



National Standards and Implementation Guide

for

Youth Friendly Health Services



List of Acronyms

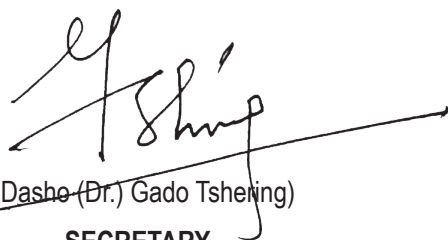
1. NPHC National Population and Housing Census
2. RGoB Royal Government of Bhutan
3. HIV Human Immunodeficiency Virus
4. STI Sexually transmitted Infections
5. RTI Reproductive Tract Infections
6. SEARO South East Asia Regional Office
7. VCTCs Voluntary Counseling & Testing Centers
8. VHW Village Health worker
9. RH Reproductive health
10. BHW Basic Health Worker
11. BHU Basic Health Unit
12. IEC Information, Education and Communication
14. ANC Ante natal care
15. IUD Intra Uterine Device
16. OC Oral Contraception
17. EMoC Emergency Obstetric care
18. MSTFS Multi-sectoral Task Forces
19. DH District Health
20. ART Anti Retroviral Treatment
21. HISC Health information and Service Center
22. TT Tetanus Toxoid
23. MH Maternal Health
24. MR Measles and Rubella
25. PLWHA People Living with HIV/AIDS
26. BNCA Bhutan Narcotics and Control Agency
27. BMI Body Mass Index

Preface

Bhutan is a country of young population with 42 percent below the age of 15 years and about 60 percent below the age of 25 years (2005, NHPC). These young people are Bhutan's assets and resources. However, this large young population has huge threat as well as opportunities. As they mature and become sexually active, young adults face serious health risks. It is a challenge for the parents, communities, health care providers, and educators alike to meet the needs of the young adults. If the needs of the young people are not met it can negatively impact Bhutan. We need to ensure that the young people visit our service centers. Therefore, it is essential to create an enabling environment for youth to generate demand for health services. "Friendlier" health services should be sensitive to the needs and concerns of youth.

In order to ensure quality services for the youth, the National STIs and HIV/AIDS Prevention and Control Program, Department of Public Health, Ministry of Health in collaboration with Reproductive Health Program and the Comprehensive School Health program has developed "National Standards for Youth Friendly Health Services and implementation guide" that will enable all health workers to mainstream youth friendly services in our delivery system. The "Standards" and the 'Implementation Guide' shall provide direction and guidelines to train all Health workers so that quality and friendlier health services are delivered to adolescents and youth of Bhutan.

I am hopeful that these guidelines will help to better position our health services for young people in Bhutan. Therefore, I would like to urge that this guideline be used to address the health needs of Bhutanese youth and help to meet them through youth friendly services.



(Dasho (Dr.) Gado Tshering)

SECRETARY

Ministry of Health

SECTION : 1

Background

Bhutan is a small Kingdom situated in the eastern Himalayas. The country is surrounded by North-Eastern states of Assam and West Bengal (India) in the east, west and south and China in the north. The country's border with India is porous, with thriving commerce and trade. Bhutan has an area of 36,000 sq. km and an estimated population of 634,982 spread unevenly across twenty districts. With a population density of 16 persons per sq km, Bhutan is one of the least populated countries in Asia. However, as the proportion of arable land is estimated at about 8% of the total land area, there is tremendous pressure on the available land, which could build up in the future if population growth remains unchecked.

All aspects of Bhutanese life are influenced by deep religious beliefs and practices. Life, illness and deaths are interpreted as the ceaseless cycle of karmic births and rebirths. Such beliefs and practices have important bearing on the health and well-being of the people of the country.

Demographically, Bhutan is characterized by a high but gradually declining fertility rate and a declining mortality rate, leading to very rapid population growth. According to the Population and Housing Census of Bhutan 2005, the overall male to female ratio was 111 males per 100 females. About one third of the Bhutanese population is below 15 years of age; nearly 12% are in the age group of 10-14 years, 11% are in the age group of 15-19 years and 9.7% are in the age group of 20-24 years. (World Population Prospects 2004).

SECTION : 2

Demographic and Social Situation of Young People in Bhutan

Adolescence and youth are critical phases of young people's development. According to the WHO **adolescents are defined as 10-19-year-olds, youth as 15-24 year olds, and young people as 10-24 year old**. This period can also be defined within the cultural context of individual countries; i.e. the age established by a society for the transition to adulthood could be perceived as marking the end of adolescence.

In Bhutan, adolescence is seen not only as a passage to adulthood but considered an important stage in itself; a rigid age limit however, does not apply. Although the age of maturity is 18 years for both boys and girls in a traditional rural setting maturity is judged by physical capability rather than by age. It is not uncommon to see children in their teens carry out important farm responsibilities. Bhutan is probably the only country where an adolescent can represent the household during a community meeting (zomdu). In an affluent household the adolescent is still a child while in a rural setting adolescents would be considered an adult.

Traditionally Bhutanese adolescents and youth are expected to fulfill certain responsibilities and duties within their families and societies. These extend from helping to care for their younger siblings and aging parents, to performing a variety of household chores. As such this can be demanding on the adolescents workload as demands of the home often limit their opportunity to go to school. Studies have revealed that parents in rural areas were reluctant to send girls to school for fear of unwanted sexual advances and pregnancy. However, with high priority given to education and the increasing awareness of parents this trend is, rapidly changing.

Adolescence is a stage prone to high risk taking and experimentation in quest of independence. Risk behaviors such as early and unprotected sex, is common during this period leading to negative and potentially serious social, economic and health consequences. Migration for education or work increases the vulnerability of adolescents. Today Bhutanese youth face new challenges, social problems such as prostitution, drug and alcohol abuse and juvenile delinquency, teenage pregnancies and STD/HIV/AIDS.

Factors Impacting Young Peoples' Health

1. Sexuality and sexual behavior

In Bhutan the societal attitude towards sex and sexuality is known to be fairly tolerant. Premarital sex is not a taboo in many rural communities. Despite this relatively open approach, it is not common practice to discuss adolescent sexual concerns with family members and siblings, which is due to the conservative nature of a Bhutanese family.

For many people in Bhutan once a couple of the opposite sexes decides to cohabit or live together and share living expenses, they are declared socially as married. However, couples are now required to register their marriage in a court of law. Further, like in many western societies it is not uncommon to find couples living together which serves as a good testing ground for the relationship before marriage.

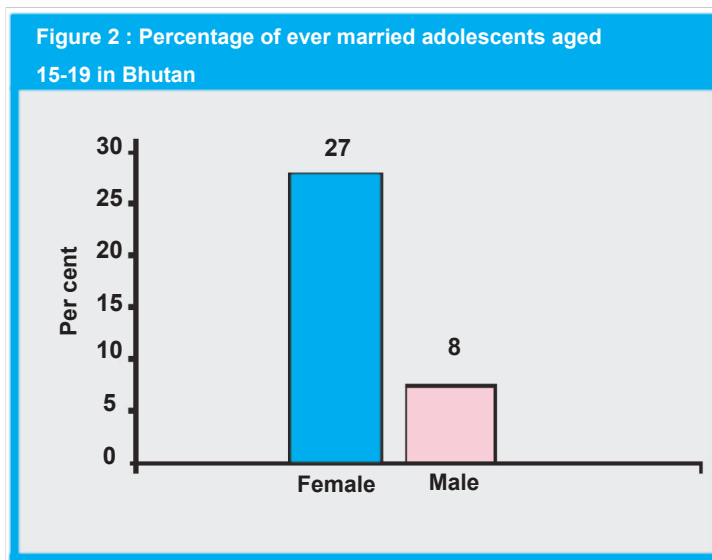
Young people's knowledge, until recently, on sex and sexuality and reproductive health in general has been vague and fragmented. Socio cultural norms and judgmental attitude of adults have left adolescents to explore their sexuality on their own. Local studies reveal early onset of sexual activity among both girls and boys. A study conducted by the DYCS in 2000 revealed that 58% of adolescents boys, viewed sexual activity as a natural process of youth and were sexually active. Another study conducted on out of school youth (2004) further pointed out that while both boys and girls were exposed to multiple partners only 60 percent used a condom during the last sexual

encounter. According to reports a few are sexually initiated as early as when 13 years old while almost 10% have had their first sexual experience by the age of 14. (Adolescent Health Fact Sheet Bhutan – WHO, SEARO, January 2007)

The reproductive health needs of adolescents/youths in Bhutan took a new turn after Her Majesty the Queen, Ashi Sangay Choden Wangchuck accepted the UNFPA Goodwill Ambassadorship in 1999. Her Majesty's frank and open discussion on adolescent sexuality and reproductive health concerns among the school population throughout the country has promoted acceptance of the subject in the school system. This has greatly enhanced the understanding of sexuality and RH issues among young people.

2. Adolescents and Marriages

Traditionally rural families in western and central Bhutan have favored the practice of early marriage mostly due to economic and social benefits. A daughter's marriage results in an increase in work force as a man often moves into a wife's family. However, lack of awareness, poverty, family problems could be other reasons for early marriage.



Source : The World's Youth 2006 data sheet, Population Reference Bureau, Washington DC.

The institution of child marriage, once relatively widespread, has largely declined as Bhutan modernized, and there are only remnants of this practice. Previously the marriageable age was 18 for males and 16 for females. 27% of female and 8% of male in the age group of 15-19 are married. In keeping with the requirement of the CRC and CEDAW, the legal age at marriage for both sexes was made to 18 years in 1996. However underage marriages as early as the age of 15 years is still known to occur especially in rural areas and often go unregistered.

It is not uncommon for a man to have more than one wife and, rarely, for a woman to have more than one husband. While the practice of polygamy and polyandry is socially acceptable the law requires that if this occurs it must have the consent of the spouse.

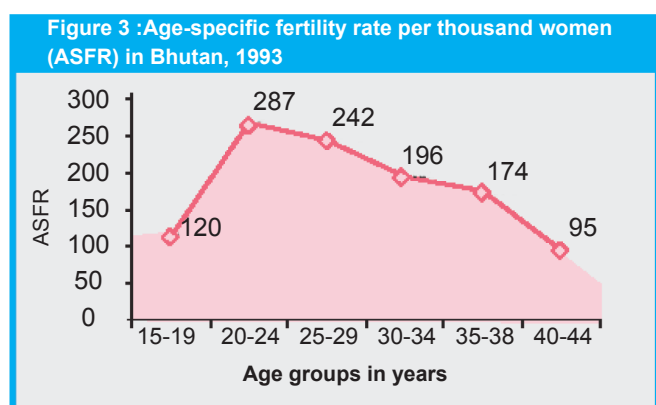
3. Early pregnancy

Adolescent mothers are at a higher risk of miscarriages, maternal mortality and give birth to stillborn and underweight babies.

The traditional practice of early marriage has led many young girls to experience early motherhood. Although the practice of early marriage has been amended through the Marriage Act in 1996 teenage pregnancy rates are still unacceptably high. About one third of births in a given year are attributed to women in the age group of 15-24 years and 6% of TFR is attributed to births by adolescents aged 15-19 years.

(Adolescent Health Fact Sheet Bhutan – WHO, SEARO, January 2007) The National Commission for Women and Children (NCWC) sources reveal that 11 percent of all births were among 15 - 19 years old.

Mortality in female adolescent of 15-19 years is higher than adolescents of 10-14 years. Adolescent girls are very vulnerable. Lack of awareness and knowledge on sexual and reproductive health, lack of skills to negotiate unwanted sex or safer sexual relations, poor parental guidance are assumed to put young girls at very high risk of unwanted pregnancy and sexually transmitted infections.



Source : World Fertility Report 2003, Population Division and DESA, UN.

Abortion as a method of contraception is socially unacceptable and illegal in Bhutan. Given the strong Buddhist beliefs and traditions, the taking of life of any sentient being is unthinkable – abortion is equated with the act of killing. On the other hand, the practice of birth control and family planning is acceptable as it is generally believed that “what is not conceived cannot be killed”.

In 1999 the RGOB officially legalized medical termination of pregnancy; the MTP is accepted if two doctors certify that the pregnancy is a risk to the life of the woman, or is likely to cause grave injury to her physical or mental health, or is likely to result in the birth of a child suffering from serious physical or mental abnormalities. The MTP also permits termination of a pregnancy caused by rape.

According to a 1991-1992 Maternal Mortality Surveillance report, complications of abortion contributed to more than 50% of the maternal deaths. 11% of the obstetric complications were attributed to abortions in the same report. There is no data available to indicate the proportion of induced abortions. Given the strong adherence to Buddhist beliefs and society’s acceptance of children born out of wedlock the incidence of induced abortion is assumed to be relatively low. However, studies have revealed that a growing number of Bhutanese women seek abortion in neighboring India. Some cases of post-abortion complications resulting from unsafe abortions have been reported in hospitals in Bhutan.

There is no written policy that bars young girls from continuing school if pregnant. However, schools in Bhutan, like many in the region, do not commonly allow young women to continue schooling under these circumstances. Among the reasons cited include the argument that, the emotional and physical strain of motherhood are too great for an adolescent to continue school. The notion of them influencing and encouraging other girls also exists.

4. Emerging threat of HIV/AIDS

The HIV and AIDS epidemic presents a significant development challenge to our nation. While the number of Bhutanese who have been detected with HIV still remains low, the potential for a widespread epidemic remains a real threat. *Till date out of 160 HIV positive people, 33 people are in the age group of 15-24.* Experience from countries around the world shows the devastating social and economic impact caused by the HIV and AIDS epidemic. There is much to be done if we are to slow down the spread of infection.

The Royal Decree on HIV and AIDS issued on May 24, 2004 reflects the deep concern of His Majesty the Fourth King over the growing problem of HIV and AIDS in the Kingdom. The Royal Government of Bhutan has accorded

a high priority to addressing this issue. The response to HIV and AIDS in Bhutan has also been guided by the principle of Gross National Happiness.

Distribution by Age:			
Age Groups	Male	Female	Total
< 5 Years	2	10	12
5 - 14 Years	1	1	2
15 -19 Years	0	6	6
20 - 24 Years	5	22	27
25 - 29 Years	26	15	41
30 - 39 Years	35	18	53
40 - 49 Years	11	8	19
50+	0	0	0
Total	80	80	160

Source : National STI & HIV/AIDS program, as of November 2008

5. Adolescents and contraceptives

Contraceptives are available free of cost in all hospitals and Basic health centers. Condoms and oral contraceptives are also available from private pharmacies which are limited in number.

The services available however, are not accessed equally by all groups.

National Surveys reveal that the major family planning users are married women (44 %); less in the separated, divorced or widowed (10 to 20 %); unemployed adults (13 %). Singles (2%) and students (1 %) and are by far the lowest users of contraception. **The use of contraceptives was only 2.4 percent in the 19-24 age groups.**

6. Adolescents and nutrition

Bhutanese in general do not show any special preferences for either gender or specific age groups. Therefore, nutrition of adolescent is similar to the nutrition status of the general population. There is no data indicating dietary practices of Bhutanese adolescents.

Many people in Bhutan have dietary deficiencies. Females, in particular, often have calcium, iron and foliate intakes below recommended values. Although adults and adolescents have similar diets in terms of healthy foods, adolescents are twice as likely as adults to report eating high calorie, low nutrient foods. Moreover, rural areas often lack access to grocery stores which provide healthy food choices besides seasonal farm produce. A study conducted by **UNICEF in 1996 revealed that anemia among young pregnant women was 68 percent.**

Promoting Young People's including Adolescents' Health - Provision of "Youth Friendly Health Services" (YFHS) from identified Service Delivery points:

Given the above scenario, the Royal Government of Bhutan (RGoB) has recognized the importance of influencing the health seeking behaviour of adolescents and youth. The health situation of this age group will be central in determining Bhutan's health, mortality, morbidity, and population growth scenario. Investment in adolescent health will yield dividends in terms of delaying age at marriage, reducing incidence of teenage pregnancy, meeting unmet contraceptive needs, reducing the number of maternal deaths, reducing the incidence of sexually transmitted infection (STIs) and reducing the proportion of HIV positive cases in 10-19 years age group and reducing addictions to various substances and their harmful impact. *This will also help Bhutan in not only realizing its demographic bonus, as healthy adolescents are an important resource for the economy, but also positively impact the National Health Indicators related to Maternal and child mortality, STI/HIV, Substance abuse, and nutrition. Thus there exists a solid Public Health Rationale to provide such investment.* Provision of "Youth Friendly Health Services" is one such strategy to influence the health care seeking behaviour of adolescents/youth and in turn impact the health indicators positively.

The RGoB has decided to implement the strategy of provision of "Youth Friendly Health Services" from selected Service delivery points (SDP) so that a large number of adolescents and young people can access and utilize them.

This strategy focuses on **reorganizing the existing health system** in order to meet the service needs of adolescents/ youth. Steps are to be taken to ensure improved service delivery for adolescents during routine check ups at sub centre clinics and to ensure service availability on fixed days and timings at the BHU and District Hospital (DH) levels. This is to be in tune with the outreach activities. A core package of services would include preventive, promotive, curative and counselling services. The framework of services is presented in the later part of the document. This describes the intended beneficiaries of the youth/ adolescent friendly health services (target group), the health problems/issues to be addressed (service package) and the health facilities and service providers to be involved.

Such friendly services are to be made available for all adolescents, married and unmarried, girls and boys during the clinic sessions, but not denied services during routine hours. Focus is to be given to vulnerable and marginalized sub-groups. A plan of service provision as per level of care may be developed.

In keeping with the spirit of convergence the YFHS strategy emphasizes the need for inter-sectoral linkages with other departments at the policy and programme levels. This is needed in order to create a supportive environment for adolescent interventions and to improve awareness levels among adolescents. The health system is to be 'reorganized' to cater to the service needs of adolescents. Special focus is to be given on linking up with the VCTCs and establishing appropriate referrals for HIV/AIDS and RTI/STI infections and linkages for other diseases. In this regard, operational linkages that have been proposed between the reproductive health programme and the National STI and HIV/AIDS Control Programme (NACP) need to be strengthened and utilized for YFHS.

