UN, multilateral and bilateral agencies. While the needs of married adolescents are met, those of unmarried adolescents are not systematically addressed by the programme. Clearly, the programme for the care of pregnant adolescent women has to be nested within reproductive health but greater visibility for adolescent pregnancy will better address the problem of higher mortality and morbidity risk during adolescence.

All other countries made similar presentations that helped to better understand the variations in programming relating to health. It also brought home the point that while the principles in programming for public health in improving adolescent health are the same, adaptations are needed to suit each country. The presentations, discussion and summary brought to light the numerous opportunities that exist in programming at different levels and how they can be utilized in improving adolescent health and development.

4.1 Barriers to Adolescent-friendly Health Services (AFHS)

A review of health services shows that information and services needed by adolescents and young adults are not available in many places or are not

accessible, for example because these are far away. Even where they are accessible, these services are often not utilized because of lack of privacy, confidentiality, a dull facility environment or judgemental attitude of providers. While health services and providers struggle to cope with limited resources and heavy demands, adolescents often lack faith in the services especially if there is shortage of medicines and the facilities are not clean and in a good state. For HIV/AIDS and STI, adolescents often do not access health services because of stigma or sociocultural reasons. They may be scared at being reprimanded by health staff for their wrongdoing.

Availability, Accessibility, Acceptability of Health Services

In many places the health services that adolescents - or even adults need - are just **not available**. The prevailing laws and judgmental health workers withhold them from adolescents.

Even when health services are available, adolescents may not be able to obtain them, e.g. because clinics are located far away. In other words, they are **not accessible** to adolescents.

Adolescents may not want to obtain the available services because of concerns about privacy. In other words, they are **not acceptable** to adolescents.

The VIPP methodology was adopted to identify barriers to adolescent-friendly health services. Participants were divided into ten groups to identify barriers to adolescent health care. These barriers were then clustered under broad headings. The barriers related to policies and health services constraints, the latter include unaffordable costs, provider's attitude, inconvenient timings or long waiting time. The lack of information and attitude of adolescents constrain the use of available services. There are sociocultural barriers that include social taboos, cultural bias, fear and inadequate support from the community.

4.2 Access vs Utilization of AFHS

In addition to barriers, the decision to utilize health services is determined by the nature of the problem and the circumstances of the individual and the

family. An adolescent may not have any hesitation in seeking health care for an injury accident or respiratory infection but may be quite reluctant to do so if there is a concern about sexually-transmitted infection or HIV. An adolescent whose family is well-educated and well-to-do, and who lives in an area close to a health facility providing adolescent health services, may be able and willing to use the services but this may not be true for a poor adolescent on the street.

4.3 Ensuring Quality Health Services for Adolescents

The concept of quality assessment and quality improvement was first initiated in the private sector and subsequently was successfully used in public health sector in reproductive health and child health even in resource-constrained settings. To sustain the application of standards, action is required at all levels to ensure quality improvement at the point of services delivery. Quality assurance and quality improvement include structure, process and outcomes. The structure includes settings and human resources in the settings in which the services are delivered. The process relates to activities and experiences in delivering and receiving care. Outcomes measure the impact that the use of health services has on adolescents in terms of satisfaction with services, quality of life and physical, sexual and psychosocial health. Based on the structure, process and outcomes, standards of quality are established to assess the client-centred care.

