Adolescents are a great human resource that could become the engine of national growth and prosperity. This potential can only be realized if society can ensure that they remain healthy. WHO has been playing a leadership role to strengthen the health sector response to the health needs of these adolescents. However, prevention of risk behaviours among adolescents requires contributions from several sectors outside the health sector.

A meeting of the national programme managers of the South-East Asia Region was held in New Delhi, India, on 25–27 November 2014. The objective of this meeting was to review the status of adolescent health (AH) in SEAR countries and to promote implementation of adolescent-friendly health services (AFHS) by strengthening partnerships and intersectoral coordination. Presentations and discussions were conducted on thematic areas in AH. Innovative approaches and experiences with multisectoral partnerships for AH programmes were shared. Group sessions were conducted to review and formulate regional AH indicators. This meeting report presents the summary of activities undertaken during this meeting and its conclusions and recommendations.
Strengthening intersectoral collaboration for adolescent health

Report of a meeting of regional programme managers,
New Delhi, India, 25–27 November 2014
Acronyms

AFHS  adolescent-friendly health services
AH  adolescent health
AHD  adolescent health and development
ASRH  adolescent sexual and reproductive health
BCC  behaviour change communication
DALY  disability-adjusted life years
GBV  gender-based violence
HMIS  health management information system
IEC  information, education and communication
LARC  long-acting reversible contraception
MDG  Millennium Development Goal(s)
MMR  maternal mortality rate
NCD  noncommunicable diseases
PHC  primary health centre(s)
RH  reproductive health
SEAR  WHO South-East Asia Region
SHS  School health services
SRH  sexual and reproductive health
UHC  universal health coverage
UNFPA  United Nations Population Fund
UNICEF  United Nations Children’s Fund
WHO  World Health Organization
WHELE  Women’s Health and Life Experience Study
Adolescence, the second decade of life, between the ages of 10 and 19 years is the most crucial period in a person’s life. During this phase, not only do enormous physical and psychological changes occur, but the behaviour and social perceptions of adolescents also develop, which have significant impact on their adult lives. 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 (AHD), expanded and sustainable actions remain a priority. WHO has played a leadership role in strengthening the health sector response in this area at the global and country levels. Through its 4S strategic approach, steady progress has been achieved which has resulted in achieving the goals of AHD. The four “Ss” are:

- Strategic information
- Services and supplies
- Supportive evidence-based policies
- 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. The need of the hour is to focus strategically on the fourth S, i.e. strengthening other sectors and establishing workable mechanisms for intersectoral partnership, coordination and collaboration for reaching out to adolescents for promotion of their holistic growth and healthy lifestyle.

In this context, a meeting of national programme managers of the WHO South-East Asia Region (SEAR) was organized in New Delhi, India, on 25–27 November 2014 by the WHO Regional Office for South-East Asia. The participants included national AH programme managers, focal points from AH programmes from ministries of health and education; representatives of United Nations Population Fund (UNFPA) and United Nations Children’s Fund (UNICEF) and consultants on AHD. (See Annex 1 for list of participants)
Dr Arun B Thapa, Director, than Department of Family Health and Research, WHO Regional Office for South-East Asia welcomed the participants and shared the overall objectives of the programme. He commended the significant progress achieved in SEAR to meet the numerous challenges faced by the huge population of adolescents. He noted that several Member States had developed AH programmes with the support of WHO and partners and adapted the global AH training packages to their local context. They had started building the capacity of health-care providers to deliver appropriate services in a sensitive and non-judgmental manner; however, they faced numerous challenges in scale-up of implementation. The main focus of the AH programmes had been sexual and reproductive health (SRH), including HIV. However, increased attention was needed to address unhealthy lifestyles, mental health and violence. It was important that partnerships were developed with the stakeholders and people who were “influencers” for adolescents, to empower them with knowledge and skills and generate demand for health services.

The meeting was inaugurated by Dr Tawhid Nawaz Director, Programme Management, WHO Regional Office, who read out the Regional Director’s address. Noting that there were an estimated 350 million adolescents (10–19 years of age) in SEAR. Adolescents were full of energy and life, yet they were vulnerable to several public health challenges. The recently released WHO report on “Health for the world’s adolescents” highlighted that more than a quarter (27%) of adolescent deaths in 2012 out of 1.3 million deaths globally, occurred in WHO South-East Asia Region. Unintentional injuries, particularly road injuries, were the leading cause of adolescent deaths. Globally, depression was the number one cause of illness and disability in this age group and suicide was responsible for one in every six deaths among adolescent females in SEAR.

Available data from the Region indicated that adolescents were facing a range of health and social challenges. Early marriage and childbearing were common, thereby increasing the risks of maternal mortality and morbidity. Anaemia, under-nutrition, stunting, obesity and substance abuse were common among adolescents in some countries and were causes for concern. Moreover, several risk behaviours of noncommunicable diseases (NCDs) were initiated during adolescence. The explosion of information and communication technologies, electronic and
social media that surrounded sections of today’s adolescents was associated with risks and opportunities. Changing cultural values and the influence of media promoted certain behaviours like consumption of fast food, use of tobacco and alcohol. Such behaviour among adolescents led to reduction in physical activities and contributed to overweight and obesity. These behaviours increased the risk for NCD later in life. The same technologies presented a promising opportunity to reach out to adolescents in large numbers with correct knowledge and promote healthy behaviours.

The involvement of other sectors in addition to the health sector was crucial for the prevention of such health risk behaviours among adolescents. It was very encouraging to note that the school enrolment of girls and boys in the Region and their retention in schools had progressed steadily. This provided a significant opportunity for the education and health sectors to collaboratively empower adolescents with appropriate knowledge and skills to avoid health risks and promote their health.

Provision of health services is the direct responsibility of the health sector. It is a common observation that the existing health services are not able to attract adolescents and young people. The standard reasons are lack of awareness, shyness or embarrassment, financial constraints and concern about the negative, unsympathetic and judgmental attitude of health-care providers. On the other hand, health-care providers have to develop the capacity to deal effectively and sensitively with adolescent clients. Biased and judgmental attitudes of providers and lack of privacy and confidentiality act as significant barriers to care-seeking behaviour.

He concluded that collaboration and coordination among relevant sectors to support AH still remained a challenge. It was critical that multisectoral and multi-stakeholder partnerships be developed to holistically address AHD in the Region. The efforts of Member countries to strengthen coordination among health, education, youth and relevant partners so as to develop effective multisectoral approaches for strengthening AH programmes were appreciated.

Dr Josephine Sauvarin, Technical Adviser, Adolescent Sexual and Reproductive Health, United Nations Population Fund (UNFPA), Asia and the Pacific Regional Office, Bangkok, highlighted that the early initiation of sexual activity and lack of adequate knowledge and skills to avoid risky behaviour were placing adolescents at a higher risk of unwanted pregnancies, unsafe abortions and sexually-transmitted infections including HIV/AIDS. In addition, inadequate availability and access to adolescent-friendly health information and services, along with environmental challenges related to poverty and cultural prejudices adversely affected their health. Violence, coercion and sexual abuse also posed
serious challenges to their health. She emphasized the need for efforts to develop school-based interventions to address violence, substance misuse and enhance the demand for using the services among adolescents.

Dr Genevieve Begkoyian, Chief of Health, UNICEF, New Delhi, stressed upon building common understanding, coordination and partnership among various UN partners to strengthen AH in the Region. She affirmed that it was right to invest in adolescents, since they were the future and their reproductive behaviour had a lot of impact on their nations’ health. There was a need to increase collaboration between WHO, UNICEF and UNFPA as well as between the different Regions.
3. Objectives

Dr Neena Raina, Regional Adviser, Child and Adolescent Health, WHO Regional Office for South-East Asia, explained the objectives of the regional meeting. The broad objective of the meeting was to review the progress of the AH in SEAR and to promote implementation of adolescent-friendly health services (AFHS) so as to address the basic needs of adolescents in the Region.

The specific objectives of the meeting were to:

1. review the progress of implementation of AH programme in the Region;
2. provide an update on the technical guidelines and tools on AH;
3. discuss suggested monitoring indicators and build consensus on these indicators; and
4. to discuss country plans for effective collaboration among different sectors.

(See Annex 2 for agenda)
Strengthening intersectoral collaboration for adolescent health
4. Proceedings

4.1 Overview of AH programmes

4.1.1 Global overview

Dr Valentina Baltag, Scientist, Department of Reproductive Health and Research, WHO Headquarters, focused on the global situation of adolescents. There were four arguments for giving more attention to the health of adolescents based on demography, demographic dividend, public health across the life-course and human rights. She said that the sheer number of 1.2 billion adolescents, which was 16.4% of the total global population, called for investment in AH. Despite the fact that mortality during the adolescent years was relatively low, it was estimated that in 2012, 1.3 million 10-19 year olds died, mostly from preventable or treatable causes.

The argument for more attention to the health of adolescents from the public health perspective was that the decline in mortality has been the least in 10–14 year olds and 15–19 year olds in comparison with other age groups. On the other hand, mortality due to HIV, which was the second leading cause of death globally, increased among adolescents. When the disability-adjusted life years (DALY) was considered, self-harm, iron deficiency and depressive disorders were the leading causes among adolescents in the South-East Asia Region.
She said that the WHO report on universal health coverage (UHC) unpacked what UHC meant for AH care, focusing on health manpower, quality standards and decreasing the financial vulnerability of adolescents.

The report also pulled together a range of services and interventions that could be provided to adolescents through different platforms, for example, health facilities and schools. It also provides the results of a review that was carried out to explore the adolescent component of UHC. The review identified important implications for financing, health manpower and the quality of services.

The report also synthesized the work that WHO had been carrying out on the development and monitoring of quality standards for health services for adolescents.

Finally, while discussing the upcoming global initiatives, it was pointed out that the issue would come up for discussion during the Executive Board Meeting in 2015 and it was proposed to develop a framework for accelerated action for AH centred on goals on positive aspects that Member States could strive towards. The overall aim of the framework would be to provide countries with a basis for developing a coherent national plan for the health of adolescents, and to align the contribution of all relevant stakeholders for its implementation.