A "strategic national plan" needs to be developed for steering and bringing synergy to various health sector and intra-sectoral initiatives that impact the adolescent and young people's health.

Objective of the YFHS strategy:

The broad objective of the YFHS strategy is to improve availability, accessibility, acceptability and use of *quality health services by young people (10-24) seeking services* for issues and problems that are of concern to them and impact the health indicators of the country.

Guidelines for establishing Youth Friendly Health Services:

- a. Define a comprehensive package of health services to be provided to the young people from specified Service Delivery points (SDP).
- b. **Develop National Standards** on delivery of 'Quality Health Services' for young people.
- c. **Provide Quality health** services to the youth of Bhutan through provision of "Youth friendly health services" from selected "service delivery points" (SDP) during **the routine working** hours of the service.
- d. Establish **youth friendly health 'Clinics/Centres'** in identified health care centers/ service delivery points that will provide services at "**convenient**" timings for Youth.
- e. Develop **innovative models** for provision of services including those **from Youth Centres** and other locations.
- f. Establishing a "**telephone helpline**": There are also plans for establishing a "hotline" in the Thimphu HISC. This helpline can also be used to impart accurate and age and culture appropriate information and carry out counseling on many youth related issues. The staffs at the HISC can be trained as per the adapted guideline.
- g. In order to **orient the health workers** on dealing with the youth issues such as youth seeking STI treatment, adjustment problems, sexual and reproductive health problems, and other psychological problems at the health centers, **orientation** of the health workers will be conducted by utilizing the existing WHO package, that will be adapted for Bhutan. A three day Masters Training will be conducted for the Health Care providers in the first year. This will be followed by training of the hospital staff for delivering youth friendly services in the hospitals. Since it is important to maintain the skills and improve the services, a refreshers training on the same subject will be conducted during the third year.
- h. **Supportive Supervision, on going capacity building and Monitoring:** Mechanisms to provide supportive supervision, ongoing capacity building, and carry out monitoring will be developed.
- i. **Intra-sectoral collaboration** – The provision of YFHS and the orientation of the health workers will be carried out as a collaborative effort. The following Programs will be involved :
 - Reproductive Health Programme
 - Comprehensive School Health Programme (CSHP)
 - Mental Health Programme
 - Nutrition Program

- National STD and HIV/AIDS Prevention and Control Program (NACP)
- Others as per programmatic needs

In order to avoid duplication of efforts and hence wastage of resources, the NACP would like to propose to the above Programmes to work together for establishing “youth friendly health services”.

j. Budgetary Provisions : The MoH, RGoB will make the necessary provisions.

k. Technical Support : The MoH, RGoB will collaborate with UN agencies (WHO, UNFPA, UNICEF, UNODC, UNAIDS etc) and other donors and development partners to seek technical and financial assistance to establish and scale up YFHS in Bhutan.

SECTION : 3

Development of National Standards for Youth Friendly Health Services:

A standard is a statement of desired quality. Standards have been developed for ascertaining the performance of health facilities for adolescents and youth. They are valuable in strengthening programme implementation, monitoring and evaluation. This is because they set clear performance goals and make explicit the definition of quality required for a service. They provide a clear basis against which performance can be monitored, assessed and/or compared.

The 'National Standards' will ensure that the services being provided to the young people including adolescents are not only relevant to the present day conditions and the trends, but are also *available, accessible, acceptable, appropriate, effective and equitable*. The National Standards will ensure that the service quality is uniform across all the service delivery points. It is expected that adhering to the laid down standards would also improve the *access and utilization* of such services.

The **key 'friendly' characteristics** of services for adolescents are at the levels of the **1) user, 2) provider and 3) health system**. These in turn are the determinants of quality of the services.

From the user's perspective, health services must be:

- (i) accessible – ready access to services is provided
- (ii) acceptable – that is, healthcare meets the expectations of adolescents and youth who use the services.

From the provider's and manager's perspective, services must be

- (i) appropriate - required care is provided, and unnecessary and harmful care is avoided
- (ii) comprehensive – care provision covers aspects from prevention through to counselling and treatment
- (iii) effective – healthcare produces positive change in the health status of the adolescent and youth.
The health system must focus on efficiency in service delivery, that is high quality care is provided at the lowest possible cost.
- (iv) equitable – that is, services are provided to all adolescents who need them, the poor, vulnerable, marginalized and difficult-to-reach groups/areas.

Process of Developing the National Standards for YFHS in Bhutan:

The details of the process utilized to develop the National Standards are given in the Annexure. Following are standards that will guide implementation of YFHS interventions in Bhutan. Each of the standards will be explained in detail in the following section.

- 1. Health Facilities provide the specified package of health services that adolescents and young people need.**
- 2. Health Facilities deliver effective health services to adolescents and young people.**
- 3. Adolescents and Young People find the environment at health facilities conducive to seek services**
- 4. Service providers are sensitive to adolescents' / Young Peoples' needs and are motivated to work with them.**
- 5. An enabling environment exists in the community for adolescents and young people to seek the health services they need.**
- 6. Adolescents and young people are well informed about the availability of good quality health services from the service delivery points.**
- 7. Management systems are in place to improve/sustain the quality of health Services**

SECTION : 4

Implementation Guide for YFHS

Purpose of the 'Implementation guide'

The Ministry of Health, Royal Government of Bhutan has decided to promote adolescent health and development in the country. To this effect, it has decided to launch "Youth / Adolescent Friendly Health Services" (YFHS) and has developed National standards for provision of such services. This strategy is now to be implemented in the districts in the primary health care setting. In this context, this document is intended to guide district health programme managers in implementing the YFHS strategy.

This document is guided by the discussions held and consensus developed at the workshop organized by MoH, RGoB to develop the "**National Standards for provision of Youth Friendly Health Services**" in April, 2008. Special attention is to be given to gender and equity differentials at every stage of implementation. The YFHS strategy is to be implemented within the framework of inter-sectoral convergence.

This guide presents **what to implement and how to implement** the YFHS strategy. It also presents an overview of the strategy. The guide discusses the desired quality in implementation of the YFHS strategy. This dimension of quality is defined in terms of key principles or standard statements, which are to be fulfilled in order to achieve the expected results, viz., improving the health seeking behaviour of adolescents and contributing towards the long-term health goals/outcomes of reduced MMR, IMR, TFR and HIV infections in this age group.

The YFHS will be implemented in phases. The first phase (within 3-4 months of the acceptance of the standards) will cover the 30 identified hospitals. The second phase (next 6-12 months) will cover selected BHUs and other hospitals. The rest of the delivery points will be covered in the third phase. The guide also details how the strategy is to be implemented. It outlines the steps that are to be undertaken for creating a supportive environment, generating awareness among adolescents, organizing services, improving capacity of service providers, and monitoring service provision and utilization. Essential actions are specified to guide the programme managers to meet the desired standards. These actions are to be further adapted as per the context specific requirements of the states and districts, without compromising on quality.

It is expected that the district programme managers will use this implementation guide, once they have undergone an orientation on YFHS issues. For this purpose a one-day orientation package for programme managers has been suggested. This guide is not intended as a prescriptive document. It is a suggestive framework for implementation of the YFHS strategy for programme managers, facility incharges and health care service providers.

What To Implement?

This section focuses on standards or principles that can guide programme managers and others to effectively implement the Youth Friendly Health Services.

A standard is a statement of desired quality. In a number of countries around the world (eg Bangladesh, India, United Kingdom, and South Africa), standards have been developed for ascertaining the performance of health facilities for adolescents and youth. Standards are valuable in strengthening programme implementation, monitoring and evaluation. This is because they set clear performance goals and make explicit the definition of quality required for a service. They provide a clear basis against which performance can be monitored, assessed and/or compared.

The key 'friendly' characteristics of services for adolescents are at the levels of the 1) user, 2) provider and 3) health system. These in turn are the determinants of quality of the services. From the user's perspective, health services must be:

- (i) accessible – ready access to services is provided
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- (i) appropriate - required care is provided, and unnecessary and harmful care is avoided
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- (iii) effective – healthcare produces positive change in the health status of the adolescent and youth. The health system must focus on efficiency in service delivery, that is high quality care is provided at the lowest possible cost.
- (iv) equitable – that is, services are provided to all adolescents who need them, the poor, vulnerable, marginalized and difficult-to-reach groups/areas.

Given the above, following are standards that will guide implementation of YFHS interventions in Bhutan. The rationale for each standard is also explained in brief. These standards emanate from the various policy documents and statements that already exist in the country.

1. Health Facilities provide the specified package of health services that adolescents and young people need.

This standard seeks to ensure that the specified package of health services is provided. In many places, health facilities do not provide adolescents with the health services they need. Often, general health complaints are used as an entry point to provide the required health services. This standard seeks to ensure that the specified package of health services is in fact provided.

2. Health Facilities deliver effective health services to adolescents and young people.

In many places, health services are not provided effectively by service providers for a variety of reasons viz. service providers are not in place, they do not have the required competencies, the required supplies, equipment and basic amenities are not available etc. This standard therefore stresses that health facilities should be well equipped to deliver services to adolescents and youth as per their need/s.

3. Adolescents and Young People find the environment at health facilities conducive to seek services

Adolescents will not seek health services if the physical environment and procedures are not appealing to them. This standard focuses on ensuring that a reasonably conducive environment exists in health facilities for adolescents to access these services.

4. Service providers are sensitive to adolescents' / Young Peoples' needs and are motivated to work with them.

Due to a variety of reasons, e.g. judgmental attitudes of service providers, lack of privacy and confidentiality etc, many adolescents do not seek health services. Services providers are to be technically competent and motivated to provide services to adolescents as per their need/s. This standard seeks to ensure that the service providers imbibe and demonstrate appropriate attitudes and behaviour to reassure the adolescents in addressing their needs. The standard therefore seeks to address issues relating to service providers attitudes and motivation.

5. An enabling environment exists in the community for adolescents and young people to seek the health services they need.

In many situations, community members (especially parents) are not aware of the value of providing friendly health services to adolescents. They do not believe that adolescents should have access to these health services. This deters service providers from providing health services to adolescents, and deters adolescents from seeking the same. The standard seeks to address these environment-building factors.

6. Adolescents and young people are well informed about the availability of good quality health services from the service delivery points.

Adolescents are generally not aware of where they can get good quality health services. The standard seeks to address the gaps in knowledge and awareness among adolescents on health, sexual and reproductive health issues and emphasizes the importance of seeking quality services in time from the service delivery points.

7. Management systems are in place to improve/sustain the quality of health services

Data that is gathered at sub-centres, primary health centres and community health centres is generally sent to a higher authority for analysis. Often no feedback is received. Only rarely is the data used locally to address problems and take remedial measures leading to an improvement in quality. This standard focuses on the importance of monitoring systems to ensure that interventions are effectively implemented as planned and that appropriate feedback mechanisms are in place. Mechanisms (eg. exit interviews, client interview tools) that utilize the adolescents and Young people clients of the facility for monitoring may be developed.

This section has outlined seven standard statements, which will guide the effective implementation of the YFHS implementation strategy. Subsequent sections of this document detail the guidelines for operationalizing the YFHS strategy. Implementation of the strategy is to be guided by these standards.

How To Implement?

This part of the document details out steps and actions to be carried out for making operational the YFHS strategy and achieving the desired standards. These operational guidelines on how to implement indicate the **minimum and core actions** that are to be undertaken if the strategy is to be effectively implemented. The operational guidelines below are organized in terms of the seven standard statements discussed above.

SECTION ONE : SERVICE DELIVERY PACKAGE

STANDARD -1: Health Facilities provide the specified package of health services that adolescents and young people need.

Package in terms of promotive, preventive, curative and referral services

1. Promotive Services:

1.1. Focused care during the antenatal period

Pregnant adolescents may more conveniently access youth-friendly clinics at dedicated timings. It is generally considered that antenatal care should start early, preferably in the first trimester. Evidence shows that adolescents either don't seek care or that care is often delayed and infrequent. Community-based functionaries and VHWs may also accompany such pregnant girls from their respective villages to these clinics. Availability of female service providers, staff nurses or ANMs, will help in winning the trust of pregnant girls, since for many of them this may be the first contact with the public health system.

ANC protocol for pregnant adolescents is not different from the protocol for other pregnant women. However, the following issues need to be reiterated:

- Ensure Institutional Delivery
- Nutritional counseling: Increased risk of nutritional deficiencies as adolescents enter pregnancy with nutritional deficiency
- Contraceptive counseling
- Couple counseling
- Referral to be made for complications during pregnancy and the precautions to be taken while the patient is carried in such cases.

1.2. Counseling and provision for emergency contraceptive pills

- Adolescent boys and girls and youth may also access these clinics for ECPs (emergency contraceptives). Advance provision of emergency contraceptive pills must be considered in situations where access is likely to be restricted. There is enough programmatic evidence to demonstrate effectiveness of advance provision of ECPs in preventing unwanted pregnancies.
- Opportunity must be used to emphasize safe sex practices and risk reduction counselling.
- Information and counselling on regular contraception must be provided.

1.3. Counseling and provision of reversible contraceptives

Youth-friendly clinics are to provide services for Oral Contraceptive Pills (OCPs), condoms and IUD insertion as per the national guidelines. Service providers are to be encouraged to offer a package of contraceptives, so that young people can choose a particular method as per their need/s. Providers are to also inform the young people about

re-supply provisions and sources for further supply. Non-clinical reversible contraceptives could be made available with the community-based health functionaries and also through social marketing channels.

Dual protection is to be an integral part of contraceptive counselling. Adolescents must have information and access to methods that provide dual protection.

1.4. Information/advice on SRH and other issues

Providers must be able to address specific questions of male and female young people on common sexual and reproductive health concerns. Adequate resource materials are to be made available to providers in order for them to respond to questions posed by the adolescents. Resource materials are to cover topics related to growth and development, puberty, sexuality concerns, myths and misconceptions, pregnancy, safe sex, contraception, unsafe abortions, menstrual disorders, anaemia, sexual abuse, RTIs/ STIs, etc.

2. Preventive Services

2.1. Services for Immunization

As per the national guidelines, adolescents must be given immunization against tetanus.

2.2. Services for Prophylaxis against Nutritional Anaemia

Facilities are to provide the facility for screening of anaemia by offering routine Haemoglobin estimation. For pregnant adolescents, the national guidelines need to be adhered to. For non-pregnant adolescents, treatment is to be given in the form of iron therapy.

Service providers are to provide information on balanced diet and consumption of green leafy vegetables and other iron rich foods. Worm infections have to be treated accordingly.

2.3. Nutrition Counselling

Many adolescents suffer from a range of nutritional problems including vitamin and mineral deficiency. Some adolescents may approach providers with specific concerns regarding excess weight and obesity. Service providers are to offer appropriate advice to adolescents to address these concerns.

2.4. Services for early and safe termination of pregnancy and management of post-abortion complications

Where ever applicable and in accordance with the national laws, facilities are to be fully equipped to provide early and safe abortion services to adolescents and young people. Counselling for safe MTP services must be offered when in accordance with the national laws. Evidence suggests that younger adolescents are more likely to delay seeking a termination of pregnancy. In such a situation, referrals for MTP must be made to district hospitals. Adolescents and Young people may also access these facilities with complications attributable to unsafe abortions. Such clients are to be managed as per the Guidelines for Management of Common Obstetric Complications. Post-abortion contraceptive counselling is to be an integral component of services for those presenting with post-abortion complications.

3. Curative Services

3.1. Treatment for common RTIs/STIs

Adolescents are more vulnerable to genital infections on account of biological and social factors.

Adolescent girls may find it difficult to negotiate condom use with their partners. The following elements of quality of care deserve special attention:

- Privacy and Confidentiality - It is crucial that complete audio and visual privacy is maintained during the client-provider interaction. Similarly, access to service delivery register etc. is to be restricted to ensure confidentiality. Though this applies to all interactions, it is being reiterated so as to ensure maximum privacy and confidentiality while managing RTI/STI
- Treatment compliance - It is important to emphasize compliance with the drug regimen prescribed for each adolescent. Non-compliance will lead to treatment failure. This also includes advice on personal hygiene and safe sex during treatment.
- Partner management - As per national guidelines, partner management should constitute an integral component of services. Adolescents should be explained the importance of the treatment of their partner in order to prevent reinfections.
- Follow-up visits and referrals for treatment failures – Adolescents are to be advised to adhere to the schedule of follow-up visit. In case they do not respond to therapy, they are to be referred to higher levels.

3.2. Treatment and counselling for menstrual disorders

Menstrual disorders are perceived to be very common amongst adolescent girls. Service providers must be able to manage these problems in the following manner:

- Symptomatic treatment for pre-menstrual tension, dysmenorrhoea etc.
- Counselling for menstrual problems and hygiene
- Referrals for any investigations and for puberty-related problems

3.3. Treatment and counselling for sexual concerns of male and female adolescents

Adolescents have several concerns regarding sex and sexuality. Clients may come to the clinic with crypto orchidism or any other disorders. The clinic must be in a position to cater to the specific concerns of boys and girls on these issues. Referrals may be needed in most of these situations.

3.4 Management of sexual abuse among girls/boys.

Adolescent facilities are to offer services for management of sexual abuse, especially for adolescent girls. A separate protocol needs to be developed for such clients, whereby they will have access to emergency contraception pills, prophylaxis against STIs and PEP for HIV along with counselling as per the National Guidelines.

Additional/Optional services

In addition to the above package of services, programme managers may also consider some services according to the local needs, for example:

- Blood Grouping for RH and ABO: Adolescents usually come forward to attend these clinics for getting their blood group tested. This can also serve as an ideal entry point to introduce adolescents to the range of services being made available at the health facilities.
- Immunization for Hepatitis B and Rubella if MR not given in childhood.

4. Referral services

Selected facilities must be in a position to make appropriate referrals for care and support, especially for HIV/AIDS.

4.1 Voluntary Counselling and Testing Centre (VCTC)

Voluntary counselling and testing services are the gateway to prevention and care for HIV/AIDS.

Adolescents who are sexually active are to be imparted pre-test counselling for getting a voluntary test. A VCTC site is to facilitate access to ART if required.

