National Service Standards and Guidelines on Adolescent and Youth Health Care

Department of Health, Ministry of Health

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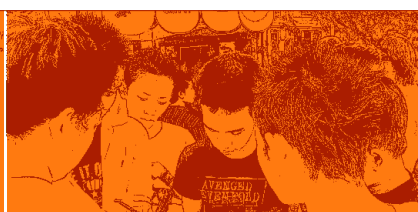
Contents



Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
AH	Adolescent Health
AYH	Adolescent and Youth Health
AYHC	Adolescent and Youth Health Care
AYHD	Adolescent and Youth Health and Development
BS	Birth Spacing
DOH	Department of Health
FAYS	Family and Youth Survey
FRHS	Fertility and Reproductive Health Survey
GSHS	Global School-based Student Health Survey
GYTS	Global Youth Tobacco Survey
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communication
INGO	International Non-governmental Organization
IUD	Intra Uterine Device
MMA	Myanmar Medical Association
MMCWA	Myanmar Maternal and Child Welfare Association
MOH	Ministry of Health
MSM	Men who have Sex with Men
NGO	Non-governmental Organization
QI	Quality Improvement
RH	Reproductive Health
RHC	Rural Health Centre
SRH	Sexual and Reproductive Health

I. Introduction

Definition

Adolescents: people 10 to 19 years old. Adolescence is a period in which a person's body undergoes major changes. These changes are physical and psychological. Moreover, the person also undergoes changes in societal status. During these changes, adolescents need to learn to adopt positive and healthy lifestyles. Adolescence is a time of opportunities but also a time of risk. It is a time where an individual makes many choices that will have an effect throughout their lives. They make choices and create habits that could either be healthy and supportive, or unhealthy and damaging. Adolescent health services not only need to help adolescents with immediate health problems but also need to equip them with the knowledge and information they need to make healthy choices later in life.

Globally, as in the Myanmar context, adolescence (10-19 years) and youth (15-24 years) are overlapping age groups. When combined, they form the group "young people", covering the age range 10-24 years.

Background

Myanmar's population is estimated at 60 million with an annual growth rate of 1.29% in 2009.[1] Nearly 60% of the population is made up of women and children. There are approximately 16 million Young people (10-24 years) in Myanmar and they account for 28% of the population. The number of youth (15-24 years) increased by 0.6% in 2001-02, 0.9% in 2004-05 and by about 3.8% in 2007, indicating an increasing growth of young people.[2] Most adolescents and youth are healthy, and they experience lower levels of mortality and morbidity compared to children and adults. Most adolescents and youth also believe that they are healthy.

Adolescent Reproductive Health at a Glance in Myanmar reported that adolescent pregnancies in 1998 were reported to be 8.9% of total pregnancies in Yangon.[3] Unmarried girls and young women are especially prone to unwanted pregnancies because reproductive health (RH) services are targeted mainly at married women. There is a high unmet need for birth spacing (BS) services and a significant number of unwanted pregnancies end in abortion.[4] According to the 2007 Fertility and Reproductive Health Survey (FRHS), 11.39% of pregnancies in married adolescent aged 15-19 ends in abortion and university educated women have the next highest rate of 9%, a strong reason why RH education and contraceptive services should be targeted towards adolescents and university students.[5]

There is a significant **lack of knowledge** among adolescents. Some 66% of females in the 2004 Family and Youth Survey (FAYS) reported that a woman can become pregnant if she has intercourse during menstruation.[6] 38% of adolescent do not know that a woman can become pregnant if she has sex only once. Only 11% of never married females correctly identify the mid-cycle as the period when one is most likely to conceive. Some 30% of ever married females 15-24 have never heard of anemia. There are also gaps in their understanding of BS as 20% of the 15-19 year olds have never heard of contraception and only 17% have heard of the emergency contraceptive pill. Menstrual irregularity is a common problem among young women and one

1. Health in Myanmar, 2011 Ministry of Health.
2. Report on Situation Analysis of Population and Development, Reproductive Health and Gender in Myanmar. UNFPA, July 2010.
3. Adolescent Reproductive Health at a Glance in Myanmar. WHO-SEARO, 2007.
4. Fertility and Reproductive Health Survey 2007, DOP and UNFPA, October 2009.
5. Nation -wide cause specific Maternal Mortality Survey, 2004-2005, Yangon, UNICEF, 2006.
6. Family and Youth Survey 2004: Country Report. Ministry of Immigration and Population and UNFPA. Yangon, October 2006.


that causes much concern. Most girls will turn to their mothers for help on this issue. It appears that increased education is needed for both girls and mothers.

The effect of cultural values: There are strong cultural values against premarital sex. This is very helpful in protecting young people from making mistakes they may regret for the rest of their lives. The majority of Myanmar people do not tolerate the cohabitation of the couple without marrying. However, like many places in the world, there is a double standard. Male youth are more agreeable on the concept that there is nothing wrong for young men and women to cohabit before marriage. Community attitudes towards young men who have sex are more forgiving than for young women who have sex.[7] This might make it especially difficult for unmarried women to seek health care for RH issues.

One of the barriers to providing services and education is a fear that talking about RH and BS will make adolescents and youth more likely to experiment and initiate sexual activity.

No individual SRH/HIV education intervention can prevent all teenage pregnancies or the transmission of STIs, HIV or AIDS. This is not surprising, given the complexity of the environments in which young people live, and where behaviors are also influenced by broader issues such as gender, poverty and availability of health services. However it is clear that SRH/HIV education, when following good practice standards, has a significant positive impact on the health of young people.[8] ,[9]

Early marriage: While the age of marriage in Myanmar is generally high, there are some areas where early marriage is still common. The following is a list of health problems that are more likely to occur in adolescent mothers:

- *Anemia:* The World Bank reports that anemia is 2 times more common in adolescent mothers than among older ones.
- *Premature Birth:* Infants born to adolescent mothers are more likely to be premature, of low birth weight, and to suffer consequences of retarded fetal growth.
- *Spontaneous Abortion and Still Births:* Young adolescents under the age of 15 are more likely to experience spontaneous abortion and still births than older women.
- *Maternal and Infant Mortality:* The maternal mortality among adolescents is higher than among adult mothers. The babies born to adolescent mothers are likely to have higher mortality rate in the first year after the births than the adult mothers' babies are.