Dr Venkataraman Chandramouli, Scientist, Department of Reproductive Health and Research, WHO Headquarters, discussed the journey of AH since the International Conference on Population and Development in 1994. He reviewed the progress in reducing poverty; improving access to drinking water sources, increase in primary school enrolment, mobile phone use and in eradication of polio and decrease in under-5 mortality. On the other hand, very little progress had been made in the area of adolescent sexual and reproductive health (ASRH). Weak progress was noted on abolition of child marriages and reduction in adolescent birth rates in SEAR.
Abortion services were limited and patchy; programmes were available; one in three women experienced physical and sexual violence and still issues like menstrual health problems and menarche were not adequately addressed. At the country level, not much progress had been made because of inadequate commitment, weak capacity of the implementation machinery and health providers, sociocultural barriers in discussing issues with adolescents and lack of accountability. Reaching adolescents was, however, critical to improving maternal health and achieving other MDG.

To translate these efforts into reality called for generating evidence, developing advocacy and programme support tools, running comprehensive sexuality education programmes and being mindful of limitations. It was highlighted that much more needed to be done to fulfil the promises made to young people in the Programme of Action of the ICPD. Inadequate commitment, discomfort about the subject, weak capacity, fund shortage and no real accountability were the reason for programme failures.

Countries with positive deviants were highlighted. While discussing the success story of addressing teenage pregnancies in England, it was pointed out that the primary reasons for success were found to be political leadership, availability of strategic information and evidence-based multisectoral strategies.
Finally, he concluded by saying that AH has been included in global public health and figured in a number of international commitments, high profile publications, multicountry initiatives and donor support. International organizations were positioning themselves to guide public health action in countries. National governments all over the world were also in the process of putting national youth policies and strategies in place. However, many obstacles still existed and needed to be overcome. There was very little sound epidemiological 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; inadequate resources; and weak coordination and collaboration. In addition, there were inhibitions in dealing with issues of sexuality, substance use, violence and mental health in relation to adolescents.

### 4.1.2 Regional overview

Dr Neena Raina highlighted the demographic and health indicators, knowledge, perception and behaviour of adolescents. She called attention to the diversity and commonalities of AHD problems among countries. She mentioned the risky behaviours which are acquired by them during this period, early marriage and pregnancy, tobacco use and second-hand smoking, mental health problems, and occurrence of physical violence.

The needs of adolescents are: safe and supportive environment, because they live in an adult world. They need information and skills, because they are growing and developing; and counselling and health services, because they need a safety net. She talked about risk and protective factors for adolescents and pointed out that the health sector had the main responsibility and should support the other sectors.
We know that specific interventions are effective and can be delivered to Adolescents

<table>
<thead>
<tr>
<th>Evidence-based preventive and curative health interventions for adolescents</th>
<th>Existing delivery mechanisms that could be used to deliver interventions at scale</th>
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<tbody>
<tr>
<td>• Provide age-appropriate sexual health education</td>
<td>• School health programme</td>
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<tr>
<td>• Delay early marriage and early pregnancy</td>
<td>• Nutrition programme</td>
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<td>• Provide contraceptive services including condoms</td>
<td>• Youth programmes</td>
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<td>• Prevent, screen and manage STIs, HIV</td>
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<td>• Prevention of Substance use</td>
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<td>• Work and Child Welfare</td>
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AFHS could be the link between school health and other relevant areas. Dr Raina presented some advancements made in provision of AFHS in Haryana, India. She listed the available evidence-based preventive and curative health interventions for adolescents and the existing delivery mechanisms that could be used to scale up interventions. She recommended that a multisectoral collaborative approach with other technical units within MoH and collaboration with other ministries / departments to solve these problems.

She also talked about ways of preventing early marriage - by prohibiting early marriage, informing and empowering girls, keeping girls in school and influencing cultural norms that supported early marriage. Global and national commitment as well as better understanding of the adolescent mind and brain was required to bring this about.

Dr Josephine Sauvarin talked about the situation in the Region from the UNFPA perspective. She noted the prevalence of early marriage and adolescent fertility in the Asia–Pacific region and indicated that the countries of SEAR were the major contributors for this burden. Education reduced the risk of early marriage and early pregnancy, based on World Bank data, which says “For every year a young woman remains in school after age 11, the risk of unplanned pregnancy declines by 7% for women with at least a primary education”.

On the other hand, as the age of menarche decreases and age at marriage increases, the proportion and duration of premarital sex is increasing. She highlighted that already 17% of unmarried adolescents aged 15–19 years in the Philippines were sexually active. There was sound evidence that comprehensive sexuality education, comprehensive knowledge on HIV/AIDS, gender and power showed a positive impact on AH.
She encouraged participants to think of new ways to reach and involve young people both in low-income and middle-income countries as well as high-income regions, who were the earliest adopters of information and communication technology such as mobile phones, the Internet, instant messaging, and social networking sites including Facebook and Twitter.

Dr Genevieve Begkoyian, Chief of Health, UNICEF, described the regional situation on AH issues and reiterated UNICEF’s commitment for AH at regional and country levels. She mentioned the positive development approach adopted by UNICEF, that is, from “at risk” towards “at promise” state as well as advocacy for promoting AHD through different programmes at country level. Highlighting the importance of data availability and focusing on high-risk adolescents, she compared and discussed available service delivery models for AH concluding that a combination of models was required.

The following are useful principles that are used to design, implement and monitor the AH services model:

- **Equitable**: all adolescents in age group 10–19 years are able to obtain services;
- **Accessible**: adolescents are able to obtain the available health services;
- **Acceptable**: adolescents are willing to obtain the available health services;
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- **Appropriate**: the right health services (i.e. the ones they need) are provided to adolescents; and
- **Effective**: the right health services are provided in the right way, and make a positive contribution to their health.

Describing some interventions implemented by UNICEF in selected areas, she said that Mamta Taruni Abhiyan was a peer education programme for adolescents. The peer educators were motivated girls with leadership qualities who were trained and targeted for Out-of-school adolescent girls’ scheme for promotion of menstrual hygiene – it is a social marketing programme of sanitary napkins. She identified some limitations, and a list of high-risk adolescents clusters were highlighted for special attention.

4.2 Implementation status of AH programmes: country experiences

4.2.1 Bangladesh: AH programme review and implications for renewal of national strategy

Dr KM Zahirul Haque, Programme Manager, Adolescent and School Health Programme, DGHS, Dhaka, Bangladesh presented a short programme review and implications for renewal of national strategy on AH. The primary objective was to review existing government and nongovernment initiatives to address AH issues. Six thematic areas were addressed, namely: reproductive health, early marriage/divorce, HIV/AIDS and other STI, nutrition, violence, mental health, tobacco and substance abuse, with the specific objective of examining their strengths and weaknesses so as to ascertain how well they were addressing the health needs of adolescents.
Key recommendations from this review on six thematic areas were as follows.

**Adolescent sexual and reproductive health**
- prevention of early marriage and enforcement of law;
- sharing family planning knowledge for both married and unmarried adolescents;
- establishment of adolescent-friendly corner at all the urban and rural health facilities;
- inclusion of RH-related chapters in teachers’ training curriculum;
- formulation of separate national adolescent policy addressing all aspects of adolescence;
- training the gatekeepers as the best way to provide information;
- household level counselling by field staff of community clinics, health assistants, and female health workers;
- distribution of RH information through call centres; and
- participation of adolescents in all forums.

**Violence and injury against adolescents**
- large-scale media releases required to spread information on national helpline;
- focal person/unit/ in the Ministry of Health and Family Welfare to coordinate with all sectors and other ministries;
- designation of a separate line director; and
- creation of safe environment for survivors (including one-stop crisis centre and hotline).
Nutrition
- nutrition-related lesson on academic curriculum;
- school-based nutrition programme to be more focused; and
- all recommendations to be shared with technical core committee of the national nutrition services.

Tobacco consumption
- incorporation of a specific strategy in the national strategic plan to prevent adolescent tobacco use; and

Mental health
- proper screening of mental health problems; and
- school-based counselling services.

Finally, the most important recommendation was to identify focal person for strengthening coordination with related sectors and ministries and other stakeholders.

4.2.2 Bhutan: Renewal of AH strategy

Ms Sonam Peldon, Programme Officer, Adolescent Health Programme, Ministry of Health, quoted His Majesty King Jigme Khesar Namgyal Wangchuk:

“I have always believed that a nation’s future is mirrored in the quality of her youth and that it is the government’s sacred duty to provide good education and a conducive environment for young people to become strong, capable leaders for the future.”

The adolescent population in the country was 23.9%; 56% of the population was under 25 years, and considered having huge potential. All adolescents in Bhutan including out-of-school adolescents; under-employed and employed adolescents; adolescents engaging in risky behaviours; young monks and nuns; orphans; marginalized adolescents in rural and hard-to-reach areas would be covered under this strategy. However, as outlined in the National Youth Policy, disadvantaged adolescents would be priority target groups.
The strategy was developed to address the following health issues: adolescent sexual and reproductive health (ASRH); HIV (including STI); nutrition and micronutrient deficiencies; mental health; use of tobacco; alcohol and other psychoactive substances; injuries and violence (including road safety); hygiene and sanitation including oral health; and environmental and occupational health of adolescents.

### Situation in Bhutan

- 30.8% are married before the age of 18 years (BMIS 2010)
- 10% have had their first sexual experience, by the age of 14 yrs
- 11% of all birth were among 15–19 years old
- MMR – 2.5 times higher in the adolescent age group

The six strategic objectives of the strategy were to:

- develop, deliver comprehensive life skills-based information package and curriculum that focuses on improving health and well-being of adolescent and youth;
- provide a safe and supportive environment through evidence-based, cost-effective policy and programme interventions targeting adolescents and youth in all settings;
- set up youth-friendly health services (YFHS) and increase the availability, access and utilization of such clinics;
- provide adolescents and youth with support, opportunities and resources they require in order to actively engage in implementing and decision making processes;
- enhance communication, coordination and collaboration with stakeholders to strengthen and sustain partnership in implementing AH programmes; and
- strengthen availability and use of strategic information on indicators of interest concerning AH for planning, implementing and evaluation of AH programme.

The indicators selected for monitoring implementation of these strategies were listed; and key achievements made on policy, implementation and advocacy so far were highlighted.
4.2.3 India: Multisectoral approach

Dr Sushma Dureja, Deputy Commissioner (AH), Ministry of Health and Family Welfare, Government of India, presented the newly launched national AH programme in January 2014, known as Rashtriya Kishor Swasthya Karyakram (RKSK). The programme had adopted a multisectoral approach and further complemented the RMNCH programme. It was envisaged that for better and improved health outcomes, engaging with adolescents and linking community-and facility-based care was a must. The rationale for the national AH strategy was that it was a key decade during the life course, and behaviour or conditions that were formed or begun during adolescence were associated with more than 33% of the disease burden and almost 60% of premature deaths among adults.