4.4 Causes of Low Utilization of Health Services by Adolescents

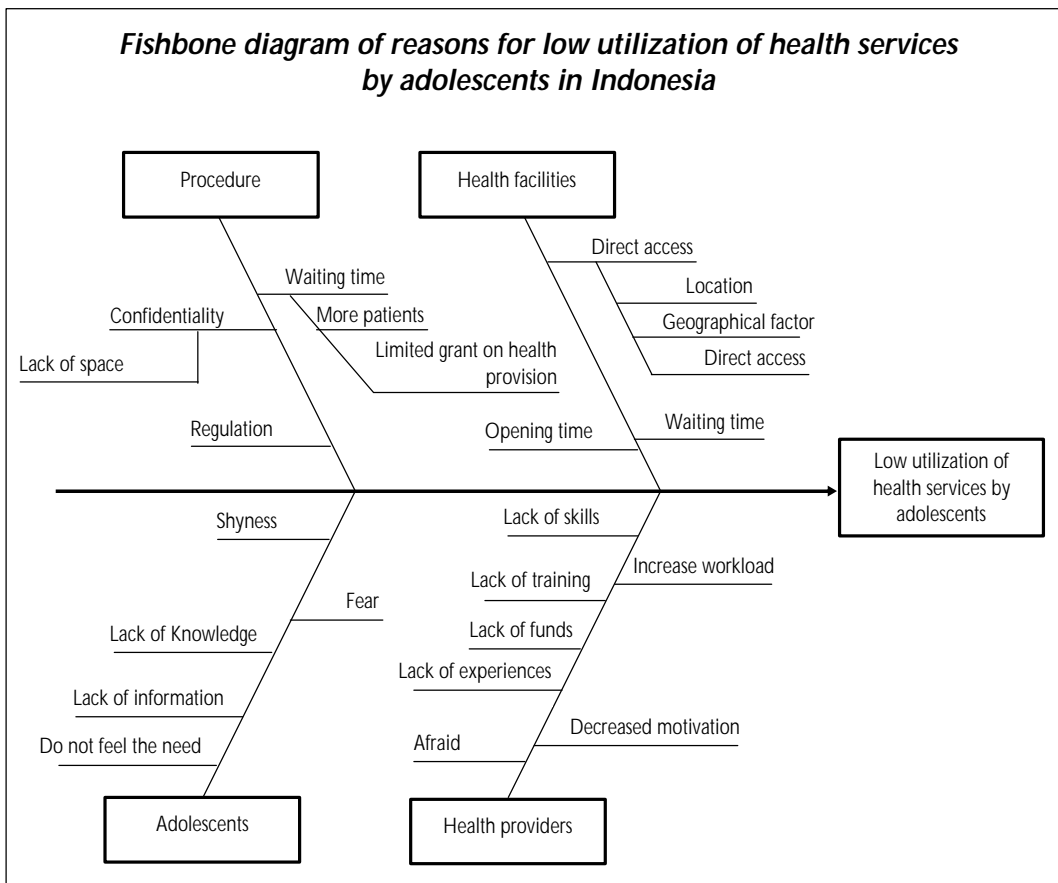
The fishbone analysis technique was used for groupwork and feedback. Four groups participated in the exercise. The theme for fishbone analysis was low utilization of adolescent-friendly health services. The root causes and the factors responsible for them were similar and often overlapping among countries.

In Myanmar (an illustrative example), the root causes identified were: (i) poor access; (ii) attitudes and skills of providers; (iii) family and community factors, and (iv) attitude of adolescents. Access to health facilities is poor because of high cost of transport and medicines, the unsatisfactory location of facility and timing which is not suitable. Health care providers are not

motivated, and lack the needed skills. They are rushed for time, are often unfriendly or even rude. Providers do not provide information and lack appropriate equipment. Parents or other family members are not free to accompany the adolescents to health facilities and they impose undue restrictions on their mobility. Adolescents themselves lack perception of the disease, and are unable to bear the costs of services. Often the adolescents fear retribution or feel shy to discuss their problems with health care providers.

Indonesia fishbone

The causes responsible for low utilization of services by adolescents in Indonesia are summarized in the illustration below:



The Bangladesh presentation, in addition to factors listed by Indonesia and Myanmar, highlighted the lack of specific policy on services to adolescents, limited mobility of girls, and lack of privacy and confidentiality while dealing with adolescents, as additional reasons for low utilization of services.

Participants from Maldives brought out the lack of media involvement in publishing available health services materials and in health promotion. The presentation by India stressed on the long waiting time, restrictive attitude of parents due to religion and tradition as additional constraints. Difficulties in terrain leading to long distance to facilities were highlighted by participants from Bhutan, Maldives and Nepal. Loss of daily wage; peer influence, and lack of parental guidance were the factors brought out by Bhutan and Nepal. Thailand mentioned lack of faith of adolescents in health facilities as the possible factor.

4.5 Basic Package of AFHS

The terms minimum package; basic package, and core package may be used by countries to define the package tailored to the needs of adolescents. The basic package of health services in ideal circumstances, should address all the promotive, preventive and curative-health services that adolescents require. However, in resource-constrained settings, health services should at the very least address urgent and important public health problems. An example from the National Adolescent-friendly Clinic Initiative (NAFCI) from South Africa was also provided. It is summarized in the box.

NAFCI Essential Services Package	
➤	Information and education on sexual and reproductive health (SRH)
➤	Contraceptive information, counselling, and provision
➤	Pregnancy-testing and counselling, antenatal and postnatal care
➤	STD information, prevention, diagnosis and syndromic management
➤	HIV information, VCT, and appropriate referral
➤	Information, counselling and referral for violence/abuse and mental health problems

4.6 Attributes of AFHS

It was emphasized that AFHS are 'context'-dependent. Gathering information about health of adolescents, care-seeking behaviour and barriers in using services in 'your particular context' will help to select the desired 'adolescent-friendly' characteristics of 'your health services'. Provider characteristics have an impact on all dimensions of quality and are therefore an important focus for quality improvement strategies. Once the characteristics of an adolescent-friendly service have been decided, setting standards, that is, expectations of health care providers' performance, as well as the performance of the facility/system is a key component of the delivery of quality adolescent-friendly health services.