4.2 Prevention of Mother To Child Transmission

Ideally, access for PMTCT is to be an integral component of focused ANC services. Adolescents are to be counseled about the risk of HIV infections during pregnancy and must be encouraged to undergo testing and undergo therapy for prevention of transmission of infection. Adolescents are to be referred to appropriate facilities in the district for access to ART.

For services that are not available on the spot, mechanisms are to be in place to ensure effective referral to other service delivery centres and/or counseling centres.

4.3. Referral for Psychiatric services, for substance abuse, sexual abuse and others.

4.3 Rehabilitation.

Services for rehabilitation relating to *substance abuse, domestic violence, HIV/AIDS and other* areas will be provided at appropriate centres.

5. Outreach Services

The outreach services are provided by BHUs and in some degree by the Village Health Worker (VHW) and through school visits. However, there is a need to make these services more regular and productive. It is envisaged that effective school health services will provide opportunities for getting timely referrals. The school outreach services could be also seen as a mechanism for demand generation and social marketing of the adolescent friendly service delivery point.

5.1 Periodic health check ups and community camps

In each academic year, the MO in-charge must list the number of schools to be covered, based on which an annual work plan is to be developed after taking into consideration the holidays and academic activities etc. Bi-annual health check-ups must be a part of the plan. A school health card can be used for this purpose. School teachers –especially the **School health coordinator** – and **“peer leaders”** must also be involved for carrying out anthropometrical examinations and tests for measuring visual acuity and for health education and health promotion activities. District Medical officers may consider organizing orientation for one or two interested teachers from selected schools in consultation with the Ministry of Education. Some activities (such as anthropometrical examination) can be conducted by teachers, thus reducing the requirements of the medical officers' time.

Adolescent health camps, in collaboration with DYS, MoE and others, may be organized periodically to increase awareness about adolescent issues and availability of adolescent services, provide health education and health check-ups. Counselling can also be provided at these camps to adolescents who need it.

5.2 Periodic health education activities

Health education and health promotion activities are to be organized in schools for the adolescents. The MO in-charge or HA/HW – in close cooperation with the School Health Coordinator and peer leaders - can conduct sessions on health-related issues during the assembly. “Question box” activities can also be organized in schools. A simple health resource such as reading books or CDs can be made available to the school teachers / health coordinators and peer leaders and they can organize discussions and other co-curricular activities in the schools.

5.3 Co-curricular activities

Providers may prefer to organize question box activities in schools. Students are encouraged to anonymously drop questions in a letterbox. These questions are then taken up for discussion in the health assembly. Depending on staff availability, the medical officer or any other trained nursing staff from a nearby BHU/DH can attend these sessions and respond to specific questions.

Provision of Services at various levels of Service Delivery points (SDP)

Domains	Community level, (VHW)	BHU 2 (HA, Midwife, BHW) Facility and through Outreach clinics,	BHU 1 / District hospital	Referral Hospital	Others
Anemia prevention and treatment	Information, 6 monthly deworming, Weekly distribution of FsFe to out of school adolescents both boys and girls Refer anemia cases to BHU 2 /BHU 1/DH	Information, FsFe distribution, and deworming if not done in past six months Hb estimation Treat mild to moderate anemia with daily FsFe supplementation for YP (10-24yrs) Refer if no improvement Linking up with schools for distribution of FsFe	Growth and development monitoring, Hb estimation Diagnosis of anemia and its treatment including injectable iron (Iron-dextran). Blood transfusion in cases of severe anemia	Diagnosis and management of cases not responding	Schools: IEC, 6 monthly deworming and weekly FsFe to students 10-19 years both boys and girls
Growth and Development, Nutrition and body image	IEC, Nutritional Counselling regarding balanced diet, promoting kitchen gardening, refer to BHU 2 for issues related to growth and development, and body image	IEC Growth and development monitoring (Ht, Wt, BMI) Counselling for puberty related concerns Information and services for managing acne and other body image concerns Refer severe cases, suspected hormonal problems	IEC Growth and development monitoring Treatment of Severe acne Refer for any growth and development related problems, micronutrient deficiency Services for managing severe acne	Management of severe body image related problems, investigations for growth and development related and nutrition related problems. Services for managing severe acne	Schools: Growth and development monitoring (Ht, Wt, BMI), IEC on growth, balanced diet, hygiene, hand washing, water and sanitation,

Domains	Community level, (VHW)	BHU 2 (HA, Midwife, BHW) Facility and through Outreach clinics,	BHU 1 / District hospital	Referral Hospital	Others
Problems related to Menstruation, and sexual concerns (both boys and girls)	<p>Information on menstruation and menstrual hygiene,</p> <p>Management of minor discomfort and pain during menstruation (paracetamol)</p> <p>Linkages with 'peer group educators'</p> <p>Refer to BHU/DH</p>	<p>IEC on and management of sexual concerns</p> <p>Management of minor discomfort and pain during menstruation (paracetamol)</p> <p>Management of anemia</p> <p>Referral of cases</p> <p>Linking with schools and Peer group educators for IEC on Menstrual and sexual concerns</p>	<p>Management of Dysmenorrhea, irregular periods, Diagnosis and treatment of PCOD wherever facilities exist, Management of anemia</p> <p>Management of referred cases –menorrhagia, severe dysmenorrheal</p> <p>Management of sexual concerns of boys and girls</p>	<p>Management of PCOD</p> <p>Management of Sexual concerns that are referred</p>	<p>Schools: IEC, Menstruation and menstrual hygiene, Removal of myths related to menstruation and sexual concerns of boys and girls by School Health Coordinators and peer group educators</p> <p>Information regarding availability of YFHS services</p>
Prevention of Adolescent Pregnancy	<p>IEC on consequences of early marriage, early pregnancy, and Safe sex,</p> <p>Condom distribution</p> <p>Information and support for obtaining emergency contraception,</p> <p>Refer in case of unwanted pregnancy,</p>	<p>IEC on consequences of early marriage, early pregnancy, and Safe sex,</p> <p>Condom and OC distribution</p> <p>Emergency Contraception distribution</p> <p>Refer in case of unwanted pregnancy to DH/RH,</p>	<p>Condom and OC distribution</p> <p>Emergency Contraception</p> <p>Management of unwanted pregnancy</p>	<p>Condom and OC distribution</p> <p>Emergency Contraception</p> <p>Management of unwanted pregnancy</p>	<p>Schools: IEC on consequences of early marriage, early pregnancy, and Safe sex,</p> <p>Information regarding availability of YFHS services</p>

Domains	Community level, (VHW)	BHU 2 (HA, Midwife, BHW) Facility and through Outreach clinics,	BHU 1 / District hospital	Referral Hospital	Others
Care of pregnant adolescent	<p>Early registration of adolescent pregnancy,</p> <p>Provision of ANC - FsFe, nutrition and birth preparedness</p> <p>Providing basic information regarding 'danger signs'</p> <p>Identification and referral of adolescents with danger signs,</p> <p>Support institutional delivery, Postpartum care</p> <p>Mobilizing family and community support.</p>	<p>Early registration of adolescent pregnancies, ANC, Intra- natal and post natal care</p> <p>Referral for EoC</p> <p>Nutritional counseling,</p>	<p>ANC, Intra- natal and post natal care</p> <p>Management of obstetric complications</p> <p>Referral of serious cases</p> <p>Post –abortion care</p>	<p>ANC, Intra- natal and post natal care</p> <p>Management of obstetric complications</p> <p>Management of serious cases</p> <p>Post –abortion care</p>	<p>Schools: IEC on needs of a pregnant woman, benefits of institutional delivery, new born care</p> <p>Sensitizing the staff on encouraging and supporting pregnant adolescents to continue education.</p> <p>Sensitizing teachers and school students for supporting pregnant adolescents (School health Coordinators and counselors)</p>
Contraception	<p>Information about contraception,</p> <p>Distribution of condoms,</p> <p>Raising awareness regarding FP services</p>	<p>Provision of condoms and OC, injectables, IUD insertion</p>	<p>Provision of Emergency. Contraception,</p> <p>FP counseling</p> <p>injectable contraceptives</p>	<p>Managing complications related to contraceptives</p>	<p>Schools: IEC on contraception</p>

Domains	Community level, (VHW)	BHU 2 (HA, Midwife, BHW) Facility and through Outreach clinics,	BHU 1 / District hospital	Referral Hospital	Others
STI/RTI	IEC on RTI/ STI, Raising awareness Condom distribution Referral of RTI/ STI cases	Information, Diagnosis and Syndromic management of STI Management of RTI/ STI	Syndromic management of STI Lab diagnosis and management	Management of complicated cases of RTI/ STI	Schools: IEC on RTI/STI
HIV/AIDS	IEC, Condom distribution Sensitization of communities on HIV/ AIDS Mobilizing family and community support. Collaboration with MSTF at community level on HIV/AIDS issues.	IEC Condom distribution MSTF activities on HIV/AIDS prevention	VCTC, ART follow up; Case management; Management of O.Is MSTF activities on HIV/AIDS prevention	VCTC; ART; Case management; Management of O.Is Care and support to PLWHA	VCTC at HISC Schools: IEC on HIV/AIDS prevention Life Skills education
Immunization	Raising awareness regarding Immunization	Provision of TT	Provision of TT and MR	Provision of TT and MR	Schools: IEC on immunization,
Mental Health	Recognition of MH problems in the community and reporting and referral, Raising awareness on mental health and on epilepsy. Mobilizing family and community support.	Information and counseling on Managing stress, psycho-social problems Initiation of treatment of minor problems Follow up on the treatment and referral Community based rehabilitation	Rehabilitation of mild impact cases Diagnosis and treatment Community based rehabilitation	Psychiatric clinical services, Management of referred cases – depression, suicidal, dissociative conversion disorders, etc	Schools: IEC on Mental health, stress management and Life Skills education, Recognition and referral of cases requiring mental health services by the teachers.

Substance abuse	Identification Information and counseling related to alcohol and other substance abuse	Information and counseling Initiation of treatments and referral	IEC on substance abuse Diagnosis and treatment Referral for complicated cases	Detoxification and rehabilitation	Schools: IEC on Link up with BNCA
Others	Provision of First aid, IEC on violence and injury prevention Management of minor illnesses	Management of minor injuries	Dental and skin services Ophthalmological services Management of gender based violence and sexual coercion Management of major injuries, fractures etc. Management of major illnesses	Management of referred cases other than those mentioned above Management of major illnesses	Schools: IEC on Violence and injury prevention

Key Points:

Package of services should be such that it responds to the needs of adolescents and young people.

Services should be comprehensive, that is, there should be a judicious mix of preventive, promotive and curative services

Services at Youth Friendly Clinic/Health Facility:

Core Package:

Sexual and reproductive Health: Information, counselling and services related to menstrual problems, sexual concerns, prevention and management of early pregnancy, contraception, abortion, etc. STI/RTI management, Referral services for VCT and PMTCT,

Nutrition counselling, prevention and management of anaemia and nutritional and body image concerns

Substance abuse

Mental Health

Rehabilitation – Substance abuse, Mental health, violence, others

Optional/Additional Services: Depending on local needs

Outreach Services: School Health and Community camps:

Health check-ups, health education and awareness generation

STANDARD -2: Health facilities deliver effective services to adolescents and young people

Steps are to be taken to ensure that services are effectively delivered to adolescents and young people who approach the health facilities. For ensuring effective services the following components are crucial:

Service Providers:

- Adequate and appropriate (identified) service providers are in place. At all health facilities, defining the staff profile is needed and it has to be ensured that the identified staff is present in all clinic sessions.
- Service providers are clearly aware of their roles and responsibilities in relation to the functioning of the health facility.
- Service providers have the competencies required to provide the specified health services effectively.

Location, ambiance, and supplies:

- The facility incharge must be able to take a decision to locate/set up clinic in the existing infrastructure. A signboard -with the appointed name of the clinic and its timings -should be put up.
- The decision should be guided based on the availability of a separate room for the clinic, timing and frequency of organizing the clinic, and the expected level of utilization of services by adolescents.
- If the clinic is to be organized atleast once a week, there has to be sufficient dedicated space. Clash of timings with routine health care needs to be checked. If there is no clash of timings, the same room that is used for OPD in the morning may be used for the adolescent clinic in the afternoon. The CSHP, DYS is in the process of developing certain guidelines for students to visit health centres. This must be taken into account while deciding upon the timing for the YFHS clinic.
- The waiting area is to be identified with appropriate seating arrangements, provision of drinking water and clean functional toilets. Also, reasonable cleanliness must be ensured.
- Adequate IEC and other materials, supplies and basic amenities are available. The specified supplies, equipment and basic amenities are available in each type of health facility.

Guidelines and Procedures:

- Clinical management guidelines and standard operational procedures (SoP) for YFHS are in place for the provision of the specified health services. A suggested format for SoP is given in the annexure. The “clinical job-aids” that are being finalized by WHO should be made available to the health care providers.

IEC and resource materials:

- Informational/educational materials directed at adolescents are available. In case a dedicated space is available for running a clinic for adolescents, relevant posters and communication materials may be displayed. It is suggested that an adequate number of information booklets are made available as take away material in these clinics. Reading material, in English and Dzongkha, should be available on relevant issues, especially handouts that adolescents can take without having to request for them.

Partnerships with local NGOs, education institutions, HISCs, VCTCs and media may be explored specifically for this purpose. A resource directory containing contact details of VCTCs, ART centres and other referral centres could be made available for facilitating referrals.

Out reach level services

At this level services are to be provided to any youth and adolescent girl or boy who approaches, irrespective of marital status, gender or educational status. The out reach provider (HA/BHW/ANM/MO) must have essential supplies for provision of health service package as stated in the standards. Most importantly, the staff should be physically present during the designated hours of the clinic.

During outreach sessions organized in the villages, providers can also provide services to adolescents. The providers should develop and maintain linkages with peer educators, VHWs, youth centres, and other agencies/personnel on a regular basis.

BHU level

At the level of the BHU, a dedicated clinic is to be organized at least once a week. This is in addition to the services being provided to adolescents who approach these facilities at any time (routine) for any services. Materials and supplies as listed above should be ensured in adequate quantities at the BHU level clinic.

District Hospital level

At the level of the district hospital, a youth friendly clinic at a dedicated time may be organized at least once a week. This would be in addition to service provision to all adolescents who attend the DH at any time for any service. At least one doctor and two support staff could provide services at this level. The VCTC counsellor may be involved for counselling on SRH issues. Appropriate linkages are to be established with the sites where facilities for VCTC, ART may not be available.

Key Points:

For effective services:

- Adequate and appropriate staff must be made available during clinic sessions
- Staff must be competent and aware of their role and responsibilities
- Adequate and appropriate materials/supplies, including information literature for the young people to be made available
- Key aspects of organizing services for young people at various levels have been discussed.
- Additional features for organizing services may be identified locally. A prerequisite for effectively organizing and delivering services is the availability of competent and skilled providers, and ensuring privacy and confidentiality.

STANDARD -3: Adolescents and young people find environment at health facilities conducive to seek services

In order to attract young people including adolescents, appropriate conditions should be created at the facility to put them at ease and ensure that they can comfortably access the services. Both the location and ambiance of the clinic area should be inviting and comfortable, clean and have basic amenities as highlighted earlier.

Attention should be given to the following factors:

1. Staff

On all clinic days it must be ensured that the designated staff is present. Punctuality and regularity must be enforced. Staff attending to the adolescents and young people must have the qualities that put them at ease for them to avail the services they need and are being offered. Follow-up actions, when ever required, must be ensured to enhance the credibility of the clinic with the adolescents and young people.

2. Registration Procedures

Procedure for registration and retrieval of records of clients (at least at the special clinic) will be made simpler. If the client does not wish to reveal personal details, address, etc. the staff should not insist on it. The clinic policy on maintaining confidentiality should be clearly stated in the form of wall posters and displayed prominently.

3. Privacy and Confidentiality

Arrangements of visual and audio privacy:

- Clinic rooms must have doors, window and door curtains and a screen surrounding the examination table.
- In order to ensure privacy and confidentiality, it is advisable to have give clear instructions to the staff about not allowing any one into the clinic when a client is already there.
- The staff should not discuss the details regarding any client outside the YFHS.
- The confidentiality policy of the clinic may be displayed and clearly expressed to the client and accompanying adults / parents in the first session itself.
- Client records to be kept out of reach of unauthorized persons.
- Protocols and procedures (SOP) to preserve anonymity should be well known to all personnel. The SoPs containing the protocols on privacy and confidentiality are annexed.

4. Clinic timings

The provider in charge of the facility must decide on the clinic timings and frequency of operation. It is advisable to have clinic timings that suit the needs of adolescents and young people. Due attention is to be given to school timings and work timings of adolescents / YP who are engaged in employment in the area. Availability of staff and rooms (after routine OPD hours) may be also checked. The guidelines developed by CSHP for referral of students to health facilities may be kept in view while deciding on the timings.

5. Appropriate signboard

The clinic is to have an appropriate signage reflecting the name, location of clinic and its operational timings. Display board of the DH / BHU may indicate the availability of services for adolescents. District medical officers can decide on the appropriate branding of these clinics to give them a distinct identity. The name may be identified in consultation with young people.

Key Points:

- Location and ambiance of the clinic area is inviting and comfortable. The clinic is clean and has basic amenities like drinking water and a clean toilet.
- Clinic timings suit the needs of the adolescents/YP
- Privacy and confidentiality are assured
- Staff are friendly
- Signboard is prominently displayed

Aspects of organizing services for adolescents at various levels have been discussed. Additional features for organizing services may be identified locally. A prerequisite for effectively organizing and delivering services is availability of competent and skilled providers.

STANDARD 4: Service providers are sensitive to adolescents' / Young Peoples' needs and are motivated to work with them.

Utilization of services from nearby health facilities should be the logical choice for adolescents/young people. Yet, available evidence, including Focused Group Discussions (FGD) with adolescents and young people during the workshop held for development of these standards, indicates that when adolescents/young people approach clinics and health centres for help, they are at times, scolded, humiliated, refused information or simply turned away. Hence it is critical to orient service providers towards delivery of quality services to adolescents, without being judgmental.