The programme framework addressed six thematic areas as follows:

- nutrition
- sexual, reproductive and maternal health
- mental health
- prevention of injuries and violence (including gender-based violence)
- NCD prevention and control
- prevention of substance abuse.

The programme built on the existing interventions of the adolescent reproductive and sexual health (ARSH) programme (clinics, counselling services, weekly iron and folic acid supplementation programme, and the menstrual hygiene scheme). In addition, two new community-based interventions had been introduced i.e. peer education and AH days.

Multisectoral collaboration was established between the stakeholders. Their roles were identified as follows:

- consultative group for policy formulation;
- development of resource material;
- organization of national- and state-level training;
• formulation of communication strategy;
• peer educator programme;
• implementation of folic acid supplementation programme; and
• supportive supervision.

4.2.4 Nepal: Expansion of AH services

Mr Bhogender Raj, Senior Public Health Administrator, Ministry of Health and Population, informed that ASRH programmes had been further expanded in his country. He said that the adolescent population in Nepal was 24.19% and over half of the women aged 20–24 had a child before reaching age 20. The unmet need for family planning in 15–19 years old adolescent was 41.6% and only 14.4% adolescents used modern contraceptive methods. The ASRH Programme Implementation Guide was developed in 2007 and amended in 2011. The national ASRH programme scaled up rapidly in 2011. The focus was to expand the coverage of the programme by establishing 1000 adolescent-friendly health facilities to reduce the adolescent fertility rate to 70 per 1000 women (15–19 years) by 2015.

Health services for adolescent population, such as: family planning; safe motherhood (antenatal care, delivery and postnatal care + emergency obstetric care network); safe abortion services; information, education, and counselling (IEC) on HIV/AIDS, STI and gender-based violence; social mobilization and behaviour change communication (BCC); social media; mHealth; hotline; comprehensive sexuality education (CSE)/counselling in schools through peer educators; and BCC skill-based training. The ASRH training package under the National Health Training Centre (NHTC) were scaled up.
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Multisectoral collaboration and targeted approach had been adopted. The training package had been formulated to build the capacity of the health-care providers. Training packages for district health managers and orientation guidelines for health-care providers and for various district-level stakeholders had been finalized. Several tools and IEC materials had also been developed as supportive documents to generate demand for AFHS.

Following the findings of a national study that reviewed the demand and supply side constraints in accessing ASRH services in 2014, it was proposed to give adequate attention to BCC skills and also to improve the quality of adolescent services. In addition, a new innovative service delivery model – SMS service and helpline – were developed.

4.2.5 Indonesia: Experience of adolescent health services

Ms Childa Maisni, Head of Sub Directorate School Age and AH provided details of AFHS in Indonesia. The adolescent group constituted 18% of the total population. Intervention to AH problems would give significant leverage to the overall health status of the population.

AFHS started from the community base (family, peers, school, community groups, social workers, and hotline) to primary health services, at primary health centres (PHC), and adolescent clinics (private/NGO).

A referral system was also implemented in AH care through a tiered referral
process. Hospitals were provided for secondary and tertiary level of friendly health services for adolescents.

AFHS has been implemented in Indonesia since 2003 and national AFHS standards were developed in 2010 with support from WHO Headquarters. Guidelines to implement the national AFHS standards were developed in 2013, using limited monitoring tools and ensuring that the AFHS practice quality improvement cycle was consistent every six months.

Five standards of AFHS included: human resources, health facility, adolescent participation, networking and health management.

4.3 Multisectoral approach for AH programme components

4.3.1 Bangladesh: Prevention of early marriage and adolescent pregnancy

Dr Quamrun Nahar, Project Coordinator, Centre for Population, Urbanization and Climate Change, International Centre for Diarrhoeal Diseases Research, Bangladesh, shared the experience of preventing early marriage supported by ICDDR/B/PLAN. Median age at first marriage for females 20–24 years was 16.6 years and 64% of them married before the age of 18 years. Fear among parents of breaking social norms, feeling of social pressure from others, social insecurity (sexual harassment), poverty and dowry were the common reasons given for early marriage.

Delaying age at marriage was a priority for the government and development partners. Significant social changes had occurred, especially rapidly rising secondary school enrolments for girls. There was a close link between child marriage and education. However, the expected impact (based on demographic theory and global experience) on increasing age at marriage was challenging.
Several nongovernmental organizations were working with the Government of Bangladesh to delay the age of marriage, such as the Female Secondary School Assistance Programme, UNICEF; Kishori Abhijan and Adolescent Peer Organized Network through BRAC; EKATA project of CARE; ARSHI project of USAID; community policing programme through Asia Foundation and Plan Bangladesh. Strategies and programmes were directed to address this issue at the national/policy level as well as at the community, family and adolescent levels.

A two-pronged strategy was adopted to mobilize family members and adolescents. At the family level, the focus was to engage boys and men as key ‘change agents’ to stop child marriage, increase awareness of families and communities; especially the parents, on the consequences of child marriage. Life skills and technical skills and livelihood support were provided to girl children, and awareness generated among young people of the negative impact of self-initiated early marriage.

Actions proposed for the future were as follows:

- raising awareness about the benefits of delaying marriage outweighing the cost;
- continuing integrated programme with other sectors including health and education; promoting alternative options to child marriage;
• involving communities and gatekeepers to strengthen community-based child protection mechanism and enforcement of law;
• continuing activities of enhancement of social security through community mobilization;
• ensuring continued education for girls;
• generating employment for girls in poverty-stricken regions, particularly through vocational and technical skill-building;
• keeping girls in formal/non-formal education system;
• mobilizing advocacy programme-based communication for behaviour impact; and
• planning to get expected social change to stop child marriage.

4.3.2 Thailand: Addressing adolescent pregnancy

Dr Bunyarit Sukrat, Bureau of Reproductive Health, Department of Health, Ministry of Public Health, expressed concern about the increasing trend of adolescent pregnancy in his country. He noted that in 2011, the adolescent birth rate was 53.6% compared with 33.7% in 2001. The rate of premarital sex was on the rise and use of contraceptive showed minimal increase, which resulted in high unsafe abortion and unwanted births.

The main priority was to ensure the availability of contraception and abortion services owing to the increasing number of unsafe abortions. While adolescents could easily access emergency contraceptives and were increasingly using condoms at first initiation, abortion services were still not easily accessible to young adolescents. Abortion services for adolescents under 15 years of age were available with the consent of the parents.
Within this context, the Thai government had the policy to support every birth to be desirable, safe and good quality by promoting all Thai people to have good reproductive health under the condition of voluntariness and equity. The main thrust was to focus on family bonding; promote appropriate SRH behaviours and compulsory sex education, improve SRH services and YFHS, and ensure legal support to the Reproductive Health Bill.

The new initiatives to curb the trend to prevent repeated teen births and teenage pregnancies was to provide free long-acting reversible contraception (LARC) implants and intrauterine devices to all adolescents who gave birth at below 20 years of age. Once the programme was mainstreamed, it would be extended to all adolescents, both ever and never pregnant. Introduction of the combination package of mifepristone and misoprostol for termination of pregnancy in the Thai health service systems was under way and there were plans to establish an abortion surveillance system.

### 4.3.3 Maldives: Prevention and management of GBV among adolescents

Dr Mariyam Jenyfa, Senior Medical Officer, Health Protection Agency, Malé, presented the initiative taken to address the issue of gender-based violence (GBV). She informed that one in four Maldivians belongs to the 15–24 years age group. The Women’s Health and Life Experience Study conducted in 2004 in Maldives
brought to light the magnitude of the problem and served as a launching pad for a response from the State and other concerned organizations. One in every three women was a victim of GBV. In this context, it was revealed that childhood sexual abuse (sexual abuse before the age of 15) was found to be relatively common in the country. At the national level, overall 12.2% of women aged 15–49 years were sexually abused before the age of 15.

National Reproductive Health Strategy 2014–2018 and national adolescent and YFHS were developed with focus on GBV. The integration of GBV care for women and girls into health services has been included among the strategic actions of the Health Master Plan (2006–2015).

In response, under the Seventh National Development Plan (2007), a national policy that calls for the adoption “of an integrated, zero-tolerance approach to GBV” and “advocates for the elimination of violence against children” was developed. Under the policy, the establishment of support services for vulnerable children and women was proposed. In addition, the Domestic Violence Act 2012 was enacted and included duty of care by the health sector. This led to the development of the Plan of Action from the health sector for domestic violence by the Ministry of Health and Gender in June 2013. One of the crucial activities included in the said Plan of Action was the development of national guidelines for health-care providers in order to streamline and ensure a high-quality health sector response to GBV. These national guidelines supported health-care providers in ensuring delivery of high-quality and comprehensive services to the survivors of GBV and also to prevent GBV in the community. The guidelines provided medical providers with directions to manage GBV survivors.
The following list of conditions was selected for passive screening for GBV: adverse reproductive outcomes; unintended pregnancy; unsafe abortion; delay in attending antenatal services; depression; anxiety; post-traumatic stress disorders; suicidal or self-harm attempts; unexplained reproductive symptoms; dysmenorrhea or dyspareunia; chronic pain; traumatic injuries with implausible explanations; unexplained headache; repeated health consultations with no clear diagnosis; and intrusive husband at consultations. Confidentiality, privacy, safety, non-discrimination and respect were the guiding principles in approaching survivors of GBV.

It was a challenging task to provide quality services to the survivors of violence. One of the lessons learnt was that addressing GBV in an effective manner required multisectoral, multi-pronged interventions. All concerned sectors needed to collaborate to assess the existing situation and decide what piece of the puzzle each one could take on, as a single organization/sector might not be able to carry out all required actions.

4.3.4 Bangladesh: Prevention of GBV

Dr Shimul Koli Hossain, Programme Manager (Adolescent and Reproductive Health), Directorate-General of Family Planning, Ministry of Health and Family Welfare, shared the initiatives taken for prevention of GBV. Young girls, poor women, pregnant women, homeless and street beggars, commercial sexual workers, and orphan girls were often the victims of GBV. The consequences were: unwanted pregnancies; restricted access to family planning information and contraceptives; abortions; unsafe abortions; antepartum haemorrhage (APH), complications from frequent, high-risk pregnancies and lack of follow-up care; sexually-transmitted infections including HIV; persistent gynaecological problems; and psychological problems including suicide.