What are Youth-friendly Services?

"Simply stated, services are youth-friendly if they have policies and attributes that **attract youth to the facility / programme**, provide a comfortable and appropriate setting for serving youth, **meeting the needs of young people** and are able to retain the youth clientele for follow-ups and repeat visits".
Focus on young adults: Making reproductive health services youth-friendly (1999)

This can be achieved through a favourable policy environment, improved clinical and communication skills of providers, their positive and supportive attitudes and access to drugs and supplies. The expectations of adolescents and their families and communities have to be taken into account while organizing AFHS.

5. INITIATIVES IN MAKING HEALTH SERVICES ADOLESCENT-FRIENDLY IN THE SEA REGION

5.1 Bangladesh

The representative from Marie Stopes Clinic (affiliated to Marie Stopes International – an NGO) in Bangladesh summarized the initiatives in making health services adolescent- friendly. It has 44 mini clinics. Twelve young

friendly clinics and a health card scheme in five districts cover 164 garment factories, four mobile clinics and 10 NGO partners. The *'Moni Mukta Asor'* (precious stones and pearls) initiative was started in June 2002 as a young people's programme. Clinic services are intermingled with recreational and developmental activities. The scheme covers four slums in Dhaka and two in Chittagaong. Talking about sexual and reproductive health with adolescents and young people is a taboo. Patience, good rapport-building and an exploring attitude are vital for opening up the minds of adolescents and young people. Youth clubs may be easy to establish but sustaining them is a challenge. Peer dropout is a cause for worry.

The project funded by EC/UNFPA and executed by Save the Children (SCF), UK in four urban areas in Bangladesh by local NGOs was presented. The factors that affect accessibility include: (i) adolescents give importance to confidentiality, clinic environment provider's attitudes and availability of medicines; (ii) there should be a one- stop service; (iii) clinic hours should be suitable, and (iv) if adolescents utilize the service, they feel empowered. The lessons learnt include identification of following barriers in accessing services:

- Information gap in service availability decreases utilization;
- Distance to clinics and related travel expenses are obstacles, especially for girls;
- Girls need someone to accompany them to the health facility (friend/sister/mother);
- Girls' dependency on male family members for buying medicines delays the treatment;
- Due to stigma, adolescents are reluctant to visit clinics even when they are near;
- Lack of proper referral system creates dissatisfaction among adolescents;
- Increased cost due to irrational prescription is an obstacle, and
- Ensuring a safety net remains a challenge.

Initiatives for improving reproductive health are likely to succeed if they are combined with provision of services for general health problems.

5.2 India

The Government of India is supporting 10 AFHS projects in tertiary hospitals in different parts of the country. The Safdarjang Hospital Adolescent Network (SHAHN) in New Delhi, India was described by Dr Rajesh Mehta. This project is part of a programme of the Government of India with technical assistance from WHO. It is the first AFHS initiated by a tertiary hospital in the Region. Under this project, AFHS are rendered by the hospital and safety net services for adolescents are provided by creating a supportive environment in the schools. Teachers, principals, and counsellors are trained by SHAHN. A range of services are provided, a research project was carried out to assess awareness among adolescents and number of tools and guidelines were prepared. For the success of AFHS, the perceived needs of adolescents including their non-health needs should be addressed. There are several advantages of locating AFHS in the premises of the hospital. Based on the experience of SHAHN, training of staff should emphasize communication skills, counselling skills and creation of congenial and friendly atmosphere.

The Government of India is now supporting nine other AFHS projects in different locations, all in tertiary hospitals. The experience from these centres can serve as pilots.

The experience of MAMTA, an NGO in implementing AFHS in district Rewari, Haryana, India, was presented. This project integrated adolescent health and development issues in the public health system. The project involved the health system with education department, women and child development and local self- government. Appropriate changes were made in timing of health facilities. The project promoted maintenance of confidentiality, and organized counselling services. It has received a very favourable response from the state public health system. It has increased the capacity of services providers at different levels, trained more than 300 peer educators and generated awareness. The experience of SWACH Foundation in promoting intersectoral collaboration between education, social welfare and health sectors in providing services and counselling was shared. The role of social marketing of contraceptives was also highlighted by SWACH representative.

The perception of UNFPA in meeting adolescent sexual and reproductive health in India was summarized by Dr Mandeep Joneja. The effort includes improving the knowledge and skills of adolescent boys and girls

in schools and those out of school. While adolescents in schools are reached through teachers, youth-friendly centres are established to involve out-of-school adolescents. The experience highlights the importance of convergence between states and centre, building partnerships and establishing donor coordination forum. The project is being implemented in five States of India with the focus on lifeskills education and AFHS.