A district-specific capacity building plan may be developed for improving capacity and competency of service providers for service delivery. The capacity-building must address their competencies relating to clinical management, with an equal emphasis on developing their interpersonal communication skills, perspectives and attitudes on certain sensitive adolescent issues like sexuality, and remaining non-judgmental. Mechanisms would need to be developed in the system to sustain the motivation of providers to serve the adolescents sensitively. This plan could include elements of self-learning, formal training, follow-up after training from time to time and follow-up supervision. The main issue is to develop appropriate strategies to change the attitude of the health care provider.

The section given below briefly discusses the training of service providers as a strategy for capacity building.

Selection of providers:

Selection of providers for adolescent-friendly clinics will vary as per the availability of staff. However gender issues be kept in mind so that adequate staff of both the sexes is available. DH are likely to have additional nursing staff for round the clock services. Therefore, such DH may be identified as sites for adolescent friendly clinics. Staff of such DHs is to undergo the requisite training. Similarly BHU staff should also be trained in a phased manner as per the strategic plan. Orientation of the VHW and peer educators should be incorporated into the training plan of MoH.

ORIENTATION OF THE SERVICE PROVIDERS:

HISC:

- Counselors

JDWRH:

- To be identified (full time responsible person)
- RHU staff
- Paediatricians, Obstetricians, Dermatologists, Psychiatrist, Medical specialist

District Hospitals:

- Medical Officer (preferably a Lady Medical Officer).
- ACO – Assistant Clinical Officer
- Emergency duty staff
- RHU staff

BHU:

- All the staff manning the unit - HA, BHW, and ANM.

Community Level:

- VHW
- Peer Educators

The major objectives of the orientation programmes are to sensitize service providers on relevant information, skills and services for adolescents / young people and also to enhance their capacities to deliver the defined package of health services according to the needs of adolescents/young people.

WHO has developed an Orientation Package (OP) that has been adapted to suit the country's needs. This package will be utilized for the orientation of the various providers including health workers. The choice and combination of the modules /sessions for carrying out the orientation would depend upon the target group being oriented. \

The following orientations (on OP and 'national standards') are proposed for service providers:

- Orientation of DHOs and DMOs – 1 day
- Orientation of District Hospital staff to provide YFHS – 3 days
- Orientation of BHU staff to provide YFHS services – 5 days
- Orientation of VHW and Peer educators – 3 days plus once a month briefing

Training of Trainers: the required number of "master trainers" will be created by carrying out a training of trainers (TOT)

The key contents of training are as follows:

- Meaning of adolescence and its implications for public health
- Adolescent Sexual and reproductive Health.
- Youth Friendly Health Services
- Sexually Transmitted Infections in Adolescents and young people
- Care of Adolescent pregnancy and childbirth
- Pregnancy prevention in adolescents
- Contraception for adolescents and young people
- HIV/AIDS in adolescents and young people
- Substance abuse in adolescents and young people
- Concluding module

Orientation programmes for health service providers are to be organized at the district level by identified district level orientation teams. The District Health Officers are to ensure that all identified staff at the YFHS / clinics in the district undergoes the required orientation before the launch of specific youth –friendly health services.

Each district should prepare a training plan indicating the total number of staff of different categories to be oriented along with the budget estimates and submit it to the MoH. Subsequently the MoH will identify the number of trainers required to carry out these orientation programmes.

Districts may be encouraged to find mechanisms for sustaining the skills and knowledge of the service providers through supportive supervision and reorientation during their periodic administrative meetings held at district headquarters. A mechanism for supportive supervision for assessment of quality of services should also be in place. Incentives in the form of recognition and rewards for good performance of service providers may help in sustaining the motivation of the health service providers. Such public recognitions act as effective motivating factors even when there are no financial gains.

Key Points:

- An orientation package will be adapted and field tested .
- All YFHS providers will be provided orientation using the adapted package.
- Mechanisms will be developed for follow-up supported by supervision.
- A system of rewards and recognitions of good performers will be put in place.
- District level orientation plans with budget estimates will be developed and submitted to MoH.
- MoH will have the responsibility of building a pool of trainers for different level of orientation programmes.

STANDARD 5 : An enabling environment exists in the community for adolescents and young people to seek services

The preceding sections have discussed service delivery-related interventions. However, it is crucial that appropriate interventions are concurrently undertaken to ensure that an enabling environment exists for adolescents to seek services. This section primarily focuses on environment-building activities to be undertaken by the Ministry of Health.

District Health Officers are to ensure that steps are taken to help key stakeholders in the community to understand and respond to adolescent needs. Key audiences are to be identified whose support would be needed for creating an enabling environment within the community. Key stakeholders can include policy makers, administrators, community leaders, service providers, parents, teachers, community-based organizations, Religious leaders/groups, NGOs and the media.

The community can be engaged in a variety of ways, like seeking their views, providing information, and involving them in prioritizing areas for quality improvement. They can help to publicise and generate demand for high quality services and increase adolescents' use of them. Linkages may be established with community-based organizations, NGOs, social marketing and franchising outlets.

- (i) At the district level, a one-day Adolescent Development and Health (ADH) orientation is to be organized by the DHO for district level officers of different departments, including civil society representatives. The purpose of this orientation would be to:
 - (a) Increase awareness on ADH and ARSH issues
 - (b) Facilitate inter-sectoral coordination, especially with, school and youth sectors
 - (c) Inform about service delivery package.

Orientation content would cover vulnerabilities of adolescents, magnitude of Adolescence related problems, need for YFHS and outline of proposed services.

- (ii). At the district level, a one-day orientation is to be organized by the DHO for the main purpose of this activity is to organize support of key district level members for addressing ADH issues as relevant for the district. Scope of discussions could cover vulnerabilities of adolescents, magnitude of ADH problems and the need for YFHS services. Special focus is to be on monitoring teenage pregnancy and early marriages.
- (iii). At the BHU level, a half-day meeting is to be organized by the ANM/HW for self help groups and other stakeholders. The main purpose of this activity is to generate support of women for participation of unmarried adolescents in the group communication activities. The meeting is to cover issues of adolescent vulnerabilities, ADH problems and need for services, role of self help groups and proposed package of services.
- (iii). At the BHU level, a half-day meeting is to be organized by the ANM/HW for self help groups and other stakeholders. The main purpose of this activity is to generate support of women for participation of

unmarried adolescents in the group communication activities. The meeting is to cover issues of adolescent vulnerabilities, ADH problems and need for services, role of self help groups and proposed package of services.

(iv). At the village level, the ANMs/VHW, while participating in the meetings of women's groups or self help groups, must generate support for adolescents' need for information and services. They can take help of other community-based functionaries in organizing such group activities.

(v). Folk media and mass media, as applicable for the setting, must be engaged for the purpose of environment building in the community.

HWs, and ANMs are to ensure that adolescent health issues are discussed on a continuous basis in community meetings.

Media can be effectively engaged in generating awareness about adolescent issues and their importance as well as spreading information about Adolescent Friendly Reproductive and Sexual Health Services. Mass media as well as folk media can be used judiciously.

In their day-to-day interactions with adult women and men clients, doctors, ANMs, BHWs, can inform them about the value of providing adolescents with the health services they need. For each group of stakeholders, communication material maybe developed in the local language. In each district, institutions and NGOs working with adolescents could be involved for this purpose. The DHO/ DMOs at the district level can take a lead in organizing environment-building activities as given in the box.

The YFHS strategy at the national and district levels are expected to cover adolescent health issues. In addition, relevant advocacy and communication materials for fostering a supportive environment for YFHS may be developed at the national and state levels. This may be further adapted in the local context. In doing so, linkages with other departments such as Education, Youth and National Commission for women and children (NCWC), National HIV/ AIDS commission etc may be established. In order to facilitate the same, National and Dzonkhag (district) level coordination mechanisms are to be established and existing mechanisms are to be tapped. Appropriate channels of publicity may be identified, such as, mass media, folk media, posters, pamphlets etc.

Key Points:

This section illustrates the key actions that the Health Department can undertake to create an enabling environment for ADH services through YFSH. This is a continuous process in which partnerships are to be established with other departments and peripheral functionaries, as appropriate.

- Efforts must be made to increase awareness of the community regarding the adolescent needs and how to respond to them.
- Adolescents must be encouraged by the community to access the services.
- Health functionaries organize meetings with other departments and the community at various levels of administration to emphasize the need and role of adolescent-friendly services
- Adolescent health issues to be discussed continuously in routine contacts with the community members.

STANDARD 6: Adolescents and young people are well informed about the availability of good quality health services from the service delivery points.

Actions are to be taken to ensure that young people including adolescents are well informed about the availability of health services. Adolescents are to be knowledgeable about their health problems including sexual and reproductive health problems. The District Health is to take specific action to conduct communication activities with adolescents as follows:

- (i) **Outreach:** Communication activities are to be conducted at the level of village outreach, and/or youth group. The target group would include unmarried and married females and males. Such group communication activities are to be conducted once a month by the ANM, Youth Coordinator and/or health workers, and by the VHW whenever feasible. Communication aids in local language are to be used. Activities are to cover topics related to:
 - (a) Behaviour change communication on delaying sexual debut, marriage, and first pregnancy, importance of spacing, fertility awareness, menstrual hygiene, care during pregnancy;
 - (b) Risk reduction counselling on RTIs/STIs and HIV/AIDS prevention;
 - (c) Nutrition education on balanced diet, sign and symptoms of common nutritional deficiencies like anaemia;
 - (d) Immunization and its importance;
 - (e) Prevention and management of substance abuse, violence and injuries;
 - (f) Gender relations and role of men.

ANMs are to ensure counselling on and provision of condoms, Oral Contraceptive Pills and emergency contraception. Adolescents participating in the outreach sessions are to be referred to Health centers as appropriate.

- (ii). BHU: ANMs and male health workers are to be responsible for conducting once a month group communication activities in schools and youth groups. This is to be linked to school health activities as reflected in earlier sections. In case a male health worker is not available, possibility of identifying a local teacher may be explored. Scope of communication activities is to include the topics mentioned above.
- (iii). Medical Officers are to conduct health checkups once in six months under the school health programme. ANMs/HAs may periodically visit schools to inform adolescents about the availability of services.
- (iv). DHO is to ensure that all sub-centres and BHUs are equipped with locally relevant communication and counselling materials handy for service providers and adolescents visiting the health centers. IEC and BCC materials are to incorporate adolescent issues.

The District Health is to specifically establish linkages with other departments. These can be as follows:

- (i) The District Health Officer is to develop a plan with District Education officer, and other officials to incorporate adolescent and youth health issues in their ongoing programmes with adolescents through peer educators and outreach workers. Occasional participation of DMO/HA/ANMs/GDMO in district level adolescent activities could be worked out.
- (ii) Adolescent education interventions (Life skills based) are being implemented in schools. DMO can draw up a plan with the district education officer (DEO) on health education activities in schools, link up schools with BHUs and gain support of parents through NGOs. MOs and ANMs are to occasionally visit health education sessions to provide input as appropriate. Health check-ups are to be periodically conducted under the school health programme. The SPEA programme of DYS should also be utilized wherever relevant.
- (iii) MO to draw up a plan for linking, YFHS Centres, with adolescent clinics at BHUs. Information about availability of health services for adolescents maybe posted in schools, pharmacies, shops, community centre etc. Folk media may also be engaged in publicizing these services.

Key Points:

This section has discussed communication activities that the Health Department is required to undertake with adolescents and young people. In order to improve knowledge of adolescents, some communication activities can be proactively undertaken by the Health Department. For other activities, linkages with ongoing programmes of various departments can be established at the district level.

Key actions:

- Health facility will have a signboard welcoming adolescents and informing them about the availability of good quality health services.
- Health staff will liaison with School Health coordinators to strengthen the CSHP, and periodically visit educational institutions to inform adolescents about the availability of quality health services. For facilitating this collaboration, appropriate authorities will write letter to schools.
- Community-based organizations (e.g. NGOs working with children/adolescents on the street) will have informed the adolescents they come into contact with about the availability of quality health services. For this necessary links will have to be established with such organizations.
- Local performing groups will provide information about the availability of quality health services for adolescents through folk media.
- Information about the availability of quality health services will be provided through the media.

STANDARD 7: Management Systems are in place to improve/ sustain the quality of health services.

Mechanisms are to be in place to monitor the performance of the health facility and to identify the needs for corrective/ameliorative actions.

Monitoring as a function comprises of supervision, analyzing data and reporting on progress. Effective supervision is necessary to ensure that activities and sub-activities are carried out in the desired manner. It is needless to say that supervision is not to be perceived as a control function. It is a tool to observe activities, detect problems, explore solutions and implement the appropriate solution to ensure that the same problems do not occur in future.

With the above understanding, monitoring of YFHS at the district level is to be undertaken as follows:

1. Actions are to be taken to ensure that mechanisms are in place to monitor the performance of clinics and to identify needs for corrective actions.
2. Service providers are to participate in problem identification and solving activities.
3. Steps are to be taken to ensure that the data is collected, analysed and used to make health services adolescent friendly.

The focus is to be on tracking the progress made on the take off and utilization of YFH services.

Service Register and Monthly Format

For this purpose, each BHU / DH facility is to maintain YFH Service Register, which will generate data on a monthly basis. The MO is to prepare a monthly report that will reflect on:

- (i) Data from service register
- (ii) Progress on training and communication activities

Name of the training/communication activity attended: _____ Venue: _____ Date: _____

1. Participation
 - 2.
- Level of participation: Invited Attending
 - If turnout is poor, specify reasons:
 2. Training/communication sessions observed
 - Sessions: Planned Held
(Start till day of visit)
 - Clarity of presentations
 - Interactivity of participants:
 - Audio visual aids used:
 - If any session not held, specify reasons:
 - 3. Training/communication materials and methodology
 - Were materials available in adequate numbers?
 - Was a schedule present?
 - What core contents were covered in training/communication?
 - Were sessions planned and held as per schedule and methodologies?
 - 4. Training inputs
 - Are planned clinical/skill-based sessions held: Yes No
If not, provide reasons.
 - 5. Supervisor's feedback on strengthening future training/communication activities

Supervisory Checklist:

Data on training and communication activities could be further obtained from supervisory checklists.

National or state level facilitator could carry out this activity during training workshops. Further, programme managers could periodically use checklists during their supervisory visits in order to assess adherence to desired standards. The district manager could do this monitoring once in three months.

Assessments:

Rapid household surveys and assessment studies can be conducted in the district at annual intervals, in order to reflect data on the following output/outcome indicators. Special surveys may also be planned to get information on these indicators in selected districts.

Indicators

- Mean age at marriage
- Mean age at first child
- Teenage pregnancy rate
- Use of reversible contraceptive methods (%)
- Unmet need for reversible contraceptives in 15-19 years age group
- Use of condoms during last sex among 15 – 19 years age group
- Prevalence of anaemia in girls of 15 – 19 years age group
- Knowledge on STIs and HIV/AIDS transmission
- Prevalence of RTI/STIs and treatment seeking behaviour

Flow of data:

BHU/DH/RH will collate the data and send it to the District Health Officer (DHO). The DHO in turn will send the data to NACP and CSHP on quarterly basis. The feedback is to be given to the HA in charge BHU on the basis of trends in utilization of services. At the district level the DHO is expected to review the reports and provide guidance. Appropriate review and feedback mechanisms at the national, districts levels are to be in place to ensure that timely corrective actions are initiated.

Quality of outreach activities may be further assessed during supervisory visits. Depending on the maturity of the health system, mechanisms for quality assurance and improvement may be instituted. Further, community-monitoring mechanisms may also provide inputs on client satisfaction with special reference to adolescents.

To conclude,

In this section, a system for monitoring YFHS interventions at the district level has been mapped. Focus is on monitoring off-take and utilization of services. Main source of data would be the service register. This is to be complemented by data from supervisory and field visits. Periodic assessments are to be undertaken for ascertaining progress on output/outcome indicators. Review and feedback mechanisms at district and national levels are to be further worked out.

Matrix 1: Actions to be taken at national/ district and local (health facility) levels for each standard to be achieved; and means of verifying the achievement of each criterion.

Standard 1: Health Facilities provide the specified package of health services that adolescents and young people need.

Criteria	Health facility level	District level	National level	Key partners	Means of verification
Input Criteria					
1. Health facilities provide the specified package of health services to adolescents and Young People or make them available through referral (Note: The services to be provided at the BHU and district hospital have been specified earlier).	Provide the specified package of health services.	Inform all Health facilities about the package of health services that they need to deliver.	Specify the package of health services to be delivered at each level (i.e. BHU and district hospital).	Nutrition, RH, Mental Health, HIV/AIDS/STI programmes of MoH	<ul style="list-style-type: none"> - Report of the Health facility. - Interviews with Health facility staff. -Exit interview with clients
2. Mechanisms are in place to ensure effective referral to other Health facilities which provide services not provided on the spot (where applicable).	- Work to build/ strengthen referral linkages.	- Assist Health facility in developing referral linkages.		Other Health facilities in the public sector.	<ul style="list-style-type: none"> - Report of the Health facility. - Interviews with Health facility staff.
Process Criteria					
1. Health services are provided on the spot in line with the package. If services are not available on the spot, clients are referred elsewhere. Both these actions are carried out in line with standard operating procedures.	-	-	-	-	<ul style="list-style-type: none"> - Record review. - Interviews with managers and service providers.
Output criteria					
1. The specified package of health services are provided to adolescents and YP.	-	-	-	-	<ul style="list-style-type: none"> -Exit interview with clients

Standard 2: Health Facilities deliver effective health services to adolescents and young people.