The primary reasons for incidence of GBV were: lower educational status of girls and women; poverty, patriarchy; societal norms to control women; misinterpretation of religion; sociocultural restrictions on women’s mobility; polygamy; dowry; stigmatization of divorce; and remarriage of women.
The activities undertaken to promote gender equity and women empowerment were as follows:

- National Women Development Policy (NWDP) 2011;
- National Education Policy;
- increase in the women labour force in garment industries;
- participation of women in microcredit programme;
- reservation for women (60% quota) for the post of primary school teacher;
- loans from commercial banks for women entrepreneurs on easy terms;
- reservation of two seats for women in each union parishad; and
- reservation of seats for women in the national parliament.

In order to respond to the needs of victims of GBV, one-stop crisis (OCC) centres were established in Bangladesh. At these centres, all required services for a survivor of violence were addressed in one place. OCC provided health care, police assistance, DNA testing, social services, legal assistance, psychological counselling and shelter service. Efforts were also made to arrange rehabilitation for survivors, create opportunities for vocational training, education or employment. OCC provided information to women and children survivors of violence regarding various services such as health care, police assistance, legal advice, psychosocial counselling, rehabilitation, reintegration and referred them to the relevant organizations.

However, there were many challenges to be addressed as follows.

- Victims were not aware about the type and extent of GBV.
- Women were not acquainted with the legal consequences of violence and were afraid of social implications.
• Usually survivors considered GBV as a private affair and did not share details with others.
• Social stigma and avoidance led to concealing the incidence.
• There was delayed justice; limited cooperation and coordination among the stakeholders.
• OCC were limited in number and the measures to prevent violence were not very effective.
• Involvement of men in prevention of GBV was minimal.

### 4.4 Promotion of school health services (SHS)

#### 4.4.1 Global review of SHS

Dr Valentina Balteg reviewed school health services (SHS) to document how these had evolved in high-income and low- and middle-income countries. Secondly, she analysed how well SHS is aligned with priority AHD needs followed by highlighting the evidence base for the most popular SHS interventions.

She presented information from 145 papers, articles, describing SHS in 102 countries and territories. Most of the settings were school-based, with vaccination, health education/promotion, screening and counselling being the common services provided. Doctors and nurses were the common service personnel in these activities.

Since the 1950s, schools had been popular settings for health promotion and health education. Early programmes were focused on teaching children about health and its determinants, but the importance of enabling them to develop the skills to resist unhealthy lifestyles was soon recognized. Most programmes now teach these skills. The development of school health promotion programmes has been influenced in general by developments in health promotion policy. The Declaration of Alma Ata in 1978, which aimed to provide a framework for the development of health strategies in WHO Member States, called for multisectoral approaches to health promotion and for public participation in developing and providing health programmes.
Early school health promotion initiatives were developed in the tradition of the medical model to prevent specific diseases or health problems. The global review on SHS: data from 102 countries showed that most of the time the SHS were based on the medical model and were screening-oriented. There had been a mismatch seen in the areas addressed and the top 10 causes of DALY lost among adolescents.

Studies had shown that there was a paradigm shift from the medical to social model of care. The focus had shifted from health check-ups to more preventive visits by health-care providers. Many current school programmes for promoting health, including all health promoting school initiatives, had holistic goals that aimed to promote the health and well-being of students, staff, and even parents, as well as to prevent disease.

SHS was an effective way to reach the underserved children and address new morbidities and concerns. Some effective school-based interventions were: vaccination, curriculum-based SRH education, motivational and cognitive approaches to counselling and contraceptive provision.

She concluded that there was room for better alignment between SHS and major public health concerns (e.g. mental health, violence prevention, and support for students with chronic conditions). Interventions that were known to be effective i.e. motivational and cognitive approaches to health dialogue, contraceptive provision, should find a place in SHS provisions.
In addition, the issues of shortage of human resources, poor coordination, inadequate financing, poor or unknown quality of care, low community involvement, equity and inadequate policies should be tackled.

4.4.2 Thailand: Promoting mental health in schools

Dr Panpimol Wipulakorn, Deputy Director-General, Department of Mental Health, Ministry of Public Health, described the mental health programme in schools. While discussing the Thai burden of mental disorders, he said that DALY loss due to alcohol use disorder, homicide and violence was much higher in the age group of 15–29 years and was alarming. Since almost all children and adolescents were in the educational system due to 12 years’ compulsory education, it was planned to develop a school-based approach to provide mental health care for children and adolescents.

The strategic plan was to integrate mental health care into the educational system by building the capacity of teachers to provide mental health services in school. The primary mechanism was to provide mental health services in school by mobile mental health teams. Under this school system approach, mental health was promoted by providing life skills, screening for vulnerable, treatment and rehabilitation services for victims and early referral.

The key factors contributing to the effectiveness of the programme were: policy support – both the health and education ministries had policies on mental health – increasing awareness of mental health issues and their significance in the healthy growth of adolescents and children; followed by teachers’ network
and mental health-care teams. However, the main challenge was that although the school mental health programme was supported by policy, the priority given to the programme varied among schools. The frequent turnover of the teachers, especially the school administrators, hit the success of the programme. Finally, limitation of resources to expand coverage of the programme was also a major concern.

4.4.3 India: School-based approach for prevention of tobacco use

Dr Monika Arora, Director, Health Promotion and Adjunct Associate Professor, Public Health Foundation of India, said that South Asia, where more than half of the world’s poor lived, was also the single largest area on the globe for production and consumption of tobacco products. Tobacco-related illnesses account for one in 10 adult deaths worldwide and it was projected that by 2030, the number of deaths would increase to 8 million each year (WHO-MPOWER, 2011).

The tobacco burden in India was unique due to rampant consumption of both smoking and smokeless forms of tobacco. The availability of myriad varieties of smoking and smokeless tobacco products made tobacco a versatile product for consumption among adolescents. These myriad varieties added to easy availability and affordability of tobacco products for children and adolescents. There were multiple levels of determinants that influenced children and adolescents to experiment and continue using tobacco, ranging from genetic factors, addictions to nicotine, and self-image to lack of knowledge about health effects and fewer refusal skills that make them vulnerable to peer pressure. Moreover, the tobacco industry is increasingly targeting adolescents, which is contributing to escalating prevalence of tobacco use among adolescents.

Project MYTRI (Mobilizing Youth for Tobacco Related Initiatives in India) was a multi-component tobacco prevention and control intervention (RCT) conducted in 32 schools in Delhi and Chennai with about 14,000 adolescents. The intervention design was developed to focus not only on classroom curriculum, but also involved parents and peers. It had shown effectiveness in decreasing both smoke and smokeless tobacco use among students.
A collaborative study between HRIDAY, University of Southern California, USA, and PHFI done on Project EX: school-based tobacco prevention and cessation programme in Delhi, India, showed that about 27% of students reported that Project EX helped to strengthen their commitment to stay tobacco-free or never use tobacco. The study found that current tobacco use was five times higher in students who were highly receptive to tobacco advertising than those who were least receptive, and tobacco use was also 12% higher in those exposed to tobacco advertisements.

Current tobacco use was almost twice as high in those students who were exposed to tobacco advertising in more than four places compared with those who were not exposed to any.

The need of the hour was to protect adolescents from the tobacco industry's targeted marketing strategies, exposure to second-hand smoke and tobacco addiction. Addiction was best prevented by preventing initiation of new smokers, and those experimenting from becoming regular users, and motivating and helping regular users to quit.

A collective advocacy drive at the global and national levels could play a significant role. A Youth for Health (Y4H) movement was launched, which was working towards facilitating concerted actions for introducing and implementing health-promoting policies and collectively campaigning on pressing health concerns for youth.

Youth health advocates assumed leadership in innovative tobacco control advocacy, education and prevention, information exchange, policy development and decision-making. Synergy between youth-led tobacco control and NCD prevention and control efforts could make a lot of difference. The ministry of health should promote policies to create tobacco-free environments for youth, e.g. tobacco-free universities, schools; and emphasize policies to protect youth from exposure to tobacco use.
4.4.4 Sri Lanka: Capacity-building of health workers for school health

Dr Ayesha Lokubalasooriya, Consultant Community Physician, Family Health Bureau, made a presentation on building capacity of health workers on school health. Various global health surveys had shown that mental health problems among adolescents were fairly high. As per Global School Health survey 2008, 37.8% of students were bullied one or more times during the past 30 days; 7.5% of students felt lonely most of the time or always during the last year; 4.9% of students felt so stressed that they could not sleep at night during the past 12 months; 32.5% of students felt sad or hopeless almost every day for two weeks; 10.4% of students considered attempting suicide; and 34% of students spent three or more hours per day on sedentary activities such as computer games or watching television.

It was decided to focus on the contents of mental health training modules. The modules primarily focused on developing skills to identify mental health problems and behavioural disorders, risk and promotive factors for mental illness and management of mental health problems. A total of 1950 school teachers and health officials were oriented on AH modules, life skills training and School Medical Inspection training. District officials were trained to develop their action plans on AH according to the WHO guideline “managing programmes to improve child health”. To facilitate the implementation of school and AH programmes, various guidelines were prepared, namely, school health guide, psychosocial guide and training guide for health officials to identify children with special needs.

The future plan of action was to review the school health programme based on WHO modules on short programme review, scaling up child-friendly schools, incorporation of AH into vocational training and strengthening field health care to non-school going adolescents and adopting a multisectoral approach (ministries of health, youth and social development, and education).
4.5 Review of existing AH projects and programmes

4.5.1 Policy analysis

Ms Justine Sass, Asia–Pacific Regional AIDS Adviser, Chief, HIV Prevention and Health Promotion Unit, UNESCO, presented a policy analysis on adolescent access, rights and realities, legal and policy barriers to SRH and HIV services in the Asia–Pacific region. She highlighted the prevalence of high level of unsafe abortions and HIV among young people in the Asia–Pacific Region. Their access to health services was influenced by multiple factors. The review was conducted by Dr John Godwin in data on legal and policy frameworks that impact on SRH and HIV service provision for young people from 32 countries in the Asia–Pacific.

He analysed this issue under four research questions, namely: what national laws, policies and strategies existed in the countries of the Asia–Pacific region that governed access to SRH and HIV information and services, along with international/regional commitments and conventions; how did these legal and policy frameworks impact on SRH and HIV service provision for young people; what legal measures protected the rights to health of young people, including young key populations; and what approaches need to be taken to address gaps in the protection and promotion of young people’s right to health and to ensure access to SRH/HIV services.

She highlighted some key findings of this study. Most countries continued to have laws of the colonial era and conservative legal traditions relating to sexuality and reproduction. Many had not updated them to suit the current needs of young people (e.g. same-sex conduct, sex work and abortion). On the other hand, laws were often lagging behind policies and were interpreted in a contrary manner, creating much confusion.