HIV and AIDS: Myanmar is one of the three countries in Asia where disease burden due to HIV/AIDS is highest. The prevalence of HIV among pregnant women aged 15-19 years was 0.3% and for pregnant women aged 20-24 years the HIV rate was 0.8%. The prevalence of HIV among high-risk sub-populations of youth were significantly higher (3.4% in 15-19 years old female sex workers, 7.4 % in 20-24 years old female sex works, 7.4% in 15-19 years old drug users, 14.8% in 20-24 years old drug users, 0.6% in 15-19 years old men who have sex with men (MSMs) and 7.1% in 20-24 years old MSMs[10]). Among adolescents there remains a large gap on knowledge about HIV/AIDS. The Behavioral Surveillance Survey report (2007) showed that only 37.7% of youth knew about three methods of HIV prevention and only 47.5% of youth were able to correctly reject common misconceptions about HIV prevention. Women have lower knowledge about HIV/AIDS than men, and young women (15-24 years) were found to be the least educated

7. Family and Youth Survey 2004: Country Report. Ministry of Immigration and Population and UNFPA. Yangon, October 2006
8. Pedlow CT, Carey MP. HIV sexual risk-reduction interventions for youth: A review and methodological critique of randomized controlled trials. Behaviour Modification. 2003; 27(2):135–90.
9. Speizer IS, Magnani RJ, Colvin CE. The effectiveness of adolescent reproductive health interventions in developing countries: a review of the evidence. Journal of Adolescent Health. 2003;33: 324–48.
10. Report of the HIV Sentinel Sero-surveillance Survey 2012, Myanmar, National AIDS Programme, Department of Health, Ministry of Health

on HIV prevention. Also hampering national efforts are negative attitudes towards condom use. Condoms are often linked to indecent relationships and prostitution, which discourages young people desire to access and use condoms.

Alcohol: A recent Department of Health (DOH) Review on Adolescent Health revealed that many young people consume alcohol though amounts and frequencies were not reported. Global School-based Student Health Survey (GSHS)[11] in 2009 showed less than 1% of students reported consumption of alcohol during the past 30 days. There is still no population-based data for the estimation of prevalence of alcohol consumption. However, anecdotal evidence suggests an increase in the trend of consumption of alcohol with easy access to beer stations in urban areas and local spirits in rural areas.

Tobacco: In Myanmar culture, tobacco has been socially and culturally accepted since ancient times. The Global Youth Tobacco Survey (GYTS) conducted in 2001-2007 revealed that one in five youths use some form of tobacco in Myanmar. In addition, many young people chew betel nuts, but no study has been conducted on the subject of oral health.

Nutrition: An anthropometric study conducted by the National Nutrition Center on the nutritional status of adolescent students in 2002 reported that stunting of growth was seen among 37.6% of boys and 30.4% of girls. Surveys have confirmed anemia as a major issue for the country with 45% of non-pregnant women of reproductive age group and 26% of adolescent school girls being anemic.[12] Most of the adolescents know the symptoms of anemia (pallor, dizzy spells) but do not know about its possible long term consequences.

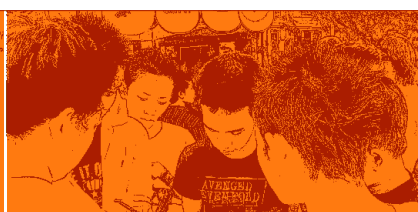
Mental health in adolescents: Each year an estimated 20% of adolescents experience a mental health problem: Most commonly the problem is major depression or other disturbances of mood.[13] The Mental Health Project was launched in 2006 and integrated into school health services as part of managing stress among school children. Mental health disorders in children represent a huge burden for the children themselves, their families, and society yet there is no evidence-based information to estimate the extent of the problem among the adolescents in the country.

Malaria and Tuberculosis: Malaria remains the leading cause of reported morbidity and mortality nationally. Nearly 400,000 clinical cases are reported annually. However, there is currently no age-disaggregated data available for the cases.[14]

Each year, some 140,000 cases of tuberculosis (TB) are detected, and an estimated 9.9 % of TB cases are co- infected with HIV according to 20 sites sentinel surveillance and 60-80% of AIDS patients are concurrently infected with TB. The age disaggregated data available for TB shows that prevalence is largest in the age group of 25 to 44 years, and the prevalence is 50 per 100,000 population among the age group of 15 to 24 years.[15]

School Enrollment: Out-of-school youth remains one of the most vulnerable populations in Myanmar. School dropout rate is highest in grade 11 (55.4 %). Currently, out-of-school youth have low knowledge about sex, RH and sexually transmitted infections (STIs). Employment opportunities for out-of-school youth are very limited and it is estimated that 90% are unemployed16. Moreover, there remains limited access to information, education and services amongst out-of-school youth, which increases their vulnerability to HIV and other RH problems. In addition, knowledge, practice and prevention of HIV/AIDS are also limited among out-of-school youth.

11. Global School-based Student Health Survey, August, 2009 MOH
12. Progress report for a study on Fe status of adolescent school girls of Myanmar. 2002 Department of Medical Research (Lower Myanmar)
13. Fisher, Jane, et al., 'Nature, Prevalence and Determinants of Common Mental Health Problems and Their Management in Primary Health Care," pp. 9–12
14. Power point presentation by Dr. Thar Htun Kyaw (26-12-2011), National Seminar on Malaria
15. Nation Tuberculosis Programme Annual Evaluation meeting 2011



Health seeking behavior: Most young people self-medicate. However the more educated young people are the more money they are likely to spend in seeking health services to prevent pregnancy, STIs and HIV/AIDS.[16]

Guiding Principles for the Development of Health Services for Adolescents and Youth

Given the concerns outlined previously and with the ultimate aim to improve and promote the health of adolescents and youth the Ministry of Health (MoH) has developed the following guiding principles:[17], [18]

- Investing in the health and development of young people as an integral part of national socioeconomic development.
- Recognizing that the health sector has a crucial role in provision of health services the health sector would support and coordinate with other sectors to develop a multi-sector approach and will address the determinants that effect health and behavior of the adolescents and youth.
- In order to contribute to the continuum of care and towards the progressive integration of activities, the Adolescent and Youth Health and Development (AYHD) programme will foster and strengthen linkages with similar strategic plans on RH, food and nutrition, mental health, locally endemic diseases (TB and malaria) and AIDS.
- The continuum of care approach will be supported across programmes and levels of care through creating a supportive and enabling environment and adoption of new delivery mechanisms like family and community outreach services and individual clinic care. This means increasing the role of parents, teachers, community leaders and other relevant adults to be aware of AYHD, promote healthy lifestyles, create opportunities to engage in healthy behaviors and reduce exposure to unhealthy conditions and behaviors.
- Reorientation of existing primary health care services and introduction with adolescent and youth friendly standardized service package and quality at various levels of health service delivery from township health department and below.
- Ensuring involvement of young people in planning, designing, implementation and evaluation of adolescent and youth health (AYH) and development programmes to promote acceptance and user-friendliness.

Stakeholders and Cause Analysis

The problems of adolescents and youth health center around four main stakeholders. In order to solve problems of adolescents and youth all 4 stakeholders need support and encouragement.[19]

1. Young people - do not have correct knowledge about health and illness and as a consequence do not seek care appropriately.
2. Community members - do not have correct knowledge about the health and illnesses of young people or of the value of providing young people with health services. They do not support the provision of health services to young people.

16. Report on Situation Analysis of Population and Development, Reproductive Health and Gender in Myanmar. UNFPA, July 2010. (pp 107)
17. Myanmar National Strategic Plan on Adolescent Health and Development (2009-2013), MOH and WHO
18. Five-year Strategic Plan for Child Health Development in Myanmar (2010-2014)
19. Outputs of National Consultative meeting on Adolescent Health Care, August 2012. , Nay Pyi Taw. MOH, UNFPA, WHO

3. Health workers - do not have the knowledge and skills to provide quality health services to young people. They are disrespectful and judgmental in their dealings with young people and do not relate and communicate with them well.