Criteria	Health facility level	District level	National level	Key partners	Means of verification
Input criteria					
1. Service providers are in place:	Service providers are present and attend to their duties.	- Work with the state authorities to ensure that identified staffs are deployed	- Define the staffing profile for each Health facility, and communicate this to the districts. DH: MO, S/N, Counsellor BHU: BHW, HA, ANM, - Deploy staff to the Health facility in line with the defined profile.	-	- Report of the Health facility. -Observation of Health facility.
2. Service providers are clearly aware of their roles and responsibilities in relation to the functioning of the Health facility.	- Ensure that every staff member has his/her respective job description.	- Ensure that the Health facility has the job descriptions.	- Prepare/update job description.	-	- Report of the Health facility. - Interviews with Health facility staff.
3. Clinical management guidelines and standard operational procedures are in place for the provision of the specified health services.	-	- Distribute the Clinical Job-aids or algorithms to the Health facilities.	- Adapt the Clinical Job-aids. - Distribute them to the districts.	-	- Observation of the Health facility.
4. Good ambience: At a minimum, the following amenities will be in place: • clean premises, • drinking water, • functional toilet, • seating in the waiting area • attractive posters and informational materials	- Carry out improvements to the Health facility as per the guidelines.	- Orient Health facility managers on the guidelines. - Support Health facility in developing plans and in carrying out follow up action. - Distribute posters and informational materials.	- Develop guidelines for making the surroundings appealing to adolescents and send them to the districts. - Develop posters/informational materials, and send them to the districts.	-	- Observation of the health facility

Criteria	Health facility level	District level	National level	Key partners	Means of verification
5. Supplies and equipment required to provide the specified health services are in place.	<ul style="list-style-type: none"> - Work with the district authorities to ensure that the supplies and equipment are in place. - If/when needed, try to find local solutions to problems 	<ul style="list-style-type: none"> - Work with the state authorities to ensure that the equipment and supplies are in place. 	<ul style="list-style-type: none"> - Specify the supplies and equipment that need to be in place in each type of Health facility, and communicate this to the districts. - Make resources available for the above mentioned items to be in place. 	Logistics and supplies department / procurement department	Observation of the health facility
6. Informational/educational materials directed at adolescents and YP are available.	<ul style="list-style-type: none"> - Display and/ or distribute informational materials. 	<ul style="list-style-type: none"> - Distribute the informational materials to the Health facility. 	<ul style="list-style-type: none"> - Develop informational materials like posters and pamphlets. - Send the materials to the districts. 	NGOs and other sectors producing educational materials for adolescents and YP.	<ul style="list-style-type: none"> - Report of the Health facility. - Observation of the Health facility.
Process criteria					
1. Service providers effectively manage adolescents and YP who seek help.	<ul style="list-style-type: none"> - 	<ul style="list-style-type: none"> - 	<ul style="list-style-type: none"> - 	<ul style="list-style-type: none"> - 	<ul style="list-style-type: none"> - Record review. - Observation of service provider-patient interaction.
Output criteria					
1. Adolescents and YP receive effective promotive, preventive and curative services.	<ul style="list-style-type: none"> - 	<ul style="list-style-type: none"> - 	<ul style="list-style-type: none"> - 	<ul style="list-style-type: none"> - 	Exit interview with adolescent and YP.

Standard 3: Adolescents and young people find the environment at health services conducive to seek services.

Criteria	Health facility level	District level	National level	Key partners	Means of verification
Input Criteria					
1. Designated staff are physically present at the health facility during clinic hours		<ul style="list-style-type: none"> - Ensure physical presence of the designated staff during clinic hours 	<ul style="list-style-type: none"> - Staffing policy as defined in standard 2 -communicate / order about timings of clinic etc 		<ul style="list-style-type: none"> - Observation to check timing / punctuality
2. Registration procedures are simple and allow confidentiality	Health facility carries out the SOP	<ul style="list-style-type: none"> - Communicate the registration policy and confidential record keeping 	<ul style="list-style-type: none"> - Develop policy statement to support adolescents and YP (who come for consultation only) to have an option for not sharing name and address at the time of registration 		<ul style="list-style-type: none"> - Observation
3. Health facility staff are fully aware of policies and procedures that protect the privacy and confidentiality of adolescents and YP and these are in place	Health facility carries out the SOP	<ul style="list-style-type: none"> - Distribute the SOP to the Health facilities. 	<ul style="list-style-type: none"> - Develop standard operating procedures for privacy and confidentiality and distribute them to the districts. 		<ul style="list-style-type: none"> - Report of the district authority. - Observe whether they are in place.
4. Confidentiality policy is clearly displayed in the clinic and is clearly expressed to the client and their parents and guardians	Health facility displays the confidentiality policy and carries out the SOP	<ul style="list-style-type: none"> - Distribute the SOP to the Health facilities. 	<ul style="list-style-type: none"> - Develop standard operating procedures (SoP) for implementing confidentiality policy as decided and distribute them to the districts. 		
5. Services are provided to adolescents and YP at specified days/timing convenient to them; in addition they are free to obtain services at any other time.	<ul style="list-style-type: none"> - Provide services on specified days/ timings and during routine timings. 	<ul style="list-style-type: none"> - Work with the Health facility to develop a plan for this. 	<ul style="list-style-type: none"> - Develop plan and guidelines for clinics at specific times and days and share it with districts. 	-	<ul style="list-style-type: none"> - Observation. -Report of the Health facility manager

Criteria	Health facility level	District level	National level	Key partners	Means of verification
6. Health facility has a signboard welcoming adolescents and YP & informing them about the availability of good quality youth friendly health services.	- Signboards are prominently displayed	- Develop sign boards.	- Design logo and text for the sign board.	- Businesses houses could be invited to contribute to this work.	- Observation
Process Criteria					
1. Services are provided on the days/times that they are meant to be.	-	-	-	-	- Observation - Interviews with Health facility staff
2. Health facility staffs apply the standard operating procedures on respecting the privacy and confidentiality of their young patients.	-	-	-	-	- Observation. - Interviews with Health facility staff
Output criteria					
1. Adolescents and YP feel comfortable with the surroundings and procedures when they visit Health facility	-	-	-	-	- Exit interviews with adolescent and YP patients.

Standard 4: Service providers are sensitive to adolescents' / Young Peoples' needs and are motivated to work with them.

Criteria	Health facility level	District level	National level	Means of verification
Input criteria				
1. Service providers have the competencies required to provide the specified health services effectively	Allow health providers to take trainings/ orientations	<ul style="list-style-type: none"> - Implement the competency building plan for the staff of identified health facilities using Orientation package. 	<ul style="list-style-type: none"> - Develop a competency building plan that addresses competencies relating to both clinical management as well as interpersonal communication. Note: The competency building plan should include elements of self learning, training, follow-up after training, mentoring, and continuous learning to address gaps that have been identified. - Training package has been developed. - Districts to conduct Trainings with the help of National facilitators - Make training package and resource persons available to the districts to implement the competency building plan. 	<ul style="list-style-type: none"> - Report of the Health facility on the involvement of Health facility staff in competency building activities.
2. A mechanism is in place to recognize and reward good performance.	<ul style="list-style-type: none"> - Apply the mechanism. 	<ul style="list-style-type: none"> - Orient Health facility managers to the mechanism. 	<ul style="list-style-type: none"> - Develop the mechanism to recognize and reward good performance, have it approved and sent it to the districts. 	<ul style="list-style-type: none"> - Report of the Health facility. - Interviews with Health facility managers/staff.

Criteria	Health facility level	District level	National level	Means of verification
Process criteria				
1. Service providers apply the competencies and procedures in their dealing with their adolescent and YP.	-	-	-	- Observation. - Interviews with Health facility staff.
2. Good performance of service providers is recognized and rewarded.	-	-	-	- Observation of completed performance assessment forms. - Individual interviews with Health facility managers/staff.
Output criteria				
1. Service providers feel motivated to provide services to young people.	-	-	-	Individual interviews with Health facility staff.
2. Service providers feel valued by their colleagues & supervisors.	-	-	-	Individual interviews with Health facility staff.

Standard 5: An enabling environment exists in the community for adolescents and young people to seek the health services they need.

Criteria	Health facility level	District level	National level	Key Partners	Means of verification
Input Criteria					
1. All adult patients visiting Health facility will have been informed about the value of providing adolescents and YP with the health services they need.	- Communicate with all adult patients about the rationale for providing health services to adolescents /yp.	- Identify key institutions and networks that need to be engaged to influence public opinion. - Identify other players (e.g. other Govt. departments / NGOs) best suited to reach out to these institutions/networks. - Brief them about the rationale for providing adolescents and YP with the health services they need.	- Ensure that communicating about the value of providing adolescents with the health services they need is addressed in the training package.	-	- Interviews with Health facility staff.
2. Community members will have been briefed about the rationale for providing adolescents and YP with the health services they need.	-		- Develop a communication tool that district officials could use to communicate on this matter with key institutions and networks that need to be engaged to influence public opinion.	-	Interviews with heads of key institutions/networks.
3. Information about the rationale for providing adolescents and YP with the health services they need will have been communicated through the mass media.	-		- Develop BCC strategy and messages - Conduct a national/state level publicity campaign.	-	- Articles in the print media. - Programmes on radio and television.

Criteria	Health facility level	District level	National level	Key Partners	Means of verification
Process Criteria					
1. Orientation meetings are held at district and sub-district levels with all major stakeholders including officers of other departments	-	-	-	-	- Observe selected meetings -Record/ reports review.s
2. Service providers communicate effectively about the rationale for providing health services to adolescents and YP in their interactions with adult patients.	-	-	-	-	- Observe selected interactions.
3. The rationale for the provision of health services to adolescents and YP is discussed in community meetings.	-	-	-	-	- Observe selected meetings.
Output criteria					
1. Officials of other departments are aware of the value of providing health services to adolescents and YP					- Individual Interviews
2. Community members are aware of the value of providing health services to adolescents and YP.	-	-	-	-	- Interviews with gatekeepers. -focused group discussions
3. Community members support the provision of health services to adolescents and YP.	-	-	-	-	Interviews with gatekeepers.

Standard 6: Adolescents and young people are well informed about the availability of good quality health services from the service delivery points.

Criteria	Health facility level	District level	National level	Key Partners	Means of verification
Input Criteria					
1. Health facility has a signboard welcoming adolescents and YP & informing them about the availability of good quality youth friendly health services.	- Put up the sign boards.	- Develop sign boards as per approved design.	- Design logo and text for the sign board.	Local businessmen could be engaged to participate in this.	- Observation.
2. Health facility staff will have visited educational institutions to inform adolescents and YP about the availability of quality youth friendly health services.	- Make a plan to visit educational institutions. - Visit them according to the plan.	- Send a letter to heads of educational institutions about YFHS. - Send a list of educational institutions to Health facilities to interact with.	- Send a letter to the district educational officer about the Youth friendly health services (YFHS).	-	- Report of the Health facility on visits made. - Interviews with Health facility staff and heads of educational institutions.
3. Organizations (e.g. NGOs working with children/ adolescents on the street) will have informed the adolescents and YP they come into contact with about the availability of quality youth friendly health services.	-	- Organize briefings on YFHS for organizations which come into contact with adolescents and YP, especially adolescents at greatest risk / vulnerability.	-	-	- Interviews with heads of selected organizations.

Criteria	Health facility level	District level	National level	Key Partners	Means of verification
4. Local performing groups will have provided information about the availability of quality youth friendly health services through folk media.	<ul style="list-style-type: none"> - Identify and engage performing groups. - Develop a plan for their performances. - Support them in their performances 	<ul style="list-style-type: none"> - Identify and engage performing groups. - Develop a plan for their performances in the district. 	<ul style="list-style-type: none"> - Develop a plan for performing groups. - Develop contents for use by the performing groups. 	<ul style="list-style-type: none"> - Performing groups. 	<ul style="list-style-type: none"> -Reports on number of performances done
5. Information about the availability of quality health services will have been posted in pharmacies and shops in the area.	<ul style="list-style-type: none"> - Select the pharmacies and shops and display the posters. 	<ul style="list-style-type: none"> - Print posters for display and distribute to health facilities 	<ul style="list-style-type: none"> - Develop posters for display at pharmacies, shops etc. and send to districts 	<ul style="list-style-type: none"> - Develop posters and send them to the districts. - Voluntary organizations could be engaged in this work. 	<ul style="list-style-type: none"> - Observation of selected pharmacies and shops.
6. Information about the availability of quality health services will have been provided through the media.	<ul style="list-style-type: none"> - 	<ul style="list-style-type: none"> - Brief media persons periodically about the YFHS. 	<ul style="list-style-type: none"> - Develop messages and have them approved. - Conduct a national level publicity campaign. 	<ul style="list-style-type: none"> - 	<ul style="list-style-type: none"> - Articles in the print media.

Criteria	Health facility level	District level	National level	Key Partners	Means of verification
Process Criteria					
1. Health facility staff are visiting educational institutions to inform adolescents and YP about the availability of good quality health services.	-	-	-	-	- Observe selected sessions.
2. Organizations which come into contact with adolescents and YP are briefing them about the availability of quality health services.	-	-	-	-	- Observe selected sessions.
3. Local performing groups are providing information about the availability of quality health services through folk media.	-	-	-	-	- Observe selected performances.
Output criteria					
1. Adolescents and YP are well informed about the availability of good quality health services.	-	-	-	-	- FGD with adolescents in the catchment area of the Health facility.

Standard 7: Management systems are in place to improve/sustain the quality of health services.

Criteria	Health facility level	District level	National level	Key Partners	Means of verification
Input Criteria					
1. Mechanisms are in place to monitor the performance of Health facility (including Health facility staff) and to identify needs for corrective / ameliorative actions.	<ul style="list-style-type: none"> - Weekly assessments carried out. 	<ul style="list-style-type: none"> - Distribute the self-assessment tools to the Health facility, and orient the Health facility manager/staff to it. - Develop a plan for assessment visits to the Health facilities. - Provide supportive supervision to health facility staff. 	<ul style="list-style-type: none"> - Develop a monitoring system that includes the following elements: <ul style="list-style-type: none"> - weekly self- assessment by Health facility managers, - monthly external assessment by district coordinators, - six monthly external assessment by the state level coordinators. - Develop monitoring tools and distribute them to the districts. 	<ul style="list-style-type: none"> 'Resource institutions' could be engaged to make a valuable contribution to this. 	<ul style="list-style-type: none"> - Observe monitoring plan. - Interviews with Health facility manager/staff.
2. State and district coordinators have the competencies needed to provide facilitative & supportive supervision in a respectful manner.		<ul style="list-style-type: none"> - Participate in competency building of supportive supervision. 	<ul style="list-style-type: none"> - Develop a competency building plan (which includes. Self-learning, training, follow up after training and ongoing learning) for supportive supervision. - Implement the competency building plan. 		<ul style="list-style-type: none"> - Observe monitoring plan. - Interviews with Health facility manager/staff.

Criteria	Health facility level	District level	National level	Key Partners	Means of verification
<p>4. A strengthened management information system is in place that gathers information on the following issues:</p> <ul style="list-style-type: none"> • Age • Sex • Reason for visit (i.e. the presenting issue/problem) • If referred, from where? 	<ul style="list-style-type: none"> - Apply the revised system. 	<ul style="list-style-type: none"> - Distribute the revised MIS format to Health facility. - Orient Health facility managers to their use. - Monitor their use. 	<ul style="list-style-type: none"> - Review the existing management information systems. - Develop ways and means of strengthening it. - Orient district coordinators to the revised format, and distribute it to them. 		<ul style="list-style-type: none"> - Observe monitoring plan. - Interviews with Health facility manager/staff.
Process Criteria					
<ol style="list-style-type: none"> 1. Assessments are carried out as specified. 					<ul style="list-style-type: none"> - Observing an assessment exercise. - Reports of the Health facility. - Interviews with Health facility managers/staff..
<ol style="list-style-type: none"> 2. Service providers participate in problem identification and solving activities. 					<ul style="list-style-type: none"> - Interviews with Health facility managers/staff. - Minutes of meetings held to discuss the implications of the findings for the work of the HHealth facility.
Output criteria					
<ol style="list-style-type: none"> 1. Data are collected, analyzed and used to make health services more adolescent friendly. 					<ul style="list-style-type: none"> - Interviews with Health facility managers/staff.

Matrix- 2 : Actions that need to be taken at district level to support the implementation of the initiative.

Actions to be taken at District level					
Standard 2	Standard 3	Standard 4	Standard 5	Standard 6	Standard 7
<p>1. Work with the state authorities to ensure that identified staffs are deployed</p> <p>2. Ensure that the Health facility has the job descriptions of staff.</p> <p>3. Distribute the Clinical Job-aids to the Health facility.</p> <p>4. Orient Health facility managers on the guidelines to make surroundings appealing.</p> <p>5. Distribute posters and informational materials.</p> <p>7. Work with the national authorities to ensure that the equipment and supplies are in place.</p> <p>8. Distribute IEC materials to the Health facility.</p>	<p>1. Ensure physical presence of the designated staff during clinic hours</p> <p>2. Communicate the registration policy and confidential record keeping to the health facilities</p> <p>3. Distribute the SOP to the Health facilities about privacy and confidentiality.</p> <p>4. Work with the Health facility to develop a plan to provide services to adolescents at specified days/ timing convenient to them in addition to the routine hours.</p> <p>5. Develop sign boards as per approved design.</p>	<p>1. Implement the competency building plan for the staff of identified health facilities.</p> <p>2. Orient Health facility managers to the mechanism to recognize and reward good performance.</p>	<p>1. Identify key institutions and networks that need to be engaged to influence public opinion.</p> <p>2. Identify other players (e.g. other government departments/ NGOs) best suited to reach out to these institutions / networks.</p> <p>3. Brief them about the rationale for providing adolescents with the health services they need.</p>	<p>1. Develop sign boards as per approved design and send to health facilities.</p> <p>3. Send a letter to heads of educational institutions about the adolescent friendly health services (AFHS).</p> <p>4. Send a list of educational institutions to Health facilities to interact with.</p> <p>5. Organize briefings on AFHS to organizations which come into contact with adolescents.</p> <p>6. Identify and engage local performing groups and develop a plan for their performances in the district.</p> <p>7. Brief media persons periodically about the AFHS.</p>	<p>1. Distribute the self-assessment tools to the Health facility, and orient the Health facility manager/staff to it.</p> <p>2. Develop a plan for assessment visits to the Health facilities.</p> <p>3. Provide supportive supervision to facility staff.</p> <p>4. Participate in competency building of supportive supervision.</p> <p>6. Distribute the revised MIS format to Health facility.</p> <p>7. Orient Health facility managers to their use.</p> <p>8. Monitor their use.</p>

In relation to standard 1:

- The service package decided by the Government will be disseminated to the managers of identified health facilities
- District will do a mapping of referral facilities (to which adolescents can be referred for services not available at the spot) including the organizations which provide information and advice to adolescents on health issues as well as 'non-health' issues outside the context of a health worker-patient interaction, and establish a mechanism for information-sharing and to discuss possible collaboration

Matrix 3

YFHS - Actions to be taken at health facility level					
Standard 2	Standard 3	Standard 4	Standard 5	Standard 6	Standard 7
<p>1. Work with the district authorities to ensure that the supplies and equipment are in place</p> <p>2. If and when needed, try to find local solutions to problems</p> <p>3. Display and/or distribute posters and information materials</p>	<p>1. Health facility carries out improvements as per the guidelines about cleanliness and basic amenities</p> <p>2. Health facility carries out the SOP about easy registration and confidential record keeping</p> <p>3. Health facility follows SOP on Confidentiality / privacy and displays the policy</p> <p>4. Provide services at specified days/timing convenient to them; in addition they are free to obtain services at any other time.</p> <p>5. Signboards are prominently displayed</p>	<p>1. Ensure availability of trained providers</p> <p>2. Apply the mechanism to recognize and reward good performance</p>	<p>1. Communicate with all adult patients about the rationale for providing health services to adolescents</p>	<p>1. Make a plan to visit educational institutions periodically</p> <p>2. Visit the educational institutions according to the plan</p> <p>3. Put up the signboards strategically</p>	<p>1. Weekly self-assessments carried out</p> <p>2. Apply the mechanism for service providers to participate in discussions on how they could deal with challenging situations in their work with adolescents, more effectively</p> <p>3. Apply the revised MIS that gathers information on the following issues:</p> <ul style="list-style-type: none"> • Age • Sex • Reason for visit (i.e. the presenting issue / problem) • Source of referral
<p>Standard 1 is about specified package of services</p>					

ANNEXURE

PROGRAMATIC SUPPORT FOR IMPLEMENTATION

Levels of implementation: National, District, Community

NATIONAL LEVEL

The responsibility at the national level will be the National steering committee / Expert Group for adolescent health.