A finding was the mismatch in consent laws and youth realities; the age gap between the age at consent for sex and age at consent for medical intervention is wide. Throughout the region, abortion services had been restricted to very
few criteria and parental consent was required for minors. This hindered and criminalized abortion services rendered to young people. Change in these laws would open up more opportunities for health promotion among young people. Not only the abortion services, but also homosexual activities, harm reduction for drug abusers and HIV services were affected by these limitations enforced by the colonial laws. This criminalization created a power imbalance between the police and young people, which led to increased vulnerability to police abuse, harassment, extortion and violence.

Some good practices noticed among the regional countries were highlighted. One of these was the ‘mature minor’ principle that recognized the capacity of some minors to independently consent to services. She also noted that eight countries either had done or proposed to expand independent access to HIV testing for young people.

She concluded with the following recommendations for the region:

- increasing youth engagement in advocacy and decision-making on legal and human rights issues linked to SRH/HIV;
- recognizing the evolving capacity of adolescents to make independent decisions regarding their health;
- building technical capacity and operational guidance for health workers to understand their legal responsibilities;
- improving law enforcement practices; and
- building a better evidence base to inform SRH/HIV policies.
She also called for strengthening partnership between UNAIDS, UNDP, UNESCO and UNFPA to develop a legal advocacy toolkit and support development of shadow/alternative reports as part of the upcoming Convention on the Rights of the Child and Universal Periodic Review (UPR) processes in at least three countries.

4.6 Sexuality education

4.6.1 Sri Lanka: Sexual education programme for adolescents

Mr Anura Abeywickrama, Assistant Director of Education, Health, Physical Education and Sports, Ministry of Education, presented the school sexual education programme in Sri Lanka. The education policy in Sri Lanka was developed by the National Education Committee. The curricula and syllabi were drawn up by the National Institute of Education and all subjects had competencies-based syllabi. These sexual education syllabi were taught in two subjects: health and physical education, and science. Science was taught in all classes whereas health and physical education was a compulsory subject for junior school students, but optional for senior school students.

With this approach, sexual education was started from Grade eight (08) in the health and physical education subject and Grade ten (10) in science subject. A wide range of topics related to sexual health were covered in this syllabus; not only physical growth and maturity, but the psychological changes and challenges were also dealt with.

The resources for this teaching were developed by collaborating with school teachers. Pre-service programme, provincial, zonal, and divisional level workshops, postgraduate education, diploma course and teacher training college courses were designed for teachers involved in sexuality education at schools and colleges of education.
In conclusion, he summarized the challenges and obstacles faced; teachers’ attitudes towards sexual education, lack of skills of teachers in teaching sexual education, parental attitudes, cultural norms and values, religious norms and lack of subject teachers.

4.6.2 India: Adolescent education programme

Adolescent education programme to impart sexuality education in India was started in 2005 with joint national agency coordination and monitoring board. It was designed to address the growth and development issues of young people, STI and gender issues. However, it was soon suspended by seven states, as the content of the programme was socially unacceptable. This led to joint action by UNESCO and UNFPA to study the school health delivery system and its opportunities and challenges among selected countries: Bhutan, India and Nepal. This initiative was at its planning stage and the need for similar studies was recognized as essential to get the information for advocacy of these programmes.

4.7 Monitoring and evaluation of AH programmes

4.7.1 Case studies and systematic review of evaluations of AH programmes

Dr Venkataraman Chandramouli presented case studies and systematic review of evaluations of AH programmes. He traced back the evolution of AH services in India to 2001 when AFHS was initiated. It was a critical component of a multifaceted approach to improve AH. In 2001, a Global Consultation on AFHS was held. After this, a WHO-supported pilot project on AFHS initiatives in states/union territories was conducted. Later in 2005, an implementation guide on ARSH strategy (with a focus on AFHS) was developed. Implementation started in 2006 as part of the National Reproductive and Child Health Strategy with the support of states/union territories. Finally, it got shaped into the form of a national AH programme (Rashtriya Kishor Swasthya Karyakram), which was launched in 2014.
The states and non-profit organizations stepped up their efforts to implement AFHS, and a growing body of reports, conference presentations and articles documenting different aspects of efforts to make SRH services adolescent-friendly was generated. However, these useful lessons had not been collated and synthesized and little was known about evaluation trends.

Dr Chandramouli described a review by Andrea J Hoopes, Paras Agarwal and himself conducted to learn about the strengths and weaknesses of evaluations and studies that have been carried out and to get an overall picture of the state of efforts to introduce AFHS in India.

Published articles and evaluation reports publicly available since 1 January 2000, Medline, EMBASE, gray literature, NGO: international and indigenous professional societies, the Ministry of Health and Family Welfare and other sources gathered from co-authors were accessed to collect articles for this review. Any article or report that described a research study or an evaluation on making AFHS in India was included.

The aims of the evaluations/studies included were to assess quality of health services (13 evaluations and three studies) to describe utilization of health services by adolescents (four evaluations and four studies), to measure SRH knowledge of adolescents exposed to a programme or service (four evaluations and four studies) and to assess behavioural outcomes or health impacts (few). However, none of them were to assess the health impact of the project. Main findings extracted from this review were that few evaluations/studies commented on programme design or fidelity of implementation. Many evaluations/studies found increased health service utilization and some increased knowledge about SRH needs of adolescents among clients themselves and health service-providers.

In conclusion, he stressed the usefulness of these evaluations and studies of AFHS initiatives being performed and disseminated, and encouraged Member States to carry out similar reviews to learn about the strengths and weaknesses of AH programmes.
4.8 Updates

4.8.1 Healthy transition package for adolescents

Dr Rajesh Mehta, Medical Officer (Child and Adolescent Health), WHO Regional Office, noted that significant progress had been made in achieving MDG 4 and 5, though much more needed to be done. The social as well as cultural determinants in health service-seeking behaviour of adolescents were to be addressed. Adolescent mothers were at 50% higher risk of perinatal deaths. Correctable conditions like maternal undernutrition and iron deficiency anaemia was related to 20% of maternal mortality as well as low birth weight and Intra Uterine Growth Retardation. Women with epilepsy, infected with rubella, or exposed to tobacco and alcohol had greater risk of having babies with birth defects. Of pregnant women not being treated for gonococcal infections, 10% resulted in neonatal deaths.

<table>
<thead>
<tr>
<th>Intervening during pregnancy is too late for many interventions</th>
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</thead>
<tbody>
<tr>
<td>• Intervening after a woman is pregnant has limited impact:</td>
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<tr>
<td>– First few weeks after conception are critical for fetal development</td>
</tr>
<tr>
<td>• Week 5: brain, spinal cord, heart begin to form</td>
</tr>
<tr>
<td>• Week 6: Neural tube closes; the heart is pumping</td>
</tr>
<tr>
<td>• Week 7: Brain and face are rapidly developing</td>
</tr>
<tr>
<td>• Most women do not seek prenatal advice/care before 12 weeks when it is too late to modify many risk</td>
</tr>
</tbody>
</table>

Pointing out that pre-pregnant health status and behaviours were associated with RH outcomes directly or indirectly, he said that many risk behaviours were initiated during adolescent age; for instance, 90% of adult smokers started smoking before the age of 20. Intervening during pregnancy would be too late for healthy outcomes, since most fetal development took place early in the first trimester of the pregnancy. Hence, intervening before pregnancy: proximal to the period immediately preceding pregnancy and distal at adolescent period (10–19 years of age) was considered. Healthy transition at adolescent period will be in the continuum of care across life course for healthy adolescent, healthy RH outcomes and healthy adulthood.
This approach had to be incorporated in the healthy transition package.

- professional education – health worker capacity;
- public awareness – health education;
- evidence-based intervention (pre-pregnant care package already developed);

- accessible and affordable services;
- monitoring and evaluation; and
- research to review whether intervention is efficacious or not.

The following health problems and risk behaviours and their contribution to maternal and childhood mortality and morbidity need to be addressed by this preconception care model; SRH issues such as too early or too frequent pregnancy; unintended pregnancy; nutrition-related health problems such as diabetes mellitus and iron deficiency anaemia; alcohol and drug abuse; tobacco abuse; vaccine-preventable diseases; genetic conditions; mental health conditions; HIV and STI; GBV; and environmental health issues such as pollution and exposure to pesticides.

An intervention delivery channel must be identified depending on the intervention. Information and communication technology can be used as a channel to provide as well as collect information. The existing opportunities are the health facilities, school and outreach. A healthy transition package can be added to a preconception care package.
4.8.2 Sri Lanka: Preconception care

Dr Anoma Jayathilake, National Professional Officer, WHO Country Office, Sri Lanka, presented the preconception care experience so far. She mentioned that although the maternal mortality rate (MMR), infant and under-five mortality rates were going down in the course of time, the incidence of congenital anomalies has remained static. The decreasing trend of low birth weight leveled from 2001 to 2006. The other rationales of intervention were GBV, teenage pregnancy, undernutrition and missing gaps of continuing care. It was intended to go beyond MDGs 4 and 5 and to fill the gap in the lifecycle approach.

This intervention was targeted at newly married couples where the woman was 15–49 years of age and legally married and the service was provided by midwives. The expected outcomes were increase in RH awareness and improved health status of couples. The tools used for the intervention were: invitation card, screening tool, guidelines for midwives, book for couple and BMI chart. The invitation card was provided to couples at the marriage registration. Then the couples informed the midwives and the screening was done to identify the risk by using the tool before referral for examination by a medical officer.

Two health education sessions were provided to the couples (known as Suduru Kadella – Happy Home). Immunization was also provided. Capacity development for health workers who participated in the intervention was also included. The intervention was piloted in 2011 in two districts and in 2012, it covered 17 out of 26 districts.
The project was monitored by measuring indicators of percentage of couples receiving preconception screening, and two health education sessions. In Sri Lanka, MCH policy was revised in 2014 with the goal of promoting the health of women and their partners.

4.9 Regional framework: health indicators for AH

Strengthening programming for AH in countries was supported by WHO Headquarters and the Regional Office with consistent attention to the linkage with measurement as an integral part of the process. In line with this approach, the AHD Unit in the Regional Office participated in a process with AHD in WHO Headquarters in October 2014 to support the development of a set of indicators to inform and monitor the health status of adolescents to be used globally, regionally and nationally. Following this expert consultation in Geneva, the AHD Unit had introduced the draft set of AHD health indicators at this regional programme managers’ meeting to continue a regional process of reviewing, vetting and/or adapting and adding indicators considered relevant for the countries of SEAR.