4. Health facilities - do not provide health services that young people need. They do not have the required equipment, medicines and supplies, do not have referral network, are not conveniently located, are not open at convenient hours, provide services at a charge that young people cannot afford, do not have a welcoming ambience, do not guarantee privacy and confidentiality.

Why Standards?

To support the improvement of AYH, these standards were formulated to ensure all stakeholders know what needs to be done. Standards have three functions: they set goals, they provide a basis for assessment of the quality of the services and help in writing improvement plans. In other words, they define quality, measure quality and help improve quality. Since four stakeholders were identified – young people themselves, the community, the service providers, the facilities – this document has four standards, one for each stakeholder. For each standard a number of criteria have been developed that together describe high quality of care. This document sets Service Standards on Adolescent and Youth Health Care. It describes how services need to be arranged, how clinics need to link with community etc. It provides guidance for facility managers and community leaders. There is a second companion document: Adolescent and Youth Health Manual that describes the clinical standards that need to be achieved. It provides guidance for basic health staff and clinicians.

How do we improve the compliance with Standards?

The following is a set of tools that could be utilized by health service providers. (See *Quality Improvement Process for AYH in Annex 1*)

All health facilities that provide AYH care should hold quality improvement activities on a regular basis. Improvement activities are recommended every 3-4 months.

These activities consist of:

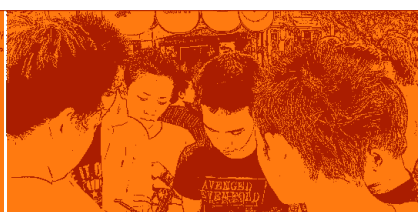
1. Meeting with a group of young people and with a group of community leaders and ask them what they think about the services.

2. Organizing client exit interviews.
   Client exit interviews are done in order to measure the quality of care from the clients' perspective. This technique allows knowledge and understanding to be more objective and makes progress is easier to determine.

3. Observing service delivery by supervisors to ensure they are provided according to protocols. A supervisor can observe the quality of care being provided during the clinic hours according to a number of checklists. Clinical checklists can be used to determine clinical quality of care. A counseling checklist can be used to determine proper counseling technique. These are collectively called data collection.

4. Holding a staff meeting in which a list of questions is answered. Any problem that is identified in that meeting is then written on an action plan and the action plan is completed over the next 3-4 months to make sure the problem gets solved in.

5. (see Annex 1 for the Quality Improvement Process for AYH)



II. Service Standards

Standard 1: Young people are knowledgeable about their health: health knowledge will be in line with their age and specific groups. They seek health care appropriately and support the services.

In order for this standard to be achieved, the following criteria need to be fulfilled:

2.1.1 Young people need to have age appropriate knowledge about AYH.

2.1.2 Young people need to know what services are available and how to obtain them

2.1.3 Adolescents and youth are actively involved in designing, assessing and providing services

2.1.1 Why would young people need to have knowledge on AYH?

If young people have the right knowledge and understanding they can choose to behave in such a way that they reduce the risk of various health problems. In addition, if young people have knowledge about AYH, they are more likely to recognize problems early, seek care and have their problems solved. Finally, they need this knowledge to lead healthy and happy lives.

To reach this criterion the following activities are suggested:

- Active counseling in the facility
- Active engagement with Youth Information Centers to provide information, education and communication (IEC) materials
- Use of peer educators
- Electronic media including telephone hotlines
- Working through the School Health Programme
- Using existing channels developed by the National AIDS Program to educate adolescents and youth
- Using IEC materials produced by other programmes. For example, the Tobacco Free Initiative Programme, the Anti-Narcotics Programme, Mental Health Programme (particularly the alcohol reduction project), road safety week materials etc.

2.1.2 Why do young people need to know what services are available and how to obtain them?

If young people know what services are available they are more likely to use them.

To reach this criterion, it is recommended that advertising is widely used. The same channels that are used to educate and inform young people about AYH can be used to inform them about the availability of services.

2.1.3 Why do adolescents need to be involved in designing, assessing and delivering services?

When young people are actively involved in designing, assessing and delivering services, the services are more likely to be acceptable, appropriate and attractive to them. In addition, the active involvement of young people makes the services more familiar and decreases the hesitation many of them will feel.

To reach this criterion, it is recommended to do active and close collaboration with the Youth Information Center and that a group of adolescent and youth advocates inside the community be formed. Examples include the use of young people in the design of layout and management of youth friendly corners, the use of peer educators in the community or the use of young people to do exit interviews or community interviews.

Standard 2: Communities (composed of local authorities, religious leaders, parents, teachers, and peers) are knowledgeable about the health of young people and about the value of providing them with health services. They support the provision of health services to young people.

In order for this standard to be achieved, the following criteria need to be fulfilled:

2.2.1 Community members understand the benefits that adolescents and youth will gain from the services and support their provision

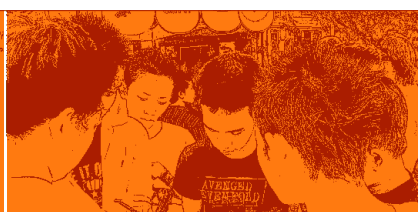
2.2.2 Some health services, information and commodities are provided in the community

2.2.1 Why is it important that community members understand the benefits that adolescents and youth will gain from the services and support their provision?

Communities are likely to oppose the provision of health services to young people if they do not understand or trust their value. When community members understand the usefulness of the services, they will not stop their children from using the services. Adolescents and youth can then use the services openly, without fear of stigma or shame. Moreover, an accepting attitude from the parents makes it easier for the young people to find an understanding parent at home. This is particularly true for the RH set of services. Finally, when community members understand the benefits, it is easier to make working relationships with schools, youth centers, parent-teacher associations etc. All these venues offer possibilities to make information available, supporting Standard 1.

To reach this criterion, following activities are recommended;

- Health service providers should try to speak to adult patients who come to the health facility about the value of providing health services to young people, address parent-teacher associations, work with religious leaders etc.
- Health service providers should initiate a dialogue with selected community leaders about the value of providing health services to young people. These selected community leaders (including parents and religious leaders) could support the provision of health service provision to young people through their words and actions. By doing so, they could create wider support for AYH initiatives in the community. Engaging them in a respectful manner will help ensure that young people can be provided with the health services that they require.
- Health service providers could work with township medical officers to organize local theatre groups to communicate the value of providing health services to young people. Local theatre groups (and other interesting groups) are a good way of using interactive approaches that promote community participation and raise community awareness about the needs and problems of young people. Other suggestions include using the opportunities created by special days. Any activity unique to young people on special days may provide even better opportunities to engage and motivate them.

- Specific activities include the following: group and community meetings, school activities, traditional media, music, song and dance, road shows, community drama, soap operas, puppet show, karaoke songs and contests.