(a) Key national level actions

- Finalize/disseminate national YFHS guidelines and standards
- Consultation and consensus building at the District level
- Communication strategy including advocacy
- Capacity development for YFHS implementation
 - Development of training plan, YFHS training packages
 - Development of IEC materials
 - Building up a core TOT team and training plan
- Management of Social Franchising [Who, how, etc]
- Logistics Management [condoms, supplies]
- Coordination and Steering the YFHS [Govt. UN, NGO professional bodies and task allocation and specification]
- Developing M and E Plan, formats, guides, schedules/responsibilities, information systems

(b) Management Structure

A “Cell” be created and ‘housed’ appropriately in the MoH for YFHS management.

DISTRICT LEVEL

(a) Key District Level actions

- Advocacy
- Coordination
- Capacity Development (Training, logistics)
- M & E
- Capacity development at district level (Training, logistics)

- ❑ Implementation of training
- ❑ Communication (Advocacy, demand generation, awareness raising,)
- ❑ Monitoring of the progress of the YFHS and Franchising and Evaluation.

(b) Management Structure:

The DMO will be responsible for the district level actions to support implementation.

COMMUNITY LEVEL (THE ACTUAL SERVICE DELIVERY POINT)

The coordination of community level actions will be through the MoH

(a) Key Community Level actions

- ❑ Development of an Action Plan
- ❑ Develop Linkages
- ❑ Capacity development
- ❑ Awareness building, demand generation, advocacy
- ❑ M & E

(b) Management Structure:

Coordination by MoH - BHU, DH, RH and Youth Centers will be the key partners

Strategy to provide YFHS at various levels

- **'Pilot' the YFHS:** - at JDWRH where 'separate' arrangements (centre/ clinic) will be made to provide YFHS. Doctors belonging to different specialties will be available in the clinic on the designated (different) days. The "School Health Coordinators" will liaison with the special clinic and the doctors manning the clinic for the referrals. The lessons learnt from the pilot phase will be incorporated for future initiatives. In charge: Full time responsible person (ACO)
- **Integrated services:** the services provided at the Referral hospital, District Hospital and BHU level will 'integrate' the services within the routine services. All the staff manning the unit will be oriented /trained to provide YFHS.

ANNEXURE

KEY ELEMENTS AND ACTION POINTS FOR ROLLING OUT YFHS

1. Identify, sensitize and engage stakeholders to support the initiative:

- Community leaders, parents, teachers, health workers, adolescents, others
- Orient the district authorities
- Orient managers / MOs of Service delivery points

2. Preparing a dedicated team of professionals and provide training to them:

- Presence of a Pediatrician & Gynecologist in all Referral hospitals
- Identify provider team and decide roles and responsibilities: Medical officer, HA, ANM, Counselor
- Selection of providers: Willing, Sensitive, Non-judgmental, motivated, both genders (one male and one female)
- Capacity building of providers: Clinical knowledge and skills as well as interpersonal communication skills
- Identifying counsellors to man the “telephone helpline”

3. Identify and develop resource materials and infrastructure to facilitate services so that:

- Written clinic policies and procedures on privacy & confidentiality should be available.
- Service providers are aware of these policies and procedures.
- Adolescent information materials are available
- The required supplies, equipment & basic amenities are available
- Reasonably good laboratory support services are in place.
- Functional referral systems are in place

4. Advocacy in the community for demand-generation for the proposed services

- Outreach activities to provide adolescents and community with information about the services available and value of providing such services
- Publicity regarding the availability of services

5. Identify and develop school and community referral networks for increasing the scope and reach of the services and demand generation:

- Utilize ANMs services for community mobilization.
- Meetings with District Education Officers, Principals, Teachers
- Meetings with Youth Clubs NGOs, other relevant govt. schemes etc
- Planning Meeting with CBOs/NGOs
- Orientation of Principals, teachers and NGO functionaries

6. Reorganization of the Facility:

- Services on specified days and times convenient to adolescents
- There is convenient waiting area with chairs, clean and functional toilets and drinking water is available
- Appealing posters are displayed
- Signboard of the clinic is prominently displayed

7. MIS and Supervision:

- System to collect, analyse and make use of data: Clinic/ service register (Institutional MIS) and forms (monthly format)
- Systems to provide staff members with the support they need to perform to the best of their abilities
- Facilitate Self-assessment – develop forms and matrices.
- Define how to verify that activities are proceeding as planned.
- Define how to determine whether adolescents are using the health services they need.

8. Develop effective referral linkages:

- With a network of BHUs.
- Referral facility to the district hospital
- Referral to a tertiary / specialist level facility /– if and when required.

ANNEXURE

SUGGESTED STANDARD OPERATING PROCEDURES (SOP) FOR YFHS CLINIC/CENTRE

Objectives:

The objectives of the standard operating procedures are to ensure:

- Uniformity and clarity of procedures
- Smooth functioning of the services
- Maintenance of quality of services

Reception and Registration:

The open space near the Rooms -- and will be utilized as the reception area for the Adolescent Center and Room --- is earmarked as the Registration Room.

- Reception area to be kept clean and have a pleasing ambience, and have facilities for drinking water, clean toilet.
- Client directly reports to the reception area
- Client is received, registered, and triaged by trained Nurse/ ANM in Room --
- Client has an option of not disclosing his / her name and / or address /or other particulars to maintain confidentiality.
- Records are to be kept under lock and key and not revealed to any unauthorized persons
- Prior appointments possible – either telephonically or in person or through messenger
- Walk-in clients would be welcome
- Parents are welcome
- Easy retrieval of records is ensured by means of the specific ID No to be provided to every client.

Privacy:

Privacy is to be ensured in the following areas and manners:

- Reception area and Registration Room No. --
- Consultation Rooms: Rooms --, --, --, and --

- It is to be ensured that clients are attended to one to one and audio-visual privacy is maintained – curtain, doors, screen for examination are available.
- Restricted entry for others while the client is being interviewed / examined.
- Chaperone: A suitable chaperone should be present while examining a client

Confidentiality:

- Wall posters on clinic policy of confidentiality are to be displayed prominently
- Registration procedures to maintain client's confidentiality.
- Clinic policy of confidentiality is to be discussed with the adolescent and parents in the first session itself
- Client's approval must be sought if confidentiality needs to be broken for any reason
- Record should be kept secure so as not to fall in the hands of unauthorized personnel.

Non-refusal of Service:

Clinic policy requires that services will not be refused because of reasons like:

- Age: outside 10 - 19 years age-group.
- Gender
- Adolescents not accompanied by parents / guardians
- Parents not accompanied by adolescents

Provisions:

The following provisions are ensured:

- Adequate physical space as described above:
 - Reception area
 - Registration room
 - Waiting Area
 - Individual consultation rooms
- Standard clinic form and files
- Job-aids: Charts folder (Note: Job-aids from WHO would be available soon)

- IEC material for clients to carry home. Appropriate pamphlets should be used during counseling as audio-visual aids and the client should be encouraged to read the same.
- Equipment: Height, weight scales, orchidometer, BP apparatus with appropriate cuff for younger clients.

Standard management protocol for each client:

- Care for the primary problem –stated by the client or discovered during interview
- Developmental screening
- Preventive counseling in the following areas (Not necessarily in the first session):
 - Nutrition
 - Physical exercise
 - Injury prevention
 - Substance abuse
 - Responsible sexual behaviour
- Immunization: Room --
 - Tetanus toxoid (TT): A dose of 0.5 ml I/M to be offered at 10 years and 15 years age
 - Other vaccines –as per programmes.
- Unnecessary procedures should be avoided, and non-urgent ones postponed for the next visit, if possible (e.g. Pelvic exam in a case of vaginal discharge or suspicion of STI, Sexual Maturity Rating for development monitoring in case the client is not comfortable with it may also be postponed for the next visit)
- Referrals: Clients who need referral should be explained the need and referred to the appropriate experts.

Medicine supplies: Iron – Folic Acid Tablets (Small Tab = 20 mg Iron, Big Tab = 60 mg Iron) are available in Room -- and may be prescribed for 1 month at a time.

De-briefing meeting of consultants:

Periodic debriefing meetings of the consultants attending the Adolescent center would be held to facilitate:

- Capacity enhancement - Professional development of the staff by providing opportunity to discuss difficult cases.
- Provision of professional back-up for such difficult cases
- Assurance of quality of services

ANNEXURE

MOVING FROM NATIONAL STANDARDS TO ACTION

Ground work to be done at the national / state level before the approved national standards can be applied

1. Dissemination of operational guidelines on YFHS developed by the MoH presented here in the “Implementation Guide on YFHS for Programme Managers”
2. **Identify and engage organizations with expertise** in the following two areas to support the initiative on an ongoing basis:
 - Quality improvement: NIMS- RENEW, Professional associations, Medical Colleges etc.
 - Health systems research
3. Inter-sectoral Coordination among the key stakeholders at the National /district level for obtaining support during implementation of adolescent friendly health services. This could be done in a meeting involving all of them, or through one-to-one meetings. Here is an indicative list of potential stakeholders who should be reached:
 - (i) Ministry of Health:
 - Directorate Public Health
 - Department of Family Welfare,
 - NACP
 - Comprehensive School Health Program (CSHP)
 - (ii) Ministry of Education,
 - (iii) Department of Youth and Sports (DYS)
 - (iv) Ministry of Rural Development
 - (v) Key International Organizations:
 - United Nations agencies
 - Bilateral agencies
 - International and National NGOs
4. Develop and carry out national level BCC campaign on adolescent and young people's health and awareness generation on health services available for them
5. Incorporate ADH indicators in the routine MIS

STEPS IN APPLYING THE APPROVED NATIONAL STANDARDS AT DISTRICT LEVEL

1. The first step in the process is the selection of districts for the initial phase. In making the choice it would be important to have clearly defined criteria. Here is an indicative list:

- The commitment of the district administrative leadership, the district health leadership and the district political leadership to the initiative.
- The commitment of the district health management team to provide supportive supervision.
- The existence of an organization (NGO / CBO) involved in providing health education and counselling services to adolescents.
- Proximity to HQ - for administrative convenience of the HQ

2. Once the selection of the district is made it would be important to inform key stakeholders in the district, and to obtain their support for it. It would be important to involve the following categories of leaders in this process:

- Political leaders
- Administrative leaders
- Health leaders
- Religious leaders
- Heads of NGOs that work in fields of health and development

3. The next step in the process is the orientation of district teams and the development of work plans for the district. For this, a 2-Day working meeting of teams from the participating districts should be organized. The proposed list of team members is as follows:

- Two-three key officials from the District Health Management team (DHO,).
- The manager of a Health facility: DMO, District hospital in charge
- A service provider.
- A representative from the mentoring institution: Referral Hospital – Faculty from department of Paediatrics, Gynaecology or any other speciality.
- A representative from the organization (NGO/CBO) providing adolescent's health information and counselling (if there is one).
- Two adolescents (from educational institutions or work places in the district).

The proposed objectives of the meeting are as follows:

- To orient the participants to the rationale for the national standards and guidelines, the process by which they were developed and their objectives.

- To orient the participants to quality improvement.
- To review the list of standards and guidelines - with a view to assess if the district teams believe that all of them are equally relevant to their respective districts.
- To review the complementary roles that the district health management team and the mentoring institution will need to play in supporting the service delivery points achieve the standards (Annex 2 outlines what needs to be done at district level to support the implementation of the initiative. This should provide the basis for the discussion).
- To develop a six-month work plan for the district health management team and the mentoring institution, of each selected district.
- To select the service-delivery points to be involved in the first phase of implementation in each selected district.

4. The next step in the process is the orientation of the managers of the health facilities selected by the District Team Leader. The proposed objectives of this 1-Day meeting are:

- To orient the participants to the rationale for the national standards, the process by which they were developed and their objectives.
- To orient participants to quality improvement.
- To orient participants to the role that they will need to play in this initiative.
- To develop plans for them to orient their staff and to prepare for a participatory baseline quality assessment.

5. Concurrently Training of Healthcare Providers needs to be carried out to cover the health facilities selected for implementation of YFHS. The training will be done by using the Orientation Programme manuals developed by MoH for medical officers and health workers.

6. Work with district management to plan and implement environment building and awareness generation activities (inter-sectoral meetings, community meetings and multi channel BCC campaign in the district) on adolescent health and adolescent health services

7. Work with District management to incorporate ADH indicators in the routine national MIS as well as local monitoring

8. The stage is now set for service delivery in the selected health facilities to begin. The mentoring institution should work with the district health management team to facilitate preparedness at identified facilities for adolescent friendly services in the identified facilities and start service delivery.

9. Mentoring agency would be required to work with district management to carry out a quality assessment using the quality assessment tool (annex 3). In each service-delivery point, it should work with the manager and staff to explain the findings of the assessment and to develop plans for quality improvement actions by staff.

Following this, the mentoring institution should carry out periodic visits for problem identification and problem solving (keeping the district health management team closely involved in this process). During the initial phase the overall support and supervision may be provided by the identified expert agency at national level.

ANNEXURE

PROCESS OF DEVELOPING THE NATIONAL STANDARDS FOR YFHS IN BHUTAN:

The following was the process adopted to develop the National Standards:

1. A **three days workshop** that included Program Managers from the Health, Education, personnel from UN bodies, NGOs and adolescents and young people was held by MoH in the month of April 2008 to develop the National Standards for YFHS. This was facilitated by the WHO expert and some National facilitators. (See Annexure for the list of participants)
2. Consensus developed in **adapting** the standards to Bhutanese context.
3. A two day workshop to finalize the Draft National Standards and reach consensus was held 26-27th May, 2008 at MoH premises, Thimphu. (See Annexure for the list of participants)

Inputs from the Workshop held in April 2008:

Main issues that need to be addressed to promote young people's health in bhutan

1. ARSH
2. DIET
3. SUBSTANCE ABUSE
4. HIV/YP
5. VIOLENCE
6. STRESS
7. OTHERS

Primary issues under main issues

1. Arsh

- Body Image.
- Menstruation.
- Teenage Pregnancy.
- Abortion.
- Personal Relationship.
- Lack of self confidence/low self esteem.

2. Diet

- Junk Food.

3. Substance Abuse

- Peer Pressure.
- Family Background.

4. HIV/YP

- Lack of knowledge.

5. Violence

- Domestic violence
- Gang fights.

6. Stress

- Studies.
- Family Pressure.

7. Others

- Cell Phone.
- Internet.

Barriers

Factors that are responsible for poor utilization of health services by adolescents: The group came up with the following as the “**barriers**” to the utilization of Health services.

Personal Factors:

- 1) Afraid
- 2) Time factor/privacy
- 3) Money
- 4) Religious belief

- 5) Lack of secrecy
- 6) Location (accessibility)
- 7) Cultural norms/societal pressure
- 8) Communication gap
- 9) Phobia/shy
- 10) Unavailability of doctors (time)
- 11) Sanitation/hygiene
- 12) Lack of information (what? when? time)
- 13) Lack of knowledge
- 14) Peer pressure

Provider factors:

1) Major:

- Health provider's attitude
- Less facilities
- Slow services
- Insufficient of health workers and health centers
- Lack of confidentiality/privacy
- Hygiene/poor facilities
- Timing

2) Minor:

- Differentiation in social status
- Partiality/favoritism
- Absence of skilled health workers in rural areas
- Poor dissemination of information
- Lack of proper medication
- Unpunctuality of health workers
- No comfortable arrangements
- No private clinics

GEOGRAPHICAL FACTOR

RELIGIOUS BELIEFS

- Traditional treatments
- Superstitious Attitude
- Preference by health workers for traditional way of healing

TO OVERCOME THE BARRIERS

- IEC (Information Education and Communication)
- Parenting Education
- Counselling
- Peer education
- Awareness
- Maintaining confidentiality
- Appropriate doctors
- Creating more health centers
- Providing adequate and good transport
- Study and analysis
- Sex Education

Strategies to overcome barriers and improve utilization:

<u>FACTOR</u>	<u>SUGGESTED SOLUTIONS</u>
1. Health provider's attitude (differentiation In social status)	<ul style="list-style-type: none">- Counselling.- Increasing Health workers and their pay.- Strictly adhere to token services (1st come 1st serve basis)
2. Poor Facilities and slow services.	<ul style="list-style-type: none">- Specialized doctors.- More Health units.- Increased number of doctors in each OPDs.- Increase the number of furniture, introduce waiting rooms.- Provide some information.