A brief plenary presentation was made of the Geneva process followed by a brief group exercise. The group exercise was designed to provide an opportunity for the regional participants to undertake a brief review of the draft list of AHD indicators and score them. The scoring was to be done using the same criteria used for the expert review of the draft global AHD health indicators. The four scoring criteria were: 1) public health relevance, 2) valid construct, 3) feasibility of measurement and 4) changes detectable over time for subpopulations.

Table 1 below provides the summary results of the “Quick” scoring exercise conducted at the workshop, which were then ranked as a follow-up. These results are just “indicative” since as noted, the actual process in countries needs to be accomplished in consultation with all relevant stakeholders and experts with some time taken to discuss the current literature, particularly on the validity of the constructs and the feasibility of measurement. Thus the results presented below should be considered a “taste” of a possible list of AHD indicators to be finalized through an extended consultative process.
Table 1: Results of the country-scoring exercise (summarized and tabulated)

<table>
<thead>
<tr>
<th>Indicator type</th>
<th>Indicator name</th>
<th>Indicator#</th>
<th>Indicator Score</th>
<th>Ranking</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mortality</td>
<td>MMR</td>
<td>#6</td>
<td>11.2</td>
<td>#1</td>
<td></td>
</tr>
<tr>
<td>Health service output indicator</td>
<td>Skilled birth attendant</td>
<td>#26</td>
<td>10.9</td>
<td>#2</td>
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<tr>
<td>Health service output indicator</td>
<td>National standards for health service delivery to adolescents</td>
<td>#31</td>
<td>10.5</td>
<td>#3</td>
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<tr>
<td>Morbidity indicator</td>
<td>Anaemia prevalence among women of reproductive age (disaggregated for 15–19)</td>
<td>#12</td>
<td>10.4</td>
<td>#4</td>
<td></td>
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<tr>
<td>Health service output indicator</td>
<td>Health service utilization by adolescents</td>
<td>#30</td>
<td>10.2</td>
<td>#5</td>
<td>Tied scores are included here for simplicity</td>
</tr>
<tr>
<td>Health service output indicator</td>
<td>Trained health service provider on AHD</td>
<td>#32</td>
<td>10.2</td>
<td>#5</td>
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</tr>
<tr>
<td>Determinant indicator</td>
<td>Correct knowledge for prevention of HIV</td>
<td>#27</td>
<td>9.8</td>
<td>#6</td>
<td></td>
</tr>
<tr>
<td>Morbidity/health condition indicator</td>
<td>Prevalence of underweight</td>
<td>#11</td>
<td>9.75</td>
<td>#7</td>
<td></td>
</tr>
<tr>
<td>Mortality</td>
<td>All-cause mortality</td>
<td>#1</td>
<td>9.6</td>
<td>#8</td>
<td>Tied scores are included here for simplicity</td>
</tr>
<tr>
<td>Behaviour indicator</td>
<td>Intimate partner violence prevalence</td>
<td>#18</td>
<td>9.6</td>
<td>#8</td>
<td>“ ”</td>
</tr>
<tr>
<td>Indicator type</td>
<td>Indicator name</td>
<td>Indicator#</td>
<td>Indicator Score</td>
<td>Ranking</td>
<td>Comments</td>
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<tr>
<td>Behaviour indicator</td>
<td>Current alcohol use</td>
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<td>9.6</td>
<td>#8</td>
<td>&quot; &quot;</td>
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<tr>
<td>Morbidity/health condition indicator</td>
<td>Prevalence of obesity</td>
<td>#14</td>
<td>9.4</td>
<td>#9</td>
<td></td>
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<tr>
<td>Morbidity/health condition indicator</td>
<td>HIV/ Incidence among adolescents</td>
<td></td>
<td>9.25</td>
<td>#10</td>
<td></td>
</tr>
</tbody>
</table>
5. Conclusions and recommendations

5.1.1 Conclusions

Participants acknowledged that adolescents constituted one-fifth of the population in Member States and constituted an extremely important national resource. Child marriage and adolescent pregnancy contributed to persistently high neonatal and child mortality in the countries of SEAR. A well-coordinated multisectoral response was required at the national level to address these problems.

Violence, injuries, HIV and mental health issues were noted to be responsible for significant mortality and morbidity among adolescents in countries. Noncommunicable diseases risk-behaviours need to be addressed during adolescence, as many such behaviours are initiated at this stage. Participants noted the thoughtful inputs from the representatives of youth from Maldives, Myanmar and Thailand on the perspectives of adolescents / young people. The importance of multisectoral response for promoting AHD was unanimously emphasized.

Prevention of health risk-behaviours and adoption of healthy lifestyles among girls and boys are essential for their health during adolescence as well as for positive RH in the future and healthy adulthood in the long term. This lifecycle approach is essential for healthy longevity being considered in the global post-2015 development agenda.

Reaching and involving boys and men in supporting the health and development of adolescents is essential, particularly in relation to GBV issues. Strategies and interventions for undertaking this have to be developed, tested, applied and monitored.

Progress in scaling up national AH programmes in countries as well as challenges were noted by participants. They emphasized the importance of documenting progress by undertaking reviews and evaluation of the programmes periodically to make mid-course adjustments as required.

A list of regional indicators should be developed based on the global indicators. Integrating core AH indicators in the existing national health information systems (HMIS, DHS, GSHS, GYTS) would be the best way forward.
Scaling up was crucial while ensuring the quality of services and increased access for the marginalized groups of adolescent girls and boys whose needs are the greatest.

5.1.2 Recommendations

Member States should:

- continue to invest in the health of adolescents to ensure benefit of demographic dividend towards national development;
- undertake review and strengthen laws and policies related to AH issues to ensure easy accessibility and utilization of health services;
- expand existing national AH programmes rapidly to provide good quality and easily accessible health services to all girls and boys, especially the marginalized, by enhancing the capacity of providers and making facilities ready;
- broaden the package of services to include prevention of NCD risk-behaviours, and management of injuries, violence (including GBV) and mental health conditions among adolescents;
- strengthen SHS as an important service delivery platform to increase the coverage of preventive interventions for adolescents as well as accelerate progress towards universal access to comprehensive sexuality education;
- ensure the valuable involvement of boys and men in the development and implementation of adolescent RH interventions;
- strengthen the continuum of care across the life-course by introducing “Healthy transition” package to improve the health of adolescent girls and boys, improve SRH and in the long term, ensure better adult health;
- actively engage with the relevant ministries and stakeholders to ensure that girls and boys receive holistic support, information and services for their health and development;
- actively collaborate on school-based services, skills development and vocational (employability) training for in-school and out-of-school settings, with particular attention on ensuring support for the participation and empowerment of adolescents;
• systematically enhance the national AH programmes for meaningful participation of adolescents in designing the services and improving their own health and well-being;

• recognize the role of parents, families and communities in programmes and develop strategies to engage them meaningfully to enhance their support for improving the AHD and address cultural issues like gender imbalance, child marriage and early pregnancy;

• develop and implement approaches to orient all gatekeepers, including health-care providers, to improve their communication and counselling skills to ensure behaviour change towards healthier outcomes for adolescents;

• strengthen the monitoring and evaluation of national AH programmes and include regional / national AH indicators in their health information systems ensuring that non-health sector indicators are incorporated appropriately; and

• undertake quality improvement process for facility-based and community outreach AH services.

WHO and partners should:

• continue to advocate for scaling up and expanding the scope of AH in the global post-2015 development agenda and strengthen such collaboration at national and subnational levels;

• organize regional meetings of national programme managers, UNESCO, UNFPA, UNICEF, WHO, partners and other stakeholders once a year and exchange experiences and discuss new and emerging issues;

• enhance and strengthen technical support to Member States for scaling up and expanding AH programmes using multisectoral approaches, particularly to generate evidence of workable models and to give special attention to provision of services through school setting;

• continue to provide support to mobilize resources and build capacity in Member countries and assign priority to enhance managerial capacity at all levels with emphasis on district planning and programming of AH;

• provide technical support for undertaking operations research, programme review, coverage and quality assessment to strengthen policy, strategy and implementation of AH programme; and

• optimally utilize the social media sites for wider dissemination of information and experience-sharing.
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Strengthening intersectoral collaboration for adolescent health

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Annex 2: Agenda

- Global and regional overview of adolescent health programmes
  - “Health for the World’s Adolescents 2014”
  - Where are we today, 20 years since the ICPD
  - Regional overview: Progress in AH in South-East Asia
- Implementation status of AH programmes - country experiences
- AH programme review and implications for renewal of national strategy
- Renewal of AH strategy
  - National AH Programme- multisectoral approach
  - Expansion of AH services
- Multisectoral approach for AH programme components
  - Prevention of early marriage and adolescent pregnancy
  - Prevention and management of gender-based violence among adolescents
- Global review of SHS –
  - Collaborating with other sectors for widening the scope of AH programmes
  - Promoting mental health in schools
  - School-based approach for prevention of tobacco use
  - Capacity-building of health workers for school health
- Review of existing projects and programmes
  - Healthy transition package for adolescents
  - Preconception care experience so far
- Health indicators for AH: Regional framework
- Conclusions and recommendations
Annex 3: Poster presentations by Member States

- Bangladesh
  - Establishment of adolescent health service in a tertiary care hospital in Bangladesh: Experience of Dhaka Shishu (Children) Hospital - Prof. Manzoor Hussain, Director and Head of Paediatrics, Dhaka Shishu (Children) Hospital, Dhaka, Bangladesh
  - BRAC’s adolescent reproductive health initiatives
  - What do adolescents want to know? - Findings from the frequently asked questions (FAQ) databank study by Dr Quamrun Nahar, ICDDR-B, Dhaka, Bangladesh
  - Project experience from Plan International, Bangladesh
  - Adolescent health programmes in Bangladesh - Country poster presentation on adolescent health, Bhutan
  - Adolescent health programmes in Bhutan

- India
  - ARSH programme - Dr Sanjay Chauhan, Dr Beena Joshi, and Dr Ragini Kulkarni, NIRRH, ICMR
  - Rashtriya Kishor Swasthya Karyakram- National Adolescent Health Strategy –India

- Indonesia
  - Adolescent health - school health programme
  - Summary of progress in implementation of adolescent health programme in Indonesia
  - GenRe programme - adolescent health in Indonesia