2.2.2 How should the community be convinced to accept the importance of adolescent and youth health services in their own settings?

Young people may be reluctant to visit health facilities and some may be unable to do so. All efforts need to be undertaken to provide health information and services close to where adolescents and youth live or work or in places which are familiar to the young people. Outreach workers, selected community members and young people themselves can extend the reach of services into the community. The provision of health information and services by people they can easily relate to, people they can trust and in places they frequent will encourage utilization by young people. This is particularly important when we want to reach young people who are marginalized e.g., those living and working on the street. All adolescents and youth regardless of age, sex, educational status, cultural background, ethnic origin, disability or any other characteristic should be able to obtain health services that meet their needs.

To reach this criterion recommended activities are as follows:

- It would be useful to carry out outreach work in the catchment area of the health facility. The aim of outreach from health facilities is to inform adolescents and youth in the community about the services that they can access at the health facilities. In addition, the aim is to provide services to those who, for some reason or other, cannot come to the facility.
- It would be useful to establish links with organizations located in the catchment area of the health facility which work with/serve young people. When there are good links between health facilities and organizations in the catchment area, they can refer young people who need help to health facilities. They can also reach adolescents and youth that clinic services may not be able to reach.

Standard 3: Health workers have the technical competencies and attitudes needed to provide health services to young people effectively and sensitively. They provide the health services in the right manner.

In order for this standard to be achieved, the following criteria need to be fulfilled:

2.3.1 Health care providers and support staff treat young people with respect, regardless of status (religion, gender, income, marital status etc.). They are non-judgmental, considerate and easy to talk to.

2.3.2 Health care workers have the required competencies to provide the right services to adolescents and youth or to make appropriate referrals

2.3.3 Health care workers provide services according to evidence based protocols and guidance

2.3.4 Health care workers provide correct information and education


2.3.1 Why is it important that health care providers and support staff treat young people with respect, regardless of status (religion, gender, income, marital status etc.) and that they are non-judgmental, considerate and easy to talk to?

If health care providers and support staff respect young people, do not criticize, are non-judgmental, and easy to talk to, the young clients will be more comfortable in the clinic, leading to more repeat visits and a positive reputation for the clinic. In addition, more trust ensures that young people are more open with providers, answering questions more honestly and therefore giving providers better information to base a diagnosis and counseling on. It therefore improves the quality of care. Finally, this has to be done to all adolescents and youth, regardless of status. All adolescents and youth, including the unmarried, those of minority groups, those who are not legal residents etc. have a right to have high quality services.

Note that this does not mean that health care workers have to abandon their own values. They may feel that unmarried adolescents and youth that have sex are irresponsible, or that young men who have sex with men are abnormal. It does, however, mean that they do not let these feelings get in the way of how they provide services, and that they are still respectful and friendly.

2.3.2 Why is it important that health care workers have the required competencies to provide the right services to adolescents or to make appropriate referrals?

Health care workers need not only medical technical competency, but also the attitudes and skills required to talk to young people in an open and respectful way. Without these competencies they cannot provide high quality care.

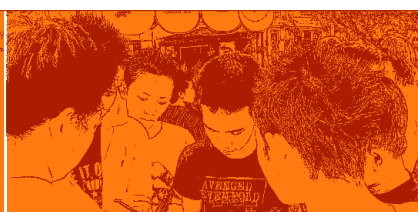
It is important that all young people obtain the health services they need either from one point of care, or from a set of points that are linked together in a helpful and friendly manner. This will also demonstrate to them that responding to their needs and problems is a priority to the health care delivery system. That will encourage them to seek help if and when they have other concerns/problems in the future.

2.3.3 Why is it important that health care workers provide services according to evidence based protocols and guidance?

Medicine is a field of science that changes quickly and it is impossible for health care workers to stay up to date on all research. The latest research is reflected in national standards, guidance, and protocols. These also reflect local culture (particularly in adolescent care), laws and strategic priorities. When health care workers provide care according to evidence based protocols they are sure to provide high quality care.

2.3.4 Why is it important that health care workers provide correct information and education?

When health care workers provide counseling, information and education according to protocols they are sure to provide high quality counseling and information.



Standard 4: Health facilities provide the required package of health information, counseling, commodities and services either on the spot or through referral. They have the equipment, medicines and supplies to do so. They are welcoming and appealing to young people. They guarantee privacy and confidentiality to young people.

In order for this standard to be achieved, the following criteria need to be fulfilled:

2.4.1 Policies and procedures are in place that do not restrict the provision of health services to adolescents and youth

2.4.2 Health care workers provide the services that young people need

2.4.3 Facility has the required amenities, equipment, supplies and commodities required to provide the services

2.4.4 Services have to be either free or affordable to adolescents and youth

2.4.5 Services have to be open at times and hours that are convenient for adolescents and youth, (for both in-school youth and out of school youth).

2.4.6 Services have short waiting times and can be had without appointment

2.4.7 Facility is clean and attractive to adolescents and youth

2.4.8 Policies and procedures are in place that guarantee confidentiality

2.4.9 Services are offered in privacy

2.4.1 Why is it important that policies and procedures are in place that do not restrict the provision of health services to adolescents?

Cultures and individuals differ in how much autonomy and independence they allow to adolescents and youth. They may or may not be allowed to make their own choices regarding their health care, especially regarding RH care. Scientific evidence suggests that health care and health status of adolescents and youth is improved when they can access services and information on their own terms.

2.4.2 Why is it important that health care workers provide the services that young people need?

It is important for health care providers to deliver the required package of health services because young people will come to utilize the services only if health facilities offer the services that they need.

Note that the adults that design and run services may not know what services adolescents and youth want or need. This is the justification for young people to be actively involved in designing, assessing and delivering services to the young people.

2.4.3 Why would it be important for health facility managers to ensure that health facilities have the basic amenities (water supply, sanitation, electricity etc.), equipment, supplies and commodities to deliver the required package of health services to young people?

Without the basic amenities, health services cannot be provided effectively. If health services are provided without all the basic amenities (e.g. running water and electricity to sterilize equipment) this might even endanger the health of the adolescents and youth. In addition, by

ensuring that the needed equipment and supplies are in place they can provide the required health services in the right way.

2.4.4 Why is it important that services have to be either free or affordable to adolescents?

The cost of services is an important element in making services accessible to adolescents and youth, particularly to those who are poor, living without parents etc. If services are too expensive, they will not be utilized.

2.4.5 Why is it important that services have to be open at times and hours that are convenient for adolescents both in school and out of school?

If services are only open at times that adolescents and youth are in school, they will not be able to come to the facility.

Note that in many youth friendly clinics, special adolescent and youth only hours are held either before or after school hours.

2.4.6 Why is it important that services have short waiting times and can be had without appointment?

Adolescents and youth tend to be deterred by long waiting times or rigid appointment procedures much more than adults. Making them wait could lead them to leave, missing the opportunity to have the services.

2.4.7 Why is it important that the facility is clean and attractive to adolescents?

Young people will not seek health services if the physical environment is not appealing to them. They are more likely to come to a health facility if it is appealing, welcoming and clear.