5.3 Thailand

Dr Yongyud Wongpiromsan described the 'friend corner' – a national programme of the Ministry of Public Health, Thailand. "Friends corners" provide primary preventive care for adolescents including health information, counselling, and basic health care, and are used for screening and referral of adolescents to secondary and tertiary centres. These "corners" are linked to schools, workplaces, departmental stores, youth centres and other settings. At present, 43 "friends corners" are operating in Thailand. Positive attributes of these "corners" are need-based operating time, trained and sensitive staff, appropriate location that is convenient, and non-stigmatizing services. The Ministry of Public Health provides all technical and financial aid. The "friends corners" coordinate with 12 regional health centres, 75 provincial public health officers, and provincial and community hospitals. Success is achieved through linkages with health facilities and through local networking with NGOs. "Friends corners" provide a suitable environment for addressing the diverse needs of adolescents. This initiative is fully supported by the government, which has expressed political commitment and established standards and targets to be achieved.

5.4 Indonesia

Dr Eny Setiasih, Indonesia summarized the activities of a project that provides knowledge and skills on Youth-friendly Health Services (YFHS) to staff in health centres (PUSKESMAS). Ten such centres were selected five in Bandung and five in Bogor. Adolescents were involved in designing the project, and counselling was an important intervention. Experience in this project shows that AFHS can be provided in health centres. For the success of AFHS, collaboration with various stakeholders including NGOs is necessary. Provision of services and increasing access determine success. Involvement of adolescents in planning services and inclusion of counselling in the provision

of AFHS increases the involvement of adolescents. In this project a competition between 10 health centres on improved quality and access was initiated with the aim to provide some indications on the important issues related to improving the quality of services and access.

5.5 Discussion Points

Political and administrative mobilization, provision of institutional support, commitment of the staff and involvement of adolescents in planning are important elements for the success of AFHS. There is no single or perfect model, of providing services to adolescents. Therefore, while planning AFHS, a mix of services depending upon the needs of adolescents should be chosen. Similarly, there is no 'right' or ideal package of adolescent-friendly health services. The package for providing AFHS has to be defined in each country. Hospital-based initiatives have some strengths in terms of building capacity and advocacy for AFHS. Social marketing and social franchising should be considered for greater success of AFHS to extend the outreach of the package. Collaboration and involvement of all stakeholders including private providers and NGOs and intersectoral involvement are important elements of AFHS. The experience emerging from pilot projects should be utilized in planning the expansion of AFHS in countries of the Region.

6. QUALITY ASSURANCE AND QUALITY IMPROVEMENT IN ADOLESCENT-FRIENDLY HEALTH SERVICES

The services rendered by the providers need to be appropriate, comprehensive and effective. For the recipients (adolescents), these have to be accessible, acceptable and equitable. It is assumed that such services are 'available' to all but sadly in many parts of the world these are not available and accessible for adults, let alone for adolescents.

Quality of care is a useful framework to improve the effectiveness and responsiveness of health services to adolescents. Quality improvement is a continuous cyclical process and not a one-time effort. It is applicable to all levels of health services and systems. It is participatory – involves all stakeholders in order to highlight different perspectives. Quality assurance is evidence-based and uses local data to identify local problems. To be comprehensive, quality assurance includes structure, processes and outcomes.

Dimensions of quality health care for adolescents

- Availability: Health services are being provided in the geographical area.
- Accessibility: Individuals who need the services, are able to obtain them.
- Equity: Different population segments groups in the geographical area who need the services are able obtain them without discrimination.
- Acceptability: Individuals who need the services, are willing to obtain the services (i.e. they meet their expectations).
- Appropriateness: The required services are provided; services that are not needed (even if harmless) as well as harmful services are not provided.
- Comprehensiveness: The services cover all the needed aspects (i.e. biomedical as well as psycho-social).
- Effectiveness: The services bring about positive changes in the health status.
- Efficiency: The services are provided at the lowest possible cost.

At present, there are different organizations (including hospitals and health centres) that provide some services for adolescents. These are utilized by different segments based on access, perceptions and affordability. The services are often provided in a piecemeal manner: these need to be coordinated.