- Myanmar
  - Adolescent and youth health activities – Myanmar
  - Progress in implementation of adolescent health programme – Myanmar
- Nepal
  - Comprehensive sexuality education as a means to prevent adolescent pregnancy - Nepal
  - mHealth: “A new initiation of adolescent sexual and reproductive health in Nepal”
  - My first baby: an innovative approach piloted in Nepal
## Annex 4: Draft country action plans on adolescent health

### Bangladesh

<table>
<thead>
<tr>
<th>Action</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establishment/Extension of AFHS (in district hospitals, MCWC, upazilla health centres, upazilla health and family welfare centres, and community clinics);</td>
<td>2014–2016</td>
</tr>
<tr>
<td>Life skills education to adolescents;</td>
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<tr>
<td>Workshops with parents/gatekeepers to prevent early marriage;</td>
<td></td>
</tr>
<tr>
<td>Strengthening of school-based approaches for mental health, substance use, SRH education and nutrition;</td>
<td></td>
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<tr>
<td>Revision of MIS forms and inclusion of adolescent health indicators;</td>
<td></td>
</tr>
</tbody>
</table>

**New Actions**

1. Healthy transition package for adolescents
   - From July 2016
2. Case studies and systematic review of evaluation of adolescent health programme

### Bhutan

<table>
<thead>
<tr>
<th>Action (Consolidation of existing services)</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>ToT on AHD including the YFHS guidebook, OP job aid</td>
<td>2015</td>
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<tr>
<td>Integrated YFHS through the youth centres</td>
<td>2015</td>
</tr>
<tr>
<td>Strengthening the AFHS by training the health workers and advocating to stakeholders</td>
<td>2015</td>
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<tr>
<td>Development of IEC materials on AFHS</td>
<td>2015</td>
</tr>
<tr>
<td>Activity</td>
<td>Year</td>
</tr>
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<td>----------------------------------------------------------------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Advocacy and awareness on mental health issues, risk factors and symptoms to the policy-makers, service providers and community.</td>
<td>2015</td>
</tr>
<tr>
<td>Development of professional mental health counsellors and social workers to provide family, individual/group, trauma, grief and crisis counselling services.</td>
<td>2016</td>
</tr>
<tr>
<td>Establishment of conducive counselling units with adequate resources and equipment for secondary schools where students can feel safe and confident to express personal problems including substance abuse, adolescent sexual behaviour, HIV/AIDs and STD (trained school counsellors are already placed in secondary schools)</td>
<td>2015</td>
</tr>
<tr>
<td>Strengthening life skills education in schools and for out-of-school youth</td>
<td>2015</td>
</tr>
<tr>
<td>Capacity-building of guidance counsellors in the Division and also at the field level through ToTs and other relevant forums at the national and international levels</td>
<td>2016</td>
</tr>
<tr>
<td>Development and dissemination of information through booklets, posters, audio-visuals and distribution to all schools and other relevant stakeholders so that parents and the society on the whole become more aware of adolescent issues, encouraging them to take active roles to creating a conducive environment for young people to grow in</td>
<td>2016</td>
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<tr>
<td>Provision of supplementary diet through baked food to students in boarding schools through the installation of ovens</td>
<td>2016</td>
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<tr>
<td>Development of implementation strategy plan</td>
<td>2015</td>
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<tr>
<td>AFHS assessments</td>
<td>2016</td>
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<tr>
<td>Promotion of pre-pregnancy package</td>
<td>2015</td>
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<tr>
<td>Inclusion of age-disaggregated data in HMIS</td>
<td>2015</td>
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<tr>
<td>Setting of crisis management centres to help people in psychological distress through online counselling</td>
<td>2016</td>
</tr>
</tbody>
</table>
### India

**Action**

- Conducting national baseline survey for adolescent health
- Strengthening communication strategy with emphasis on social behaviour change communication (SBCC)
- Inclusion of adolescent health indicators in HMIS
- Strengthening the implementation of AFHS with due focus on supportive supervision
- Constitution of a core group at the national level with representation from other stakeholder ministries and intraministerial departments to address issues of convergence

### Indonesia

**Timeline**

<table>
<thead>
<tr>
<th>Action</th>
<th>Timeline</th>
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</thead>
<tbody>
<tr>
<td>Consolidating existing programme:</td>
<td></td>
</tr>
<tr>
<td>Cross-sectoral AH national action plan with eight programme areas of AH: SRHR, nutrition, addictive substances, HIV, violence, mental health and injuries, sanitation and personal hygiene, and NCD</td>
<td>2015</td>
</tr>
<tr>
<td>Data harmonization, age-disaggregated analysis for key AH indicators and strengthening HMIS</td>
<td>2015–2019</td>
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<tr>
<td>Strengthen policy environment:</td>
<td></td>
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<tr>
<td>Marriage law</td>
<td></td>
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<tr>
<td>SRH law</td>
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<tr>
<td>GBV policies</td>
<td>2015–2016</td>
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<tr>
<td>Access to contraception for the sexually active</td>
<td></td>
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<tr>
<td>Policies on mental health and substance abuse</td>
<td></td>
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<tr>
<td>Policies on parental consent</td>
<td></td>
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<tr>
<td>Gradual scaling-up of successful model of AFHS and school health programme in five years</td>
<td>2015–2019</td>
</tr>
<tr>
<td>Education curriculum reform</td>
<td>2015–2016</td>
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</table>
New programmes:

<table>
<thead>
<tr>
<th>Program</th>
<th>Timeline</th>
</tr>
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<tbody>
<tr>
<td>Systematic studies on the determinants of GBV including child marriage</td>
<td>2015</td>
</tr>
<tr>
<td>Parenting education for parents of adolescents</td>
<td>2015–2016</td>
</tr>
<tr>
<td>Adolescent-friendly prevention, treatment and rehabilitation for adolescents most in need of services (YKAP, disabled adolescents)</td>
<td>2016</td>
</tr>
<tr>
<td>Premarital counseling and preconception care</td>
<td>2015-2016</td>
</tr>
<tr>
<td>Systematic M&amp;E of utilization and quality of health services</td>
<td>2015–2016</td>
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**Maldives**

<table>
<thead>
<tr>
<th>Action</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enactment of Reproductive Health Act – including adolescent health as an essential area</td>
<td>2015</td>
</tr>
<tr>
<td>Advocacy and sensitization to identify AH as a key priority – for parliamentarians, cabinet members and policy makers</td>
<td>2015–2016</td>
</tr>
<tr>
<td>Endorsement of mental health policy and rolling out of mental health screening for adolescents</td>
<td>2015</td>
</tr>
<tr>
<td>Multisectoral collaboration within the relevant stakeholders (MoH, MoE, MYS, NGOs) – Intersectoral task force to support the process</td>
<td>2015</td>
</tr>
<tr>
<td>Advocacy for awareness and demand generation of HPV vaccine</td>
<td>2015 onwards</td>
</tr>
<tr>
<td>Advocacy to introduce weekly iron and folic acid supplementation to adolescents</td>
<td>2015 onwards</td>
</tr>
<tr>
<td>Health promotion – continuum of healthy lifestyle through strengthening of physical activities, nutrition through school co-curriculum-healthy transition package</td>
<td>2016</td>
</tr>
<tr>
<td>Strengthening BCC component for the public health-care professionals / adolescents / parents / guardians / school counsellors / school health officers/teachers</td>
<td>2015</td>
</tr>
</tbody>
</table>
Strengthening intersectoral collaboration for adolescent health

<table>
<thead>
<tr>
<th>Implementation and strengthening of monitoring and evaluation</th>
<th>2015 onwards</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mobile phone applications on SRH targeted towards youth and adolescents</td>
<td>2015 onwards</td>
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</tbody>
</table>

**Myanmar**

<table>
<thead>
<tr>
<th>Action</th>
<th>Why</th>
<th>How</th>
</tr>
</thead>
</table>
| 1. Strengthen the school health teams in all townships | • 80% of adolescents are in formal education | • Collaboration between MoH and MoE  
• Implement life skills education at schools by school health team  
• Strengthen referral system between school health teams and health facilities  
• Conduct health examination for students at least once a year |
| | | |
| 2. Ensure the availability and accessibility of SRH and HIV services for adolescents and youth | • Adolescent fertility rate [per 1000 woman] (2005–2010) = 16 (Source: Population Division, Department of Economic and Social Affairs, United Nations, World Population Prospects: The 2012 Revision)  
• Adolescent HIV prevalence is higher (0.7%) than the general population (0.47%) | • Comprehensive sexuality education in the schools by SH team through collaboration with MOE and other departments  
• Advocacy at all levels to increase accessibility to SRH and HIV services without age barrier  
• Expansion of AFHS township coverage |
3. Reduce the prevalence of substance use and substance use disorders in young people, and increase access to harm reduction strategies for young people who inject drugs

| • Smoking prevalence among adolescents is 2.9% among students – male students (5.0%); female students (0.8%) | • Reinforce policy makers to set by-laws, rules and regulations to discourage the use of tobacco, alcohol and other harmful substances by adolescents |
| • 34.0% tried their first cigarette at age 13 or younger |  
| • Overall, 5.5% of students used any other form of tobacco on one or more days during the past 30 days | • Increase adolescents’ awareness of the adverse effects and consequences of substance misuse and abuse |
| • Myanmar Global School-Based Student Health Survey, 2007 |  