To reach this criterion it is recommend to establish a youth friendly corner.

Many youth friendly clinics have established youth friendly corners or special youth rooms in the health facility. These are areas or rooms, decorated to appeal to adolescents and youth with IEC available specifically aimed at adolescents and youth. Often the area is also used for meetings with peer educators, outreach workers etc.

2.4.8 Why is it important that policies and procedures are in place that guarantees confidentiality?

If there is no confidentiality, information about care and treatment may become public knowledge which could lead to blackmail or may damage the reputation of adolescents and youth in the community. If services are not confidential, adolescents and youth will not use them.

To reach this criterion it is recommended that client records and record books are locked away and that all providers (both health care workers and support staff) receive training in the importance of confidentiality.

2.4.9 Why is it important that services are offered in privacy?

A key factor that influences AYH care seeking behavior is whether or not seeking care could get them into trouble with parents or friends. As society strongly forbids premarital sex, unmarried adolescents and youth are unlikely to seek contraceptive services close to home and will not seek out places where services are not delivered in privacy. Married adolescents and youth may still be embarrassed to have the entire community know their problems. Services need to be provided in privacy, in such a way that they cannot be overheard or seen by others. For some services, it is important that there is a separate and private point of entry, reception area and waiting room where adolescents and youth cannot be seen.

III. Actions and Implementation Guide for Adolescent Health Care

Once the National Standards have been decided, the Ministry of Health should develop implementation guidelines to provide operational guidance for organizing adolescent and youth health care services in the identified facilities. The guidelines will delineate actions to be taken at the National, State/Regional, Township and Health Facility levels to operationalize quality services for adolescents and youth including demand generation and monitoring of the implementation.

The following tables show the different actions that need to be undertaken at the National, State/Regional, Township and Health Facility levels.

Actions to be taken at different levels for the implementation of Standards

Actions to be taken to achieve the quality standard 1:

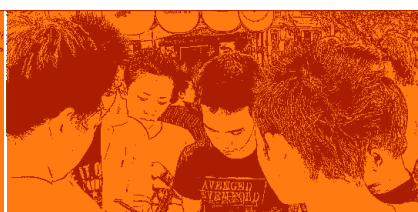
Standard 1: Young people are knowledgeable about their health: health knowledge will be in line with their age and specific groups. They seek health care appropriately and support the services.

Characteristics of Adolescent and Youth Health Care	Actions to be taken at the National level	Actions to be taken at the State/ Regional level	Actions to be taken at the Township level	Actions to be taken at the health facility level
Young people are informed with correct knowledge and information for services.	DOH/MOH officials provide guidance asking state/ regional level and TMOs to carry out facility-based and/or outreach activities.	State/Regional level officials to pass on the instructions to TMOs for appropriate actions.	TMO to plan and facilitate actions for facility-based and/ or outreach work in the catchment area of health facility.	Service providers working in conjunction with MMCWA, MMA, youth groups, Red Cross, INGO and NGO members carry out facility-based and outreach activities to reach young people in the catchment area with information for services.
Young people are engaged in the design, implementation and service delivery and engaged as peer educators.	DOH prepare guidelines on how to involve young people in the design, implementation and delivery of health services (including as peer educators).	State/Regional level officials pass on the guidelines to TMOs.	TMO to discuss with service providers from RHC/health facility to identify youth organizations and schools who can help to bring about youth participation and engagement.	Focal person or the staff who is assigned by TMO invites youth led organizations and schools and selects peer educators and groups of young people for adolescent and youth participation and engagement.
Friendly environment for young people exists to learn, recreate, share and find opportunities.	DOH/MOH officials provide guidance asking state/regional level and TMOs to establish locally appropriate youth centers (if resources allow).	State/Regional level officials to pass on the instructions to TMOs for appropriate actions.	TMO to plan and facilitate actions in the catchment area of health facility by doing feasibility study or quick assessment.	Focal person or the staff who is assigned by TMO takes appropriate activities in collaboration with organizations and young people (explore, identify and operate) to establish youth friendly center(s).

Actions to be taken to achieve the quality standard 2

Standard 2: Communities (composed of local authorities, religious leaders, parents, teachers, and peers) are knowledgeable about the health of young people and about the value of providing them with health services. They support the provision of health services to young people.

Characteristics of Adolescent and Youth Health Care	Actions at the National level	Actions at the State/Regional level	Actions at the Township level	Actions at the health facility level
Communities (composed of local authorities, religious leaders, parents, teachers, and peers) are informed of value of providing health information and services to young people.	DoH/MOH officials to develop guidelines, communicating tools and messages related to adolescent health and development targeting communities.	State/Regional level officials instruct township level and service providers to follow the guidelines and distribute communication tools and messages.	TMOs give guidance to service providers how to use communication tools and messages to communities.	Service providers inform community, including adult patients, about the common health problems and illnesses that young people face (through different channels including media, celebration of public holidays etc.).
Communities (composed of local authorities, religious leaders, parents, teachers, and peers) accept activities (education, youth centers, peer activities and health services) for young people.	DoH/MOH officials to develop guidelines, communication tools and messages related to adolescent health and development targeting communities.	State/Regional Officials instruct township level and service providers to follow the guidelines and distribute communication tools and messages.	TMOs give guidance to service providers how to use communication tools and messages to communities.	Service providers inform community, including adult patients, about the common health problems and illnesses that young people face along with the importance of providing health services to young (through individual and small group discussions/ dialogues, local theatrical groups, radio listening groups or folk media, celebration of public holidays etc.).
Communities and gate keepers have positive and supportive attitude towards health seeking behaviors of young people.	DoH/MOH officials to develop guidelines, communicating tools and messages targeting communities to have positive and supportive attitude towards health seeking behavior of young people.	State/Regional Officials instruct township level and service providers to follow the guidelines and distribute communication tools and messages.	TMOs give guidance to service providers how to use communication tools and messages to communities.	Service providers inform community, including adult patients, about the common health problems and illnesses that young people face along with the importance of providing health services to young (through individual and small group discussions/ dialogues, local theatrical groups, radio listening groups etc.).

Actions to be taken to achieve the quality standard 3:

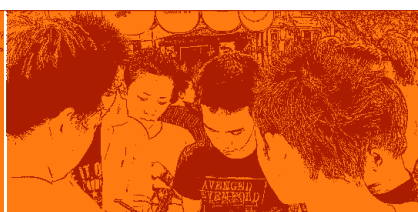
Standard 3: Health workers have the technical competencies and attitudes needed to provide health services to young people effectively and sensitively. They provide the health services in the right manner.