3. Insufficient Health & Health centres
(Absence of skilled health workers).

- Make the profession attractive.
- Start our own medical college.
- Provide more opportunities & scholarships.
- Build more health centres.

4. Lack of Confidentiality & Privacy

- Increase number of rooms in the wards.
- Health workers live up to their pledge/oath.
- Make provision for separate rooms for Counselling.
- Re-assurance from the Health workers.
- Initiating a program which helps to maintain the patient's confidentiality.

5. Hygiene.

- The number of people involved in Sanitation/cleaners/sweepers.
- Constant monitoring.
- Hi-tech machines for sterilization.
- Maintain cleanliness of the health workers.

6. Timing.

- The hospital hours.
- Doctors should take turns besides emergency service.
- Continue giving preference to students.

7. Poor Information Dissemination

- Organise more interesting Health Programmes.
- Health promotion class in the school.
- Make use of mass media to spread Information.

- Make Health documentary films.
- Use cartoons and animation to convey the information regarding Health.

The 'expert group' (See annexure for details) took the note of the above stated 'barriers' and suggested solutions as presented by the adolescents and young people, and familiarized itself with **similar 'standards'** that have been developed in **various countries**. The expert group looked at the Sri Lanka, Tanzania, Bangladesh and the Indian National Standards for ARSH and related areas. After deliberations and critical analysis, it was agreed upon to take up **the National Standards developed by MoHFW India, for the ARSH strategy under RCH II as the template** for developing the National Standards for Bhutan. The 'expert group' worked on the 'Standard statements' and the 'Implementation Guide' from India and carried out the necessary modifications /amendments for adapting these standards for the Bhutanese context. It also decided to utilize the **'package of services' as given in the Sri Lanka standards** for adaptation for the Bhutanese context.

The expert group felt that having the codified standard would play the pivotal role in materializing the concept of YFHS. Therefore, apart from orienting the providers to the needs of the youth, we would also need to devise innovative mechanisms to motivate our providers, to promote positive attitude of the people to make the delivery of effective services a reality. Involvement of the Village Health workers (VHW) will help create awareness among the community on the value of providing sexual & reproductive health services to the adolescents and young people (YP). Similarly, the media can play an equally very important role.

The group decided to develop standards for the following issues:

1. Health facilities should provide the specified package of health services that adolescents and YP need. The package could vary depending upon the level of the health facility.
2. Health facilities must deliver effective and appropriate health services to the adolescents and YP so that they can be attracted to these health facilities.
3. Adolescents and YP of Bhutan should find the environment at the health facilities conducive to seek services from such services
4. Service providers must become sensitive to the needs of adolescents and YP and be motivated to work with them.
5. An enabling environment should be created in the community that will encourage the adolescents and YP to seek health services they need from the facilities.
6. Adolescents and YP should be well informed about the availability of good quality health services from the service delivery points.
7. Management systems should be put in place to improve/ sustain the quality of health services

Draft National Standards for provision of YFHS

The group members scrutinized the Standards Statements from other countries- especially those related to RCH II from India and worked out the Draft statements. The Consensual draft statements, as suggested by the 'expert group', pertaining to the standards for YFHS for Bhutan are given below.

The draft standard statements, the rationale and the basis for each standard statement:

1. Health Facilities provide the specified package of health services that adolescents and young people need.

Rationale for the standard:

In many places, service delivery points do not provide adolescents with the health services they need.

The basis for the standard:

Every Health Centre will be required to provide a set of “assured services”. The package of services being identified for provision at different levels in the health system is entirely consistent with this. This standard seeks to ensure that the specified package of health services is in fact provided.

2. Health Facilities deliver effective health services to adolescents and young people.

Rationale for the standard:

In many places, health services are not provided effectively because service providers for a variety of reasons (e.g. service providers are not in place, they do not have the required competencies, the required supplies, equipment and basic amenities are not available etc.).

The basis of the standard:

“To achieve and maintain an acceptable standard of quality of care.”

What needs to be in place to meet this acceptable standard of quality is clearly specified. This is consistent with the spirit of the standard. Furthermore there is a need to equip service providers with knowledge and skills they need to provide health services to adolescents. This too is consistent with the spirit of the standard.

3. Adolescents and young people find the environment at health services conducive to seek services.

Rationale for the standard:

Adolescents will not obtain health services if the physical environment and procedures are not appealing to them.

The basis of the standard:

It outlines the physical infrastructure that needs to be in place. For instance, it specifies that service delivery points are accessible to adolescents/youth, centres prominently display boards providing information on the services available and the timings they are provided; that clean public utilities for males and females be provide. This is entirely consistent with the spirit (and the wording) of this standard.

4. Service providers are sensitive to adolescents' / Young Peoples' needs and are motivated to work with them.

Rationale for the standard:

Because of a variety of reasons, e.g. judgmental attitudes, service providers in many places are not motivated to serve their adolescent patients.

The basis for the standard:

“To make the services more responsive and sensitive to the needs of the community”. The standard is entirely consistent with this. Research and anecdotal evidence stresses that one of the factors hindering the utilization of health services by adolescents is the judgmental attitudes of service providers. This is what the standard seeks to address.

5. An enabling environment exists in the community for adolescents and young people to seek the health services they need.

Rationale for the standard:

In many situations:

- Community members (especially parents) are not aware of the value of providing sexual and reproductive health services to adolescents;
- they do not believe that adolescents should be able to obtain these health services.

This deters health service providers from providing health services to adolescents. It also deters adolescents from seeking health services.

The basis of the standard:

Prevailing social barriers restrain adolescents from using services, and underlines the need for environment building activities. This is what the standard seeks to address.

6. Adolescents and young people are well informed about the availability of good quality health services from the service delivery points.

Rationale for the standard:

Adolescents are generally not aware of where they can get services.

The basis of the standard:

The use of services by adolescents is limited, and that poor knowledge and lack of awareness are the main factors contributing to this. This is what the standard seeks to address.

7. Management systems are in place to improve/sustain the quality of health services.

Rationale for the standard:

- In many places service delivery points/staff do not receive supervisory visits. If they do, this is often done in a perfunctory and demeaning manner.
- Data that is gathered at sub-centre, primary health centre and community health centres is generally sent to a higher authority for analysis. Often no feedback is received. Only rarely is the data used locally to address problems and fill gaps.

The basis of the standard:

Internal and external monitoring play a vital role in ensuring the quality of health service provision. Thus there is a need to 'strengthen capacities for data collection, assessment and review for evidence based planning, monitoring and supervision'. This is exactly what this standard seeks to address.

Some of the salient discussion points are given below:

1. Health facilities provide the specified package of health services that adolescents need.

The group agreed that in general YFHS would provide the following specified services:

a. Promotive services

- Focussed care during ANC
- Counseling & provision for EC pills
- Counseling & provision of reversible contraceptives
- Information & advice on SRH issues

b. Preventive services

- Services for tetanus immunization: the group suggested that we call it "services for immunization" and for details check the national guidelines on immunization.
- Services for prophylaxis against Nutritional Anaemia
- Nutrition counseling
- Services for early & safe termination of pregnancy and management of post abortion complications: the group suggested that since induced abortion is illegal in Bhutan the services will be restricted to post abortion care.

c. Curative services

- Treatment for common RTIs/ STIs
- Treatment & counseling for menstrual disorders
- Treatment & counseling for sexual concerns of male & female adolescents
- Management of sexual abuse among girls: the group suggested that boys are also victims of sexual abuse.

d. Referral Services:

- VCT for HIV
- PMTCT
- Rehabilitation: the group felt that it would be appropriate to add this here. The YFHS may not do rehabilitation in their centers but they can always refer them to a specialized rehab centre.

e. **Outreach services:** largely agreed upon by the group. However, concerns were raised on constraints of human resources and whether, the provider would actually have time to conduct outreach services. After a exhaustive deliberation on this, the group though that it would be appropriate to keep this in our specified package and provider would have the liberty to conduct as many outreach as per the availability of time.

2. Health facilities deliver effective services to adolescents and young people

Probable Service delivery points:

Referral Hospitals (separate clinic), however, we will need to pilot at JDWNRH first and later replicate in other RRH.

BHU Grade I/DH- integrated

BHU Grade II-integrated

Youth Centers....

3. Service providers are sensitive to the needs of adolescents & are motivated to work with them.

Our main strategy/ goal will be to change the attitude of our providers. Selection of providers: to be gender sensitive

Service Provision from various types of facilities:

JDWNRH (Pilot center):

Separate clinic

Fulltime in charge (to be identified)

Train ACO and RHU staffs on YFHS

Invite specialists on clinic days (for e.g Dermatology day on Monday). The SHC can coordinate with the in charge of YFHS on the timing.

District Hospital (DH)

Integrate in the hospitals

Train all the doctors

RHU staffs

BHU

Integrate in the BHU and train all the staffs

These discussions clearly stress that health facilities at the different level of the health system will be required to provide a set of “assured services”, attain and maintain an acceptable level of quality care, ensuring the appropriate physical infrastructure, availability of providers with required knowledge and skills, making services more responsive and sensitive to the needs of community, undertake awareness and environmental building activities. There is an emphasis on internal and external review and monitoring to ensure the quality of services.

National Consensus meeting on Draft National Standards: May 26th to 27th, MoH, Thimphu

A national level meeting was held to finalize and achieve consensus on the draft national standards that were circulated earlier. After the welcome address by the chairperson and Director, Public Health, Dr. Ugen , Dr. Neena Raina, Regional Advisor, Adolescent Health, WHO, SEARO made a presentation that reflected the global, regional and national scenario and status of adolescent and young people’s health. She underlined the facts that the HIV is moving towards the young people and adolescent pregnancy contributes significantly to MMR and IMR. She also brought out the fact that not many adolescents and young people access the health system.

In his presentation and discussion, Dr. Patanjali Dev Nayar , brought out the public health need and rationale of establishing YFHS in Bhutan. He outlined the key characteristics of the YFHS and clinics that will provide such services. He then provided a brief introduction to the quality dimension of the services and how “establishing standards” would assist in quality improvement of health services.

Ms. Sangay Wangmo, PM of HIV/AIDS unit presented the process that was followed in developing the “National Standards for providing Youth Friendly Health Services”. She then introduced the standard definitions of the seven standards that were finalized by the expert group and explained the Input, process and Output criteria and their means of verification.

The participants that included representatives from UN bodies (WHO, UNFPA, UNICEF), education ministry and various units of the health ministry provided their valuable comments. A detailed and rich discussion followed in which the participants and Dr. Neena Raina and Dr. Patanjali Dev Nayar shared experiences from other countries and explored possibilities of applying them to the Bhutan context. The suggestions given by the participants were incorporated in the text and the matrices.

Ms. Sangay Wangmo requested the participants to provide any additional feedback by 6th of June 2008.

The meeting ended with a vote of thanks.

ANNEXURE

POLICIES THAT HAVE BEARING ON YOUNG PEOPLE’S HEALTH IN BHUTAN

Significant Policies in Bhutan

Health policies

The national health policy is to strive for the attainment by everyone (men, women, adolescents, children) in the country a level of health that will permit them to lead a socially and economically productive lives. Some of the core policies that underscore development in the health sector are:

- Promotion of primary health care with an integrated and holistic mix of preventive, promotive and curative care services.
- Provision of free health care services to all citizens of Bhutan, including ex-country treatment for citizens having conditions that cannot be managed within the country.
- Promotion of indigenous system of health care as a complementary part of the overall health services

The Primary Health Care approach was formally adopted in 1979 as the principal strategy to cater health services to Bhutan’s predominantly rural population. Since the adoption of this strategy, the emphasis has gradually shifted from mainly curative to a mixture of curative, preventive, promotive and rehabilitative.

Though basic health care in Bhutan is provided free of cost, limited cost sharing for advanced medical technologies, secondary and tertiary dental services is practiced. In the absence of private medical practice the government is the sole provider of health care. Pharmacies are nominally private but operate under strict licensing arrangements. Although the possibility of privatization of health services has been examined, the inherent risks currently far outweigh the possible gains. However, this situation is expected to change over time.

Bhutan’s health policies are stated as objectives in successive five-year plans(FYP). With improved physical access to health the royal government’s strategy during the last few decades has been aimed at limited expansion, with attention to consolidation of present gains and improvements in the quality of services and human resource. Some of the key policies stated in the 9th Plan are: Enhancing the quality of health services, targeting health services to reach the unreached, intensifying human resources development for health, intensifying reproductive health services and sustained population planning activities.

While Bhutan is committed to achieving the Millennium Development Goals there remain priority areas that extend beyond the provision of the MDGs. The 10th

FYP aims to put emphasis on improvement of services, development of human and institutional capacity and decentralization with a focus on rural access. ⁸

The royal government recognizes the importance of adolescent reproductive health. The need to enhance young people’s awareness in RH and FP both as individuals is reflected in the Ninth Plan of the RGoB (2002-2007).

Her Majesty the Queen Ashi Sangay Choden Wangchuck, in her role as UNFPA Goodwill Ambassador has been instrumental in giving visibility and attaining support for broader reproductive health needs of youth –especially in relation to STD/HIV/AIDS. The reproductive health booklet “Know the Facts” is an outcome of Her Majesty’s

interaction with youth across the country. The book addresses sexuality reproductive concerns of youth and is aimed at encouraging and promoting rational and informed decision making. Initiatives for young people are also being taken by the health and education sectors.

The National Medical Standards for Contraceptive Services, updated by the Public Health Department in November 2003 includes a chapter on adolescents, and young people. In 2002 an Adolescent and Reproductive Health Education and Life Skills Programme was launched with the aim of targeting specifically RH and Adolescent sexual health concerns. This programme is guided by a national steering committee comprising education and health representatives. Teachers have been trained to conduct the life skill sessions, and local case studies have been included in the programme to enhance understanding of RH issues.

Other innovative RH programmes include involving scouts, orienting Non Formal Education (NFE) teachers, school and district officers, and providing counseling training for school wardens and matrons. Youth counseling units have also been established in the Youth Information Centre under the Ministry of Education.

While the importance of reaching out to adolescents is well accepted and some initiatives have been made at several levels no special Reproductive Health services for youth is currently implemented.

The *National Strategic Plan for the Prevention and Control of STIs and HIV and AIDS* recognizes that while much has already been achieved, there will need to be an increase in activities if we are to prevent the further spread of HIV. The NSP addresses the realities of the evolving epidemic of HIV and AIDS and other sexually transmitted infections (STIs) in Bhutan. It builds on lessons learned and outlines strategic actions required to further enhance the nation's response to HIV and AIDS. The strategic plan has been closely guided by the National HIV/AIDS Commission -a multi-sectoral body functioning at the highest level and chaired by the Minister of Health. The plan engages the cumulative effort of stakeholders from beyond the Ministry of Health. It takes into consideration social, cultural and economic factors affecting individuals, families, societies and the nation at large.

The NSP aims to:

- 1) Integrate STI and HIV prevention into the core activities of multi-sectoral partners;
- 2) Create a supportive environment that facilitates the implementation of programmes and services, and reduces stigma and discrimination towards women and men living with or affected by HIV and AIDS;
- 3) Improve the quality and coverage of the national response to HIV and AIDS and STIs.

There is no written policy that bars young girls from continuing school if pregnant. However, schools in Bhutan, like many in the region, do not commonly allow young women to continue schooling under these circumstances. Among the reasons cited include the argument that, the emotional and physical strain of motherhood are too great for an adolescent to continue school. The notion of them influencing and encouraging other girls also exists

Laws and Policies and their impact on adolescents

Bhutan is signatory to the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and the Convention on the Rights of the Child (CRC). Hence, the issues related to children are appropriately dealt with in various legislative measures taken with respect to children, women and young people e.g. amendments to the 1980 Marriage Act, the 1993 Rape Act, the adoption of the Juvenile Justice Act, Civil and Criminal Codes, and the Immoral Trafficking Act and the Penal Code of Bhutan.

Under the Penal Code of the Kingdom of Bhutan a child is a person who is 18 years or younger. A number of provisions are stipulated in the Penal Code of Bhutan to ensure that child offenders are dealt in a mild manner because a child of tender age is considered incapable of exercising discretion or possessing intelligence and hence, presumed criminally incapable. The code therefore, prescribes that a child offender of ten years or younger shall not be liable for any offences committed by him or her. However, a child who is older than ten years may receive a minimum of half of the sentence prescribed for the offence. Section 114 of the Penal Code of Bhutan provides blanket provision to a child of ten years and below for any crime committed by him.

To protect children from the scourges of litigation the Civil and Criminal Procedure Code of the Kingdom of Bhutan provides that a minor cannot sue or be sued. However, if he/she has a direct stake in the outcome of the litigation the suit may be brought in his/ her name by member of joint family through a legal guardian/*Jabmi*.

1 Laws and policies on marriage

The Marriage Act of 1980 was amended during the 74th Session of the National Assembly (1996). According to the amendment, the legal age of marriage for girls was raised from sixteen to eighteen. This amendment has been favorable as it has given women legal rights to property and child support.

Both partners can initiate the procedure for divorce irrespective of the grounds on which separation becomes desirable. If wrong doing by either partner is cited as a reason for divorce and guilt is proven, the guilty partner receives only one third of all properties and liabilities held individually or jointly by the couple.

With respect to the custody of children, minors under the age of nine are awarded to the mother, regardless of who bears guilt for the separation. During this period the father, has to provide 20% for each child however, the total child support allowances should not exceed 40 percent of his monthly income as child support extends up to the age of eighteen. After the age of nine, the children themselves decide which of the two parents they wish to live with.

In matters of marriage, there is a great deal of freedom and flexibility. Young Bhutanese men and women choose their partners with a high degree of freedom without parental/family restrictions. The practice of dowry, which is prevalent in many Asian societies, is unknown in Bhutan.

2 Laws and policies on rape

The subject of rape has recently received increased attention in the government. Rape was made a criminal offence in 1953. Existing laws have, therefore, have been amended by the national legislature in 1996, reflecting much more serious punishment, especially when minors are involved. The penalties include the payment of compensation along with imprisonment and, in case of minors, the sentence range from five to seventeen years, depending on the severity of the crime. In extreme cases, the law can award life imprisonment. Recent media reports show that sexual exploitation and rape, once thought to be not a common issue is now emerging as a problem.