4. Monitoring and evaluation on AH services

<p>| • Monitoring and evaluation of AH services need to be strengthened and modified | • Revise and review training materials relevant to the current context both for health-care providers and volunteers/peers |
|  | • Develop reporting channel, supervision, M&amp;E at all levels on YFHS to reach out to youth who are involved in risky behaviours, young people who are living with HIV and in the hard-to-reach areas |</p>
<table>
<thead>
<tr>
<th>Nepal</th>
<th>Action</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Improve quality of AFHS: Revised ASRH training package in line with adolescent job aid with behaviour change perspective to service providers</td>
<td>By Jan 2015</td>
</tr>
<tr>
<td></td>
<td>Provision for participation of adolescents in Health Facility Operation and Management Committee (HFOMC)</td>
<td>2015–2016</td>
</tr>
<tr>
<td></td>
<td>Increase access of SRH information (delay marriage and pregnancy, FP, SM, GBV) through M4Health for ASRH innovative approach</td>
<td>2014–2017</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sri Lanka</th>
<th>Action</th>
<th>Why</th>
<th>How</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review current adolescent health programme</td>
<td>• To know implementation status and identify gaps</td>
<td>• Adopt tools of WHO short programme review to adolescent health programme</td>
<td>• By forming interministerial committee</td>
</tr>
<tr>
<td>Implement a multisectoral plan</td>
<td>• To optimize the implementation of NSP</td>
<td>• Consultative groups reviewing documents on WHO indicators</td>
<td>• Using social media (develop Facebook, Twitter and strengthen the helpline at FHB)</td>
</tr>
<tr>
<td>Identification of indicators for MIS on school and adolescent health</td>
<td>• Monitoring is important for strengthening the programme</td>
<td>• Implementation of the findings of the research on sexual and reproductive health through multisectoral committee</td>
<td></td>
</tr>
<tr>
<td>Innovative interventions using IT technology</td>
<td>• Wide acceptability and usage of IT technology by adolescents</td>
<td>• Linking school leavers with vocational training, entrepreneurship training and self-employment (Divi Neguma programme)</td>
<td></td>
</tr>
<tr>
<td>Discrepancies in the laws related to early marriage to be addressed</td>
<td>• Traditional laws permitting teenage girls to marry before the legal age</td>
<td>• Implementation of the package through national system with emphasis on family well-being, SRH education and life skills education</td>
<td></td>
</tr>
<tr>
<td>Economic empowerment of school-leaving girls</td>
<td>• Major determinant of early marriage</td>
<td>• Strengthening of multi-disciplinary committee at school level to reduce school dropouts and parenting programmes to empower parents to address adolescent problems</td>
<td></td>
</tr>
<tr>
<td>Development of comprehensive package to address adolescent pregnancies</td>
<td>• Even though the national rate is low, there are pockets where adolescent pregnancy rates are high</td>
<td>• Identify potential GO-NGO resources to establish centres and identify staff</td>
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<tr>
<td></td>
<td></td>
<td>• By reinforcing life skills, creation of no bullying / violence at schools</td>
<td></td>
</tr>
<tr>
<td>Reduction of child marriage</td>
<td>Strengthening intersectoral collaboration for adolescent health</td>
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</tr>
<tr>
<td>• Early marriage leads deprivation of child rights as well to a cascade of health and social problems</td>
<td>• Having a resident medical team at larger schools</td>
<td></td>
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</tr>
<tr>
<td>• In cooperation of care for child with special needs</td>
<td>• Publication of psychosocial guide for teachers to aid them in identifying and managing children with mental problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Publication of psychosocial guide for teachers to aid them in identifying and managing children with mental problems</td>
<td>• In cooperation with community paediatrician in school health services</td>
<td></td>
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<tr>
<td>Shelters</td>
<td></td>
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<tr>
<td>• Lack of shelters is a hindrance to support survivors of repeated GBV</td>
<td>• Incorporate the project into the national programme</td>
<td></td>
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</tr>
<tr>
<td>• It interferes with performance and increases the number of school dropouts</td>
<td>• By modification of school curriculum on reproductive health and by means of outreach educational programmes</td>
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<tr>
<td>• By using Indian review system (AFHS review document)</td>
<td></td>
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<tr>
<td>• Acceptance of services as well as compliance will improve</td>
<td></td>
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<tr>
<td>• Certain aspects are not addressed adequately from the current programme</td>
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<tr>
<td>Activity</td>
<td>Description</td>
<td></td>
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<td>-------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Strengthening intersectoral collaboration for adolescent health</td>
<td>• By modification of school curriculum and implementation of healthy transition package</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reduction of bullying and violence at schools and other educational institutes</td>
<td>• Defaulting of referred students with defects for specialized care</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>• Provision of domiciliary care by the public/health workers</td>
<td></td>
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</tr>
<tr>
<td>Reinforce outreach school health services</td>
<td>• Pilot project is successful</td>
<td></td>
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<tr>
<td>Improvement of school health service package</td>
<td>• By using standards of AFHS</td>
<td></td>
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<tr>
<td></td>
<td>• To prepare young adults for a healthy reproductive life</td>
<td></td>
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<td></td>
<td>• Including AH at the MOH monthly conference</td>
<td></td>
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<tr>
<td>Active participation of community paediatrician in school health activities</td>
<td></td>
<td></td>
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<tr>
<td>Scaling up of health-promoting village programmes</td>
<td>• To identify drawbacks and reinforce strengths</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Compulsory SRH education to school children and school leavers</td>
<td></td>
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<tr>
<td></td>
<td>• To prepare the young child to face future challenges</td>
<td></td>
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<tr>
<td>Evaluation of adolescent-friendly health service</td>
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</tr>
</tbody>
</table>
Strengthening intersectoral collaboration for adolescent health

- This group is at higher risk of complications

**Develop and implement healthy transition package**

- To identify drawbacks and improve the quality of services

**Provision of domiciliary services to adolescents at highest risk and who are not attending the health facility**

- To solve problems and share best practices

**Assessment of quality of adolescent care services**

**Frequent monitoring of important services**

**Thailand**

<table>
<thead>
<tr>
<th>Country experiences / innovations</th>
<th>Why</th>
<th>How</th>
</tr>
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<tbody>
<tr>
<td><strong>Action</strong></td>
<td></td>
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</tr>
<tr>
<td>Promote YFHS in hospitals</td>
<td>To enhance access to RH services among adolescents</td>
<td>Develop YFHS standard (second revision)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Integration with Department of Health, Department of Disease Control, Department of Mental Health</td>
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<tr>
<td></td>
<td></td>
<td>Apply to hospitals under the Permanent Secretary Office, MoPH</td>
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<tr>
<td></td>
<td></td>
<td>Link with outreach clinics (NGO), hotline services, etc.</td>
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</tbody>
</table>
### Multisectoral approaches - Prevent early marriage and adolescent pregnancy

<table>
<thead>
<tr>
<th>Action</th>
<th>Why</th>
<th>How</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevention of repeated pregnancies among adolescents</td>
<td>• To reduce the number of repeated pregnancies among adolescents, which is on the rise</td>
<td>• National Health Security Office: support of fund</td>
</tr>
<tr>
<td></td>
<td>• To increase access to LARC for adolescents regardless of marital status</td>
<td>• Department of Health: policy to provide LARC to all adolescents</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Health inspection process</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Royal College of OB-GYNS: Practical guidelines on providing LARC to adolescent clients</td>
</tr>
</tbody>
</table>

### Prevent and manage violence/gender-based violence

<table>
<thead>
<tr>
<th>Action</th>
<th>Why</th>
<th>How</th>
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</thead>
<tbody>
<tr>
<td>Enhance access to safe abortion services</td>
<td>• To eliminate unsafe abortion and its complications</td>
<td>• Promote options for counselling women with unintended and unwanted pregnancy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Push forward MTP into Thailand essential drug lists</td>
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<tr>
<td></td>
<td></td>
<td>• Promote the use of MVA instead of sharp curettage</td>
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<tr>
<td></td>
<td></td>
<td>• Safe abortion guideline for providers (DOH, Royal College of OB-GYN)</td>
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<tr>
<td></td>
<td></td>
<td>• Guideline for women with unwanted pregnancy (NGO)</td>
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<td></td>
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<td>• Establish abortion surveillance system</td>
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</tbody>
</table>
### School health services

<table>
<thead>
<tr>
<th>Action</th>
<th>Why</th>
<th>How</th>
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</thead>
<tbody>
<tr>
<td>Partnership and alliance</td>
<td>• Every sector has its own expertise that should be integrated into common goal</td>
<td>• MoPH: legislation, policy-makers, health service providers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• National Health Security Office: funding</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• NGO: Outreach clinic hotline</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• UN and WHO: Technical advice, funding</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Community best practices</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• MOE: CSE</td>
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<tr>
<td></td>
<td></td>
<td>• Ministry of Social Development and Human security: Support system for teen parents</td>
</tr>
</tbody>
</table>

### Prevention and management of tobacco, alcohol and drug use

<table>
<thead>
<tr>
<th>Action</th>
<th>Why</th>
<th>How</th>
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</thead>
<tbody>
<tr>
<td>Law enforcement on zoning around school area</td>
<td>-</td>
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<tr>
<td>Integrated issues into life skills education</td>
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<tr>
<td>Action</td>
<td>Timeline</td>
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<td>-----------------------------------------------------------------------</td>
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<tr>
<td>Strengthen ongoing programmes</td>
<td>2014</td>
<td></td>
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<tr>
<td>Pushing forward the draft Reproductive Health bill</td>
<td>2014</td>
<td></td>
</tr>
<tr>
<td>Prevention of repeated pregnancies among adolescents</td>
<td>2015</td>
<td></td>
</tr>
<tr>
<td>Strengthening youth engagement in policy process more effectively</td>
<td>2015</td>
<td></td>
</tr>
<tr>
<td>New initiatives: Multisectoral working group among relevant key stakeholders to work on adolescent well-being</td>
<td></td>
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<tr>
<td>Joint indicators on adolescent well-being (holistic approach)</td>
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</table>

**Timor-Leste**

<table>
<thead>
<tr>
<th>Action</th>
<th>Timeline</th>
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</thead>
<tbody>
<tr>
<td>Gradual scaling up of AFHS service to 12 districts</td>
<td></td>
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<tr>
<td>Strengthening enabling environment</td>
<td></td>
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<tr>
<td>Policies on addictive substance</td>
<td></td>
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<tr>
<td>Policies on HIV/STI</td>
<td></td>
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<tr>
<td>Policies on access to information and parental consent</td>
<td></td>
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<tr>
<td>Capacity-building to strengthen school health programme</td>
<td>2015–2016</td>
</tr>
<tr>
<td>Development of training manual for health service providers</td>
<td></td>
</tr>
<tr>
<td>High-level advocacy for securing resources on AH programming</td>
<td></td>
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<tr>
<td>Systematic age-disaggregation of MMR data</td>
<td></td>
</tr>
</tbody>
</table>
Adolescents are a great human resource that could become the engine of national growth and prosperity. This potential can only be realized if society can ensure that they remain healthy. WHO has been playing a leadership role to strengthen the health sector response to the health needs of these adolescents. However, prevention of risk behaviors among adolescents requires contributions from several sectors outside the health sector.

A meeting of the national programme managers of the South-East Asia Region was held in New Delhi, India, on 25–27 November 2014. The objective of this meeting was to review the status of adolescent health (AH) in SEAR countries and to promote implementation of adolescent-friendly health services (AFHS) by strengthening partnerships and intersectoral coordination. Presentations and discussions were conducted on thematic areas in AH. Innovative approaches and experiences with multisectoral partnerships for AH programmes were shared. Group sessions were conducted to review and formulate regional AH indicators. This meeting report presents the summary of activities undertaken during this meeting and its conclusions and recommendations.