Characteristics of Adolescent and Youth Health Care	Actions at the National level	Actions at the State/Regional level	Actions at the Township level	Actions to be taken at the health facility level
Service providers are competent and skillful to provide required health care to young people who come to the health facilities.	DoH/MOH officials working in conjunction with WHO, UNFPA, UNICEF (a) develop/adapt generic training materials and job aids. (b) develop plan for all health workers to undergo training on Adolescent and Youth Health . (c) develop reporting system for Adolescent and Youth Health services and incorporate into MIS.	State/Regional level officials (i) discuss with TMO how to translate the plans into actions in the respective townships (ii) organize training of trainers sessions for service providers.	TMOs organize and facilitate trainings on Adolescent and Youth Health for service providers including reporting mechanism training.	Service providers provide appropriate services as needed by young people.
Service providers comply with job aids and guidelines in provision of services which is user-friendly for young people.	DOH/MOH develop guidance note on compliance of job aids and guidelines on provision of services for young people in user friendly way.	State/Regional level officials pass on the instructions to township level staff and conduct regular supportive supervisory visits.	Ensure that all service providers have job aids as a guiding tool to provide adolescent and youth health services and monitor compliance of job aids and guidelines.	Service providers comply with job aids and guidelines in provision of appropriate services as young people need in the right manner, without patronizing or judging young people.
Referral and coordination mechanism in place with organizations/ institutions/ hospitals located in the catchment area for appropriate referral of young people for health care.	DOH officials provide guidance to state/regional and township levels to establish referral and coordination mechanism with other facilities.	State/Regional level officials pass on the instruction for referral and coordination mechanism to TMOs.	TMOs to identify partners who are working for the adolescents and youth (INGOs, civil society members, private clinics) and develop referral and coordination mechanism.	Service providers refer young people who need further service, advice and support to appropriate organizations/ institutions/ hospitals.


Actions to be taken to achieve the quality standard 4:

Standard 4: Health facilities provide the required package of health information, counseling, commodities and services either on the spot or through referral. They have the equipment, medicines and supplies to do so. They are welcoming and appealing to young people. They guarantee privacy and confidentiality to young people

Characteristics of Adolescent and Youth Health Care	Actions to be taken at the National level	Actions to be taken at the State/ Regional level	Actions to be taken at the Township level	Actions to be taken at the health facility level
Health facilities are fully equipped to provide required package of health services to young people.	DOH/MOH to develop a list of services that are to be delivered to young people at the different levels of health facilities and provide required equipment, material commodities in order to provide services as per the list.	State/Regional level officials • pass on the list of services to township levels • distribute required equipment, material commodities to townships • ensure availability of services to be delivered at State/Regional level • conduct supervisory visits	TMOs give guidance and ensure that required health services are provided to or refer to elsewhere for services they cannot provide. Conduct monitoring visits	Health facility managers ensure availability of required equipment, materials and commodities and that they are well-functioning to provide required health services to young people.
Health facilities provide a welcoming and appealing environment for young people (location, open hours, privacy).	DOH/MOH develops guidelines about how to make the physical environment of health facilities accessible, clean and appealing to young people for privacy. Provide necessary support to upgrade health facility to comply with the guidelines.	State/Regional level officials pass on the guidance and instruct TMOs to keep health facilities accessible, clean and appealing for privacy Provide necessary support.	TMOs to instruct and monitor service providers to keep health facilities or premises accessible, clean and appealing for privacy.	BHS/Service providers comply with guidelines keep health facilities and premises clean, with consistent water source and proper seating. Ensure opening of health facilities at convenient times for young people and appealing for privacy (e.g., curtain).
Health facility has sufficient quantity of educational materials to inform and educate young people in the catchment area of the health facility.	DOH officials develop and distribute targeted educational and informational materials for young people.	State/Regional level officials ensure that there is uninterrupted and timely distribution of educational materials at health facilities.	TMOs distribute and encourage service providers using educational and informational materials to educate and inform young people.	Service providers use/ display educational materials and provide accurate and update information to young people in the health facility and in places where they gather in the community.

Annex 1:
Quality Improvement Process for Adolescent and Youth Health

Introduction

All health service centers that provide Adolescent and Youth Health Care should hold quality improvement activities on a regular basis. It is recommended that quality improvement activities are held every 3-4 months.

These activities consist of convening several meetings in the community, conducting client exit interviews and, if possible, some observation of services. These are collectively called the **data collection**. The entire staff of the clinic then holds a meeting in which a list of questions is answered. Anything that is identified as a problem in that meeting is then written on an action plan and the action plan is completed to make sure the problem gets solved within the next 3-4 months.

The data collection activities are:

1. Meet with a group of young people and with a group of community leaders from the community and ask them what they think about the services

During the meeting with **young people** discuss the following issues:

(i) Try to estimate their knowledge about adolescent and youth health. Start asking questions about smoking, alcohol and gradually, if they are willing, ask more sensitive questions about development and A/RH. Try to use this not only as an opportunity to measure their knowledge but also to teach them new things.

(ii) Ask if they know what services are available in the local clinics and ask them to list them? Ask if they would go if they had a problem. Why? Why not?

(iii) If young people are already engaged in designing, assessing and providing services, ask how it is going. Ask if there are any suggestions to strengthen that work. If they are not engaged, ask if they would be interested in doing that. Suggest these examples: becoming peer educator, helping in client interviews, joining quality improvement meetings every quarter in the clinic etc.

During the meeting with **community leaders** discuss the following issues:

(i) Discuss the benefits of adolescent and youth health care services. Assess whether community leaders agree with these benefits. Do they agree with RH services for adolescents and youth as well? If needed, this is an opportunity to explain the benefits to community leaders and make them advocates for youth and AYHC.

(ii) How do you feel about our outreach work? What could be improved? How could you, as community leaders, strengthen it? How can we work better together for adolescent and youth health care? What other organizations could be engaged?

2. Organize client exit interviews.

Client exit interviews are done in order to ***measure*** the quality of care from the *clients' perspective*. This technique allows knowledge and understanding to be more objective and makes progress is easier to determine.

The client questionnaire is a tool that could be used to follow how the clients feel about some important aspects of the quality of care in the clinic. They all relate to the criteria that are formulated in the ***Service Standards for Adolescent and Youth Health Care***

Who should do the questionnaire?

There are 3 options for questionnaires.

(i) An independent agency can be asked to carry out the interviews. The advantages are objectivity and possibly better quality. The possible disadvantage is cost. However, if the outside agency is a group of adolescents and youth, it does not have to cost anything. It would also ensure they are involved in the improvement of the services that should reach them.

(ii) The second option is to have a staff member ask the questions. The answers can be recorded in a record book. The disadvantage is that clients will tend to be nicer in their answers (courtesy bias) and also it is not very practical for a one-person clinic.

(iii) The third way is to ask clients to fill out paper forms themselves and then put them in a locked box. After 3 months, a clinic staff member opens the box and calculates the average score for each question. The advantage is that it is quick, and cheap, and clients may feel more at ease to answer honestly. The disadvantage is that interviews then tend to be filled out by those either very pleased with the services or very displeased.

Whatever method is used, each location will need approximately 80 questionnaires and once one option is picked, it should not be changed to be comparable over time.

How to do the Interviews

It is better to space out the completion of the questionnaires over the entire implementation period between QI meetings. This way the results are less likely to be affected by the weather, holidays, etc. It is therefore recommended to interview **one or two clients per day** rather than rush all 80 questionnaires in one or two weeks before the QI activity.