3 Laws and policies on inheritance

Bhutan's inheritance Act of 1980 states that all children at the time of divorce shall have equal right to the family property irrespective of age and sex. In practice it differs from region to region, In the east and parts of central Bhutan inhabited by *Sharchops* and *Khengs*, property is distributed equally between sons and daughters. However, in western and parts of Trongsa in Central Bhutan, parents leave all their property to daughters. While in the south, the *lhotsampas* and certain areas in eastern Bhutan sons are the sole heirs.

It is also common practice to leave the family house and the farm property to those caring for aged parents. It so happens that daughters end up taking care of the parents in most cases. An adolescent can own land, property and manage family finances.

4. Laws and policies on Tobacco

Tobacco control in Bhutan presents an experience, unique in many aspects from the rest of the world. Religion, culture and tradition have been until now strong forces against tobacco use. Moreover, being small and isolated Bhutan has never been the target of interest for multinational tobacco companies. Hence, major issues concerning tobacco that plague the rest of the world such as the cultivation, manufacture and direct tobacco advertising is not an issue. The 1st ever policy on Tobacco Control is believed to have been passed in 1729 by the most illustrious historical figure, His Holiness **Zhabdrung Ngawang Namgyal**. This had significant impact on the non-use of tobacco products by the monks and the religious community.

The 82nd session of the National Assembly in support of tobacco free initiatives taken at the local levels passed a resolution banning the sale of all tobacco products in the kingdom. The nationwide ban came into force on the 17th of December 2004 declaring Bhutan as the first tobacco free country in the world. This is in line with WHO's Framework Convention for Tobacco Control (FCTC).

It is essential to understand that the ban is on the sales of tobacco products and not on smoking. This ban takes into consideration individual choices and rights. While the decision to smoke is still the prerogative of individual, the activity has to be confined to areas outside designated smoke free areas. It is now illegal to sell tobacco and tobacco products in any form in Bhutan. Individuals caught doing so are liable to penalty ranging from payment of fines to losing business licenses. This ban also applies to all visitors of the kingdom and no immunity status is being granted. The FCTC clause 2 (b) of article 6 also supports this

A high level National multi sector task force is in place to over see the effective implementation of tobacco control activities in the kingdom.

5 Laws and policies on Alcohol

The royal government has taken several measures to control the sale of alcohol since 1995. Measures include prohibiting the sale of alcohol to children below the age of 18 years, observation of dry days, pricing and taxation measures, penalties for drink driving and health advocacy and IEC aimed at reducing the consumption of alcohol. Legal restriction-applies only to open consumption in bars and restaurants.

Although activities are being carried by various sectors, no focal agency coordinates alcohol control. Alcohol control activities are undertaken by individual sectors within their sectoral mandates. Apart from the Ministry of health the other sectors involved are the Ministry of Trade and Industry, Department of Revenue and customs, Road Safety and Transport Authority (RSTA) and the Royal Bhutan Police

The main challenges faced by the implementers are enforcement and monitoring of existing rules and regulations due to man power constraints, lack of adequate funds to implement alcohol control activities. Moreover due to absence of detoxification and counseling services within the country cases are often referred out side for treatment and counseling. With the major focus on Tobacco Control, Alcohol control has taken a back seat despite it being an issue of public health concern

6 Laws and policies on Drugs

Bhutan is a signatory to the United Nations Convention against Illicit traffic in Narcotic Drugs and psychotropic Substance of 1988, and the SAARC Convention on Narcotic Psychotropic substance.

A Narcotic drugs and psychotropic substances notification was issued by the royal government in 1988 to guide action against drugs. The notification prohibits the cultivation, production, manufacture, possession, sale and purchase transportation, storage, use and consumption of all narcotic drugs and psychotropic substances in the country.

The Bhutan Penal Code 2004 provides some form of legal framework for drugs under chapter 27 – offences against the public welfare and Chapter 33 – Offences related to protected species, controlled & other harmful substances. The medicine act of 2003 also regulates the use of medicines and drugs in Bhutan and includes sections on regulation and drugs, drug testing and use. The act prohibits sale of medicine without prescription and individuals from possessing medication that exceeds the quantity prescribed.

The Narcotic Control Agency Headed by an executive Director was recently established according to provisions in the Narcotic Act, 2005 (NDPSSA Act, 2005). This office is the nodal agency for coordinating programs and policies in the area of narcotic drug control and eradication. It is an autonomous agency under a board and is currently being funded by the RGoB. Apart from legislation to protect children and youth, services such as counseling and detoxification programmes particularly for those seeking professional help is unavailable in the country.

7 Laws and policies on Juvenile delinquency

A Juvenile Delinquency Act based on the United Nations standard minimum rules for the administration of juvenile justice has been drafted, (Beijing rules 1985). The draft Act has a provision for a special court to be set up with an informal setting. It also spells out conditions for bail and procedures and stipulated time frame for court hearings while in police custody.

The juvenile court has the authority to exercise various options after a juvenile is found guilty; the last option being to direct the juvenile to the rehabilitation centre for a fixed period of time. Children under 18 given a custodial sentence are sent to the Youth Development and Rehabilitation Centre at Tsimakha in Chukha district.

The Police Act, 1980 and Prison Act, 1982 states that minors must be kept separately from other prisoners and may not be given prison work “beyond their capabilities”

Equitable and quality health services

The Royal Government of Bhutan has taken upon itself to be solely responsible for the provision of health care services. There is neither private health care industry nor private practice in Bhutan. The government nevertheless continues to provide relatively good quality health services, including expense paid referral abroad for treatments which are beyond the scope of the existing facilities in Bhutan. However, there are many changes that must be taken into account.

Besides the need to sustain primary health care there are increasing demands for secondary and tertiary level services which is, more expensive and sophisticated. As the population of Bhutan survives longer the demand for treatment of diseases that are chronic and more costly to manage will increase further. At the same time, the more affluent section of the Bhutanese population will demand better quality services than what can be generally provided through the existing facilities.

All of this will happen in a continuing environment of competition for limited resources of the government. Therefore, royal government's policy of providing free and equitable health care is expected to face tremendous challenges.

Modern Health Services

Modern health development started in 1961. The main thrust to modern health development came after Bhutan became signatory to the Alma-Ata Declaration on Primary health Care in 1978. The Primary Health Care approach (PHC) was adopted in 1979 and expanded program of immunization (EPI) services were launched the same year as an essential component of the PHC. The initial years of development focused largely on expansion of health services and increasing coverage.

Today health care services in Bhutan are delivered through a network of hospitals, basic health units (BHU) and out reach clinics. At the highest level is the National Referral Hospital in Thimphu, along with regional referral hospitals at Gelephu in the centre and Mongar in the east. The 26 District hospitals located in the district headquarters represent the middle level and 176 Basic Health units linked to these hospitals represent the lowest level. Health staffs run 485 Out Reach Clinics (ORCs) from Basic Health Units and hospitals.

Health services are now provided by well trained health care providers at all levels. In addition, more than a thousand village health workers (VHWs) form an integral part of the PHC system and participate actively in outreach activities. Their services have been invaluable as they form an important link between communities and health services

The Basic health unit (BHUs) and their out reach clinics form the backbone of the primary health care delivery system. They cater to a population ranging from 3000-5000 (BHU Grade1I) and 5,000-10,000 (BHU grade I). All BHUs are generally manned by a 3 member team comprising of a Health Assistant (HA), an Auxiliary Nurse Midwife (ANM) and a Basic Health Worker (BHW). BHU grade I in view of the larger population catchment area it covers is headed by a medical doctor.

The services at the BHU level include immunization, antenatal and post-natal care, treatment of common ailments and health education for disease prevention and control. In addition to the out patient services all BHU's are equipped to admit a limited number of patients. Outreach services are conducted through ORCs as fixed monthly sessions. BHU's attached to hospitals for outreach, and preventive services in town are known as community health units, their functions are similar to BHUs.

Each District hospital is supported by a team of - doctors, nurses, technicians and other support staff.. They vary in size and have between 10-100 beds. Besides curative they also provide preventive, promotive and emergency services. Apart from facilities for patient admission they also have specific services which include a minor operating theatre, laboratory and X ray facilities. Regional referral hospitals are equipped to provide some specialized services. Majority of specialists are posted at the National Referral Hospital in Thimphu. All hospitals are provided with an ambulance for emergency transportation of patients.

Health sector activities, in line with the Royal Government's policies, have been fully decentralized to the district level since the 5th Plan. The District health team comprising of the District Medical Officer (DMO), District Health Officer (DHO)/District Health Supervisory Officer (DHSO), are jointly responsible for planning, implementing and monitoring all district health programmes. This is done in close consultation with the District Administration and periodic guidance from the central Ministry.

The DMO is mainly responsible for the district hospital administration and provision of clinical services. The DHO/ DHSO's primary responsibility is supervision of BHU's, out reach programmes and generating district health data.

However, some of the key programmes are directly handled by specific programme managers in the Ministry of Health in Thimphu.

Referral of patients from the village level to BHU's is done by the Village Health Worker, from the BHU's to the District hospital's by the Health Assistant and from the district hospital's to the regional referral hospital's by the District Medical Officer. Patients with disease beyond the national curative capacity are referred to institutions outside the country at government expense. Decisions for these referrals are made by a referral committee at the National Referral Hospital

Health Services Priorities

As in any health system, there are severe budget constraints, and these can only intensify as people live longer and come to expect more sophisticated treatment. Health at present takes, up around 12% of the national budget and the country's total health expenditure, 90 percent of which is public and corresponds to around 4 percent of the GDP.

The current challenge for the health services is to ensure that existing facilities and their staff deliver the highest possible standards of care. There is a shortage of health man power at all levels of the health system specialists, doctors and health workers.

Sexual behavior, which is related to sexual development, has important health implications for everyone, and especially for adolescents. So it is particularly important for adolescents to be well informed about all aspects of sex and sexual health. Limited ability, on the part of adolescent girls, to manage their reproductive potential during this crucial period calls for the development of institutional and community interventions to ensure that, adolescents grow-up in a safe and healthy environment.

Promoting Adolescent Sexual and Reproductive Health (ARSH)

Many initiatives are directly or indirectly focused at promoting ARSH. Early childbearing and motherhood is a significant public health concern in Bhutan impacting infant and maternal morbidity and mortality, educational and employment opportunities and the quality of life. Available data show that women in the age group 15-24 produce about a third of the births in any given year.

The National Population and housing census (2005) reveals that more than 15 percent of all girls between the ages of 15-19 in Bhutan are currently married (urban 9.8%, rural 18.7%). Additionally 0.3 percent girls aged 10-14 (urban 0.1%, rural 0.3 %) are also married. There has been a significant drop in the total fertility rate from 5.6 per women in 1994 to 2.6 in 2005 (NPHC)

The Department of Youth Culture and sports, under the Ministry of Education has conducted a survey on teenage pregnancy and early marriages in 2000. This survey indicates that a substantial percentage of high school students (15-20 yrs) are sexually active (58%). Due to poor awareness on contraceptives and little stigma attached to single motherhood many young girls particularly in rural settings are at the risk of unwanted pregnancies.

Besides in many rural settings adolescent girls are socialized and initiated at an early age to please the man and be submissive in terms of reproductive and social behaviors while boys are socialized to be free, strong, virile and more independent than girls.

Safe Motherhood is still an area of major concern as many mothers die from giving birth. The maternal mortality rate is 255 for every 100,000 births. About 80 percent of births still take at home. The Ministry of Health's current strategy is to focus on institutional delivery through enhancing the health seeking behaviors and improving standards of maternal health in the country.¹⁶

Focusing on the needs, and rights of children in Bhutan, has always been one of the Royal Governments greatest priorities. Issues of vulnerability and risk for adolescents in relation to their reproductive and sexual health have been recognized in Bhutan, especially in relation to HIV/AIDS. A number of programs are implemented to directly or indirectly address ARSH. The National STI and HIV/AIDS Control Program (NACP) also contribute towards the promotion of ARSH.

The NACP functions under the following policy directives:

- A broad based multi-sectoral approach since 2001 with involvement of line ministries in 2004;
- An integrated and decentralized approach since 2004;
- Mandatory screening of all blood and blood products for HIV, Hepatitis and Syphilis;
- Universal precaution in all health care settings;
- Prophylactic Antiretroviral Therapy (ART) to HIV positive pregnant women since 2001;
- Counselling & psychological support since 2001;
- ART for people living with HIV and AIDS (PLWHA) since 2004;
- Rehabilitation of HIV positive Bhutanese SWs since 2004;
- Counselling and informed consent required for HIV testing of any individual (except for blood donors);
- Confidentiality of the HIV test results and of status for all PLWHA;
- Partner notification by the person with HIV infection or with her/his consent by the health care provider, or through the combined efforts of both. If at all, the infected person refuses or does not consent to notify the partner, the health sector will notify the partner;
- Contact tracing of individuals who may have been exposed to HIV through the index case.

Achievements in the health sector

In 1961 Bhutan started with a rudimentary health care setup and health indicators which were among the poorest in the world. Within a span of less than 4 decades an impressive network of health facilities has been built and over a thousand health workers trained. The consistent development strategy and investments in the health sector has brought about impressive health gains. Although the benefits have been widespread women, adolescents and children have been the primary beneficiaries of the health care services.

Today, 90 percent of the population has access to basic health services. According to the National Health Survey (2000) about 89 percent of the population had access to a BHU or an ORC within 3 hours walking distance. Only 4 percent of the population lived beyond 6 hours walking distance. The 2005 National Population and Housing Census revealed that 90 percent of households reported visiting a health facility within the past one year.

Between 1984 to 2005 there has been dramatic declines in infant mortality rates from 103 per 1000 live births in 1984 to 40.1 per 1000 in 2005 (NPHC). The under-five mortality rate fell from 162 per 1000 live births in 1984 to 61.5 per 1,000 live births in 2005 (NPHC); The population growth rate has fallen from 3.1% in 1994 to 1.3% in 2005(NPHC). The maternal mortality rate declined from 770 per 100,000 live births in 1994 to 255 in 2000).^{9, 10}

Bhutan declared Universal Childhood Immunization (UCI) in 1991, and has since been successful in sustaining coverage of above 85% for all EPI antigens, there have been no reports of poliomyelitis cases since 1986 and Neonatal Tetanus ceased to be a public health concern since 1994.¹¹ Iodine Deficiency Disorders has been eliminated in 2001. Leprosy is well under control and near elimination. Access to safe drinking water and basic sanitation is over 85% and 90% respectively. (2005,NPHC)

Data on stunting (low height for weight) is not available, but the number of underweight children declined from 19 percent to 9.4 percent.¹³ However, the trend seems to be reversing, as it appears that 18 percent of children are now overweight. This trend corresponds to a worldwide phenomenon, a precursor of so-called lifestyle diseases that are expected to become more prevalent in Bhutan.

ANNEXURE

EXPERT GROUP FOR NATIONAL STANDARDS FOR YFHS

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List of invitees to the National workshop on Developing Standards for YFHS:

1. Dr. Dorji Wangchuk, Director General, Department of Medical Services.
2. Dr. Ugen Dophu, Director, Department of Public Health
3. Medical Director, JDWNRH
4. Dr. Sonam Ugen, Joint Director, Non Communicable Diseases, Department of Public Health
5. Mr. Nidup, Lecturer, RIHS
6. Sister Jigme Choden, RENEW
7. Youth Development Fund
8. Mr. Norbhu Wangchuk, WHO
9. Mr. Yeshey Dorji, Chairman, UN Theme Group
10. Representative Armed Forces (RBA)
11. Representative Armed Forces (RBP)
12. Representative Monk Body
13. Representative Ministry of Education (MoE)
14. Representative MoE (NFE Coordinator)
15. School Health Coordinator
16. Student Representative (Males)
17. Student Representative (Females)
18. Save the Children
19. Representative National Commission of Women & Children

20. Media Representative (KUZOO)
21. Media Representative (BBS)
22. Mr. Sonam Rinchen, Reproductive Health Program, MoH
23. TB Program, MoH
24. Nutrition Program, MoH
25. Mental Health Program, MoH
26. Ms. Sonam Peldon, Comprehensive School Health Program, MoH
27. Mr. Kado Zangpo, Health Management and Information System, MoH
28. NACP, MoH
29. WHO Expert – Dr. Patanjali Dev Nayar

Secretarial assistance: Phub Zam, Office Assistant, NACP.

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Acknowledgement (last page)

The National STIs and HIV/AIDS program, Department of public health, Ministry of health would like to thank all those who have contributed immensely in developing the National Standards and implementation Guide for Youth Friendly Health Services.

This National Standards and implementation Guide for Youth Friendly Health Services have been developed in consultation with various stakeholders during several meetings. The WHO was instrumental in providing WHO experts on Youth Friendly Health Services and we are particularly thankful of Dr Patanjali Dev Nayar and Ms. Neena Raina, Regional advisor, Adolescents Health, WHO, SEARO for their time and energy and strategic inputs in outlining the design and preparing the guideline.

We would also like to thank the following personals, programs and organizations for their valuable contributions:

30. Dr. Dorji Wangchuk, Director, General, Department of Medical Services
31. Dr. Ugen Dophu, Director, Department of Public Health
32. Medical Director, JDWNRH
33. Dr. Sonam Ugen, Joint Director, Non- Communicable Diseases, Department of Public Health
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35. Sister Jigme Choden, RENEW
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37. Mr. Norbhu Wangchuk, WHO
38. Mr. Yeshey Dorji, Chairman, UN Theme Group
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41. School Health Coordinator
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44. Media Representative (KUZOO)
45. Mr. Sonam Rinchen, Reproductive Health Program, MoH
46. TB Program, MoH
47. Nutrition Program, MoH
48. Mental Health Program, MoH
49. Ms. Sonam Peldon, Comprehensive School Health Program, MoH
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51. Young People

Special thanks to all the young people who have actively contributed to the development of this guideline. Lastly we would like to thank the GFATM for their financial support and WHO for their technical assistance and financial support.