6.1 Assessment of Quality

Five case studies were presented in the meeting to illustrate quality assurance/quality improvement principles. The discussion on case studies helped in clarifying the doubts of participants and illustrated the importance of adopting a comprehensive approach. Building in quality assurance/quality improvements in AFHS is to be considered an integral part of the programme and it is necessary to strengthen the services for adolescents. Assessment of quality is done by using the data/information available, identifying the needs for new datasets, organizing a system for collecting, analysing and using the new data collected and deciding how the information will be used to bring about a change. The three core activities for quality assurance are: (i) defining quality; (ii) improving quality, and (iii) measuring quality. Assessment methods discussed were: (a) direct observation; (b) inventory, (c) interviews with providers and client/patient or care-taker; (d) record review, and (e) checking the knowledge of providers. The merits of different assessment methods were

discussed. The challenge is to select the right method- mix. This is determined by time, cost, feasibility and need considerations. The assessment framework should be consistent with the indicators selected. The indicators are decided to track inputs, processes and outcomes of the system. The indicators must be objective, sensitive to change, reflect the data needs and be based on improvements that are desired or targeted by the programme. The session was summed up by discussion on the framework for quality improvement.

Framework for quality improvement of adolescent health

Accessibility, acceptability & equity

- Adolescent-friendly policies
- Adolescent-friendly health care providers
- Adolescent-friendly support staff
- Adolescent-friendly procedures
- Adolescent-friendly health facilities
- Adolescent involvement
- Community involvement
- Provision of outreach/peer-to-peer services

Appropriateness and comprehensiveness

- Adolescents are addressed as individuals and not just as cases of a health problem.
- A comprehensive package of health services and other relevant services are provided or secured through referral linkages.

Effectiveness

- Health workers have the required competencies.
- Provider practices are guided by evidence-based protocols and guidelines.
- Health facilities have the required equipment, supplies and functioning basic services.

Efficiency

- Management information system and a system to utilize the information generated.
- A system by which the cost of services for adolescents can be monitored.

6.2 Field Visit to Assess AFHS

A briefing on the purpose of the field visit was provided. The participants were expected to assess the facilities using the quality assessment/improvement framework. They were briefed by the facilitators to assess the strengths and weaknesses related to provision and utilization of AFHS. As members of the district technical group, participants were expected to take into account both the provider and the client perspectives. The logistics were explained and the participants were divided into four groups. After completing the field visit, a report was presented using the VIPP method by each group. The strengths and weaknesses of services are summarized.

In Denpasar Selatan I, the policy for providing AFHS exists and the staff has been trained in providing services relating to adolescent health and development. Multiple health services are available, and staff are competent and pleasant. For general health services, guidelines, equipment and supplies are available. There is an effective referral system framework. The general health services should be strengthened so as to be focused on adolescent health and development. An in-depth analysis is required to determine the perceived needs of adolescents. To make health services adolescent-friendly, it would be helpful to identify what needs to make them more attractive and congenial for adolescents.

The Sanglah Hospital has established an exclusive clinic for adolescents within the premises of the hospital. There are good linkages with other services that the hospital provides. The cost of services are affordable, providers of services are friendly and the waiting periods are short. The weaknesses are that clinic timings are fixed and not adequate to meet the needs of adolescents. Data management is ineffective and suffers from poor tracking of records. Outreach services are not available to complement hospital-based services. The session was summarized by highlighting the characteristics of adolescent-friendly health services and review of strengths and weaknesses at both provision and utilization levels.

6.3 An Approach to Quality AFHS (The National Adolescent-friendly Clinic Initiative – South Africa)

The policy context of National Adolescent-friendly Clinic Initiatives (NAFCI) in South Africa was described by Dr Diana Silimperi. This initiative addresses

selected problems of nine million South Africans between 10-19 years at age. Over 60% of new HIV infections (more than 900/day) occur in the age group 15-24 years and the rates are increasing rapidly in the age group of 15-19 years. More than one third babies are born to young women below 18 years of age. Rape, violence and sexual coercion are common. The NAFCI strategy took about one year to develop.

A response to the above challenge was mounted as a collaborative programme through a partnerships between and among the national government, private sector, NGOs and international organizations. The NAFCI is linked to love-life. It is a comprehensive service performance and quality improvement accreditation programmes designed to bring about a positive behavioural change. In the initiative, the problems and needs of adolescents were identified, guidelines were developed and advocacy carried out. This was followed by incorporation of standards, assessment tools and selection of pilot sites. The project underlines the following guiding principles:

- The health needs of adolescents are best addressed by adopting a holistic approach;
- These health needs include promotion of healthy development and prevention of health problems;
- The sexual and reproductive health rights of adolescents should be fully protected, and
- It is necessary to involve adolescents and young adults in planning development and evaluation of services and programmes.

The presentation was discussed in details and the following points emerged:

- (1) The driving force for the project was the HIV epidemic. Suitable entry points need to be identified by countries that wish to implement similar initiatives;
- (2) Programme should address the needs of affluent and needy segments in the society for ensuring equity, and
- (3) While the health sector should take the lead, collaboration with other sectors is important for success.