To standardize the data collection as much as possible it is suggested doing one sample every day. For example, ask the first client 10-24 years old who comes after 9 AM to fill out the questionnaires. However, make sure these rules suit the clinic. The important part is that the standard rules are followed.

Analysis

When calculating the averages, different answers get different points. Answer 1 gets 1 point, answer 2 gets 2 points etc. Questionnaire results need to be calculated as an average for all respondents.

Then we need to ask ourselves: what level is good? What level are we satisfied with? For the client interviews we have set a minimum of 4. *If the average score for a question is below 4, that represents a problem and the meeting needs to discuss how improvements can be made.*

3. Ask a supervisor to observe services to ensure they are provided according to protocols.

A colleague or supervisor can sit in on providers' clinic hours and observe the quality of care according to a number of checklists. Clinical checklists can be used to determine clinical quality of care. A counseling checklist can be used to determine proper counseling technique.


Once the adolescent and youth health services are functioning well, it is not necessary to repeat these measurements very often. It would however be good to measure these services roughly once a year to make sure everything is functioning normally.

How to use the checklist?

The check list was designed to be an accurate representation of exactly how the provider is supposed to act. Assign a score for each observation. Give 2 points if that task is done well, 1 point if it is not well done or not completely done and 0 point if it is not done at all. At the end of the observation, add up the score, divide by the maximum score possible and multiply by 100. This gives the result as a percentage. As the grading is, to a certain extent, subjective, the score can only really be accurate to within a variation of 5% increase or decrease.

Analysis

Every indicator needs a "warning level" by which to judge satisfaction or a need to improve the performance of a service. In the case of the checklist for client/provider interaction, the warning level is set at 80 %. This makes the decision on the performance standards easier and more objective.

Any staff member whose scores below the warning line needs more coaching from the supervisor during the visit.

Clients rights during monitoring and observation

The rights of the adolescent and youth client to privacy and confidentiality should be considered at all times during a service observation. When a client is undergoing a physical examination it should be carried out in an environment in which her/his right to bodily privacy is respected. When receiving counseling, undergoing a physical examination, or receiving other services, the client should be informed about the role of each individual in the room (e.g. service provider, observers, supervisor, etc.). The client's permission should be asked every time there are observers present. If the client refuses it should not affect her service in any way. Before the consultation, the provider's permission should be received in advance to sit in and observe the client-provider interaction.

The providers should also be told that, as an observer, that person cannot participate in providing service during the consultations. The provider should not ask the observer for opinions or advice, except in extremely serious situations; the provider should be requested to behave as if the observer is not present. The observer will have to be seated fairly close to the client and provider to be able to see and hear exactly what goes on.

Before the consultation begins, the provider (not the observer) should ask the client whether it is acceptable for an observer to be present. The client should understand that s/he has the right to refuse. Furthermore, a client's care should not be rescheduled or denied if s/he does not permit an observer to be present.

During consultations:

The observer presence is definitely going to affect the interaction, probably by making both the client and the provider more self-conscious and aware of what they are saying and doing. Having an observer present will disturb most people in their normal work routine. Some become flustered, some start to forget things they normally do not forget. If this comes up, the observer should understand this. As an observer, s/he should do everything possible to make it


unobtrusive. If possible, the observer should sit in the background so that s/he is not directly in eye contact with either the provider or the client.

The observation guide is to be designed so that one can mark boxes that describe what have been seen. Because there is no fixed order for each consultation it is essential that the observer learns the structure of the observation guide so that whenever s/he see a particular action or hears a specific issue being discussed s/he knows exactly where to mark the guide. In most cases it should be possible to remember what happened and to mark the guide after the consultation if finished. Once the observer is skilled with the checklists they can be complete it after the consultation, rather than during the consultation. This is less stressful for the provider.

The observer should wear appropriate clothing (in some cases wearing uniforms) and have a pleasant smile on their face.

S/he should keep your paper and pen resting in the lap and be discreet when noting down an observation.

Very occasionally, a provider might be doing something that is potentially dangerous to the client. For example, the provider may be using unsterile equipment when doing an examination, inserting an intra uterine device (IUD), or administering an injectable. In those cases the observer should intervene calmly and without embarrassing the provider.

At the end of the consultation, the provider should thank the client for allowing the observation and, in so doing assisting in improving the services.

Feedback:

Observers must be discreet in observing service delivery. In many cases corrective feedback only causes confusion and discomfort for the client and embarrasses the provider. In general, feedback should be given after each case so that the provider and the observer can talk without the client being present. Corrective feedback during service should be limited to errors that could harm or cause discomfort to the client.

4. Organize a Quality Improvement Meeting with all Service Providers

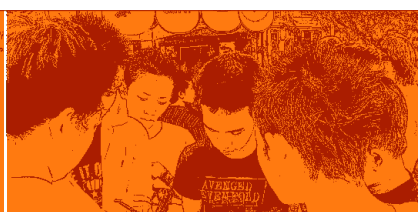
In this meeting it is important to have all staff present. In addition, if the staff could invite community members and community leaders that would be very good as they can provide useful input. If adolescents and youth from the community are also invited, that would also be very good as they can give excellent ideas regarding clients' perceptions of the services.

Before the meeting:

(i) Calculate the average scores from all client interviews and put them in a graph to compare with last time.

(ii) Calculate

- the number of clients 10-24 years old/month
- the number of clients 10-14 years old/month
- the number of clients 15-19 years old/month
- the number of clients 20-24 years old/month
- the number of young people per income group/month
- the number of young people per social status group/month

During the meeting:

Part 1 of the meeting is **problem finding**. In this part of the meeting go over the list of questions ("Questions for QI meeting") and try to answer them as best as possible. When the answer to a question is "**no**" , or when an average score on an interview or an observation is **below 4**, it has been identified as a weakness in how youth friendly services are. Put that weakness in the first column of the action plan. Continue through the whole list of questions. The staff should now have a good idea of the quality of the services and should also have the first column of the action plan filled in with a number of weaknesses.

Now comes part 2, **the action plan**. For all items that have been identified as weak, (**No** or **score <4**) and that are now on the action plan, ask and discuss with staff how to improve the work.

First prioritize. If there is a long list of problems, it helps to prioritize. Please tackle those problems first that are fit the following criteria:

- Problem is solvable with our available resources
- Problem affects many clients
- Problem affects the safety of the client

Next try to **identify root causes**. For simple problems, brainstorm causes. For complex problems, use categories of causes.

Typically it is best to formulate the problem from the clients' perspective. Describe how the problem has an impact on clients. This way all possible causes are left open and the group can focus on the final, most important outcome of the work: improving quality of care for clients.

Make sure everyone agrees on the problem statement. Include as much information on the what, where, how much, and when as possible. Use concrete data. Write down the problem on a large flipchart. For example:

"There are only very few unmarried women 19-24 years old who come to the clinic in the last quarter."

Select big categories of possible causes:

- Staff
- Policies/Rules/Standards/Habits
- Equipment/Supplies/Facility
- Clients

There is no perfect set of categories. Try to make them fit the problem, (but these four apply to most problems). Please note that these categories are not mutually exclusive. Some causes belong in more than one category.

Brainstorm (or brain writing or use Post-It notes) all possible causes in one category and then place them on the left side of a flipchart. Some causes may fit in more than one category. In that case, place them in both. If the ideas are slow in coming, use the major categories as catalysts. For example ask: "What policies/rules might contribute to the problem that…."

For each cause ask: Why? Write the answer to "why?" next to it, on the right of the flipchart. This way the underlying or root causes can be identified. Stick to those causes that are controlled by staff at their level or, at most, the level that the superior works at. When a cause is controlled

by people at much higher levels, generally it nothing can be done to address it, for example, salary levels. Trying to analyze the root causes at these high levels simply causes frustration.

Keep asking **why** until one of three things happens:

- A solution to the problem becomes apparent
- Causes that are controlled from outside or influence discussed
- Different category of causes identified

After having collected everyone's ideas about the causes and the causes behind the causes, start to organize them. Try to find root causes in the right hand column by looking for causes that appear more than once within or across categories.

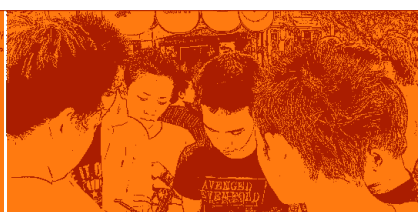
For each ***cause*** the group needs to **discuss a solution or action** that is feasible in terms of time, money, authority etc. (e.g. do not try to send someone to the Ministry of Health to argue for more salary for the staff.)

The next step is to ask **who is going to implement** or be responsible for the solution.

Often, it is clear from discussions who will be responsible for any given activity and usually this is a member of the clinic staff. However, if there is an action that needs to be taken by someone outside the clinic (supervisor/manager/director) make sure that there is someone ***within*** the clinic who is responsible for follow-up and keeping in contact with that person. Each action should have one person assigned to it and their name (not function) should be written by the activity on the action plan. Make sure that all the responsibility does not fall on the shoulders of the same people.

Finally, ask the responsible person what is a **reasonable timeframe** for the action to be taken. Stick to that timeframe. Do not impose a shorter time. If the timeframe s/he indicates is far away (e.g. more than 2 months) consider whether the action is not too complex or too large. Can it be broken up in smaller sections and can the responsibility be divided?

The last thing to do during the meeting is to set a date for the next meeting.



Annex 2:
List of Participants

Consultative Meeting for Development of National Services Standard and Guidelines on Adolescent and Youth Health Care
24-25 July 2012, Royal Kumudra Hotel, Nay Pyi Taw

1. Dr. Min Than Nyunt, Director General, Department of Health, Ministry of Health
2. Dr. Hla Myint, Director (PH), Department of Health, Ministry of Health
3. Dr. Zaw Win, Director (FDA), Department of Health, Ministry of Health
4. Dr. Htay Naung, Director (Medical Care), Department of Health, Ministry of Health
5. Dr. Nilar Tin, Director (Planning), Department of Health, Ministry of Health
6. Dr. Mg Mg Min Thein, Director (Administration), Department of Health, Ministry of Health
7. Dr. Ngwe San, Director (Laws and Regulations), Department of Health, Ministry of Health
8. Dr. Win Maung, Director (Disease Control), Department of Health, Ministry of Health
9. Dr. Thet Thet Mu, Director, Department of Health Planning, Ministry of Health
10. Dr. Myint Myint Than, Deputy Director (WCHD), Department of Health, Ministry of Health
11. U Sian Za Niang, Deputy Director (CHEB), Department of Health, Ministry of Health
12. Dr. Aung Tun, Deputy Director (School Health), Department of Health, Ministry of Health
13. Dr. Thida Kyu, Deputy Director (Planning), Department of Health, Ministry of Health
14. Dr. May Khin Than, Deputy Director (Nutrition), Department of Health, Ministry of Health
15. Dr. Thida Hla, Deputy Director (Medical Care), Department of Health, Ministry of Health
16. Dr. Theingi Myint, Deputy Director (MCH), Department of Health, Ministry of Health
17. Dr. Thuzar Chit Tin, Deputy Director (BHS), Department of Health, Ministry of Health
18. Dr. Hnin Hnin Lwin, Assistant Director (MCH), Department of Health, Ministry of Health
19. Dr. Nang Naing Naing Shein, Assistant Director (BHS), Department of Health, Ministry of Health
20. Dr. Myo Min, Assistant Director (BHS), Department of Health, Ministry of Health
21. Dr. Ko Ko Naing, Assistant Director (NAP), Department of Health, Ministry of Health
22. Dr. Su Mon Myat, Medical Officer (School Health), Department of Health, Ministry of Health
23. Dr. Su Su Lin, Medical Officer (MCH), Department of Health, Ministry of Health
24. Dr. Kay Kay Khaing Ko, Medical Officer (BHS), Department of Health, Ministry of Health
25. Dr. Myo Su Kyi, Medical Officer (NTP), Department of Health, Ministry of Health
26. Dr. Khine Nwe Tin, Medical Officer (MCH), Department of Health, Ministry of Health
27. U Aye Yee, Health Education Officer (CHEB), Department of Health, Ministry of Health
28. Daw Su Su Naing, Health Education Officer (CHEB), Department of Health, Ministry of Health
29. Dr. Khin Su Hlaing, Health Education Officer (CHEB), Department of Health, Ministry of Health
30. Dr. Mon Mon Aung, President, Myanmar Maternal and Child Welfare Association
31. Dr. Zaw Wai Soe, Consultant Orthopaedic Surgeon, Yangon General Hospital
32. Dr. Aye Aye Thein, Consultant Obstetrician and Gynaecologist, Central Women Hospital
33. Prof. Dr. Swe Swe Win, Head, Mental Health
34. Daw Tin Tin Latt, CEC, Myanmar Women's Affairs Federation
35. Dr. Khine Soe Win, Project Officer, Myanmar Medical Association
36. Dr. Khin Than Aye, Project Officer, Myanmar Maternal and Child Welfare Association
37. Dr. Khin Myint Wai, Programme Manager, Marie Stopes International in Myanmar
38. U Zaw Htoo Oo, Programme Coordinator, Myanmar Red Cross Society
39. Dr. Neena Raina, RA-CAH, World Health Organization SEARO
40. Dr. V. Chandra-Mouli, Scientist, ASRH, World Health Organization SEARO
41. Ms. Phavady Bollen, Technical Officer, World Health Organization
42. Dr. Khin Ma Ma Aye, National Technical Officer, World Health Organization
43. Dr. Ne Win, Assistant Representative, United Nations Population Fund
44. Dr. Than Soe, Programme Associate, United Nations Population Fund
45. Daw Khine Khine Saw, Programme Assistant, United Nations Population Fund

Consultative Meeting for Development of National Services Standard and Guidelines on Adolescent and Youth Health Care
16 November 2012, Royal Kumudra Hotel, Nay