6.4 Delivering AFHS

Groupwork highlighted the delivery of AFHS in countries of the SEA Region. A fictional example of Uganda for HIV/AIDS prevention programme was provided by facilitators. During this session, the participants mapped various services delivery points ; identified the multiple settings in which services can be delivered; matched the components of the package with the capacity in each site for delivery of services; groups of adolescents likely to utilize these services, and barriers to provision and utilization of services. The multiple settings identified by groups included home, schools/colleges; workplace; health facilities; shops and marketplaces; clubs, and other community locations. The components of the package included information, lifeskills provision, counselling, health services and creation of safe and supportive environment. Participants were asked to consider strategies to improve quality. Marie Stopes in Bangladesh presented as an example the quality assurance (QA) monitoring system used at the clinic and strategies for ensuring quality of care (QoC) already in place (see Box).

Marie Stopes, Bangladesh

Strategies for ensuring QoC

- Client-friendly services
- Comfortable seating and acceptable waiting time
- Comprehensive service packages
- Need-based counselling
- Continuous updating of knowledge and skills of providers
- Annual review of QoC standards
- Participatory planning and monitoring
- Confidentiality of client records
- Team motivation and commitment
- Strategic Business Planning (SBP)
- Establishing MSCS branding
- Establishing strict infection prevention practices with special emphasis on clinic waste disposal
- ISO certification (under process)

The matrix was then completed and presented by each of the groups.

7. FUTURE STEPS

Member countries in the Region placed adolescent health and development in their public health agenda to uphold ICPD commitments and MDG goals related to maternal mortality and morbidity, HIV/AIDS and other sexual and reproductive health problems; ensure that adolescent health is given adequate focus like other components of Reproductive and Child Health; meet the information and service needs of adolescents; ensure that adolescent health and development contribute to overall national development and improve the health and well-being of future generations and, took note of the public health, economic and social costs of not providing timely and relevant information and services to adolescents.

Each country during the groupwork identified doable tasks to be undertaken to implement AFHS. These were presented at the plenary. Formulation of health sector strategy, advocacy, building partnerships, and capacity-building of providers etc. were the commonly-listed steps.

8. REGIONAL VISION – BALI DECLARATION ON ADOLESCENT-FRIENDLY HEALTH SERVICES

The global vision as stated in the strategic directions for child and adolescent health by CAH/HQ was shared. Participants worked together to formulate a regional vision for adolescents of countries of the SEA Region. **It reads:**

“Our vision is to create a world in which everyone, especially adolescents enjoy the highest standards of health and development, whereby all are protected, respected, nurtured to live their life to its full potential while ensuring that their needs and rights are fulfilled”.

9. CONCLUSIONS AND RECOMMENDATIONS

At the plenary, 10 key issues to address AHD and AFHS were discussed in detail:

Ten key issues

- (1) Why should countries in the South-East Asia Region bring adolescent health into our list of public health priorities?
- (2) Within our countries, which players could contribute to adolescent health?
- (3) What is the contribution that the health ministry needs to make in contributing to adolescent health and development?
- (4) What is the importance of providing adolescents with health services they need?
- (5) What are the lessons that we can draw upon, from countries in other parts of the world?
- (6) What are the lessons that we can draw upon from within the South-East Asia Region?
- (7) What is the role that health ministries could play in ensuring that adolescents are able to obtain the health services they need?
- (8) What will it take to do this?
- (9) What is the role that international agencies could play/contribution they could make?
- (10) What are the gaps in available information?

Based on discussions, a drafting committee constituted by participants summarized the conclusions and recommendations. The main conclusions and recommendations are given below:

- The health ministries in Member countries should set a national policy, strategy and agenda for adolescent health and development; promote an integrated approach and shared understanding of adolescent needs and concerns; and initiate collection, collation and analysis of age and sex disaggregated data on married and unmarried adolescents at the national level. (Action – Member countries)
- Within countries, several ministries (Health and Family Welfare, Education, Youth Affairs, Women and Child Welfare, Religious Affairs, Law, Labour Rural Development, and others) NGOs, media, UN

agencies, and bilateral and multilateral agencies, are contributing to adolescent health and development. They should come together and form sustainable partnerships to strengthen programme implementation. Adolescents, parents and teachers should get actively engaged in this process. (Action – Member countries, WHO)

- Lessons can be learnt from global and regional initiatives on AFHS that have demonstrated success. Countries should analyse the scope of replicating and up-scaling innovative and successful micro initiatives. The available data, evidence and information should be fully utilized. (Action – Member countries)
- To improve the quality of health services and their utilization, countries should develop guidelines, tools and standards; expand the coverage of quality services; define the job description of health care providers; enhance their capacity and explore other channels for providing AFHS, such as social marketing. Supportive laws and policies should be in place to effectively deliver AFHS. (Action – Member countries)
- To provide AFHS, health ministries can consider integration of AFHS into general health services and improve planning, monitoring and evaluation; match the provision of health services with the felt and unfelt needs of adolescents and promote adolescent skills development through involvement of partners. (Action – Member countries)
- The programme on adolescent health and development should reach out to marginalized groups, integrate gender concerns; safeguard sexual and reproductive health rights of adolescents, and strengthen human resource development. (Action – Member countries)
- International agencies should provide financial and technical support in the areas of policy, advocacy, research, evidence, experience-sharing, standards and quality. Additional resources need to be generated for successful implementation of AFHS. Coordination among UN agencies, donors, and bilateral and other partners must be strengthened in order to ensure shared vision and common understanding. (Action WHO – International agencies)

Annex 1

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Annex 2

AGENDA

Sunday, 8 February 2004

Opening session

Morning (0830–1300 hrs)

Afternoon (1400–1600 hrs)

Evening (1630–1730 hrs)

Monday, 9 February 2004

- Brief overview of adolescent health and development

Note: This will cover global and regional perspectives. Both perspectives will cover HIV and young people.

- What is the place of adolescents in the national public health agenda?

What is the state of public health programming to address the nationally agreed upon public health priorities?

Note: This session will go on to examine why are things the way they are.

Country poster presentations: BAN, MAL

Tuesday, 10 February 2004

Flash exercise

- Mapping: What services are being provided? Where are they being provided? Who provides them?
- Coverage of services: Who can obtain the services they need?

- What do we know about the help-seeking and health care seeking behaviours of adolescents?
- Barriers to the provision and utilisation of services.

Note: Following the sessions, there will an open discussion on the implications of these issues for country level action.

Country poster presentations: IND, SRL, BHU

Morning (0830–1300 hrs) Afternoon (1400–1600 hrs) Evening (1630–1730 hrs)

Wednesday, 11 February 2004

Flash exercise

- Some noteworthy global initiatives in making health services adolescent friendly.
- Some noteworthy regional initiatives in making health services adolescent friendly.

- Characteristics of adolescent-friendly services.
- Actions to improve the adolescent-friendliness of health services.

Note: This session will go on to address the role that national policies and strategies need to play in making AFHS happen, as well as the opportunities and challenges that exist.

Country poster presentations: INO, NEP

Thursday, 12 February 2004

Flash exercise

- Assessment of adolescent-friendliness of health services
- Field-visit

- Field visit (continued.)
 - Feedback on field-visit
- Note: This session will address what implications the day has for follow up action at the national and regional levels.*

Reception

Friday, 13 February 2004

Flash exercise

Applying good science and good management practice in improving the quality (including the friendliness) of health services to adolescents.

- continued.
- Note: This session will address what implications the day has for follow up action at the national and regional levels.*
- Overview of tools being developed by WHO to support country level action on AFHS.

Country poster presentations: THA, MMR

Saturday, 14 February 2004

Flash exercise

Special focus on HIV and young people: The implications of the fast track strategy and its implications for country level action in terms of AFHS.

- Synthesis of conclusions and recommendations for follow up action at the country and regional levels.
- Closing session.

Annex 3

**ADDRESS BY
DR UTON MUCHTAR RAFEI, REGIONAL DIRECTOR,
WHO SOUTH-EAST ASIA REGION**

**(READ OUT BY DR GEORGE PETERSEN
WHO REPRESENTATIVE TO INDONESIA)**

Distinguished participants, dear colleagues, ladies and gentlemen,

I have the honour to convey greetings from Dr Uton Muchtar Rafei, Regional Director, WHO South-East Asia Region, to the organizers and participants of the Regional Consultation on Adolescent Friendly Health Services. As Dr Uton is unable to be here today, I have the honour to read out his address. I quote:

Adolescents comprise about 20 per cent of the population in the Member Countries of the South-East Asia Region. Thus, there are more than 300 million adolescents in this Region. Adolescents are no longer children but they are not adults either. This is a period of rapid transition as adolescents go through many physical, psychological, sexual and behavioural changes.

Adolescence is generally considered to be a healthy period. In reality a large number of adolescents in countries of the Region face dual health problems – those associated with under nutrition, early marriage and childbearing, and the lifestyle-related health problems – including STI, HIV/AIDS, obesity, substance abuse, violence, injuries etc. A large number of adolescents are out of school, are malnourished, get married early, work in vulnerable situations, are sexually active but lack the relevant information and skills for negotiating safer sex, employable but unemployed, and are exposed to pressure to use tobacco or alcohol. All these elements have serious social, economic and public health implications.

Adolescent sexuality has an overwhelming demographic impact. In some countries a large proportion of marriages and first births continue to occur

among adolescent women. Nearly 40 to 50 per cent of girls in some Member Countries of the Region are married and become pregnant before they are 20 years old. About 4 to 15 per cent of the Total Fertility Rate is contributed by 15-19 year old persons in Member Countries of the Region. Data shows that maternal mortality is three to four times in the 15-19 year age group compared to the 20 to 30-year-age group. It is clear that unless the adolescent age group is targeted with effective strategies, there cannot be a significant dent in the overall Maternal Mortality Rate in this Region. Unprotected adolescent sexual activity is also responsible for a significant proportion of STDs and HIV.

Despite the biological, public health and social significance of this phase of life, adolescent health has not received adequate attention until recently in many developing countries. It is quite clear that the currently available maternal and child health programmes, school health services or reproductive health services will not be able to meet the needs of adolescent health and development. Adolescents and their parents may not appreciate the importance of seeking treatment/guidance when the adolescents are unwell or at risk. The adolescents may also underestimate the seriousness of the problem and thus delay seeking treatment. For a variety of reasons, adolescents are unable to obtain the health services they need.

Adolescents need a safe and supportive environment that offers maximum opportunities for development, information and skills to address their health problems and to deal with their personal difficulties and conflicts effectively. It is well recognized that health care providers and health care services cannot meet their needs alone. Adolescents need a package of basic health services tailored to meet their specific health needs. These include reproductive health services; voluntary counselling and testing for HIV and other STIs; promotion of nutrition and mental health services.

What is required is adolescent-friendly health services that are easily accessible. Adolescent-friendly health services are a strategy recommended by WHO. This defines the essential service package, core values, quality standards, and a process of quality improvement. This strategy requires policy support, linkages with services for adolescents, participation from the adolescents and community support. Since there is no magic menu, each country should develop its own package based on existing policy and needs.

Although the dimensions of quality are similar for all age groups, for adolescents the two A's – Accessibility and Acceptability – are the aspects naturally equated with “adolescent friendliness”. There is also a need for privacy and confidentiality, ensuring removal of legal restrictions and cultural barriers that prevent adolescents from seeking guidance and health care, to make adolescent-friendly health services successful.

Existing hospitals and health centres can be made adolescent friendly and expand their existing services to cater to their needs. To complement and extend coverage of government-run health facilities for adolescents, other channels could be made available. Community or youth centres, marketplaces and other settings can offer community extension services for adolescents.

Health workers need to be “friendly” but they also need knowledge and skills to deliver the required package. Clinical guidelines and treatment algorithms are recognized tools “to assist practitioner decisions about appropriate health care for specific clinical circumstances. It will be necessary to develop knowledge, skills and competencies in the area of adolescent health and to encourage providers within a network to participate in a Quality Improvement programme.

I am informed that a beginning in this regard has already been made in the Region. The concept of providing targeted, appropriate and “friendly” services to cater to the needs of adolescents is increasingly being recognized. Four countries (India, Indonesia, Nepal and Thailand) have undertaken pilot projects for providing adolescent-friendly health services. Safdarjang hospital in New Delhi, India has developed the Safdarjang Hospital adolescent health care network (SHAHN) involving schools, colleges and NGOs. It provides information, education and health services using an integrated approach. Eight more centres are being supported in India. In Thailand, the Ministry of Public Health has developed 350 health-promoting hospitals committed to health promotion and to making health services more user friendly.

In some Member Countries, there are programmes which focus on specific areas like substance abuse, street adolescents, HIV/AIDS, school health and reproductive health. Although they have played an important role, much more needs to be done to expand and integrate them and to improve their quality.

Policy makers will want to know the cost of providing adolescent-friendly health services – that is, the marginal costs that may be added to the existing health system. One of the main concerns is likely to be service capacity, as rapid expansion could be problematic. However, the price of NOT delivering such services also needs to be demonstrated. This is perhaps best achieved through models which predict disease burdens and long-term health and social costs if adolescent health is neglected. Some consideration needs to be given to the type of data that should be collected in order to generate such models.

I understand that during this Regional Consultation, participants will have an opportunity to share country experiences and will be familiarized with tools and guidelines for promoting adolescent-friendly health services developed by WHO. I am sure, this will bring us one step closer to the goal of adolescent-friendly health services in the Region.

Thank you". Unquote.

I shall, of course, be apprising the Regional Director of your deliberations and their outcome, which, I am sure, will be positive.

And, in conclusion, I wish you fruitful deliberations and a pleasant stay in Bali.

Thank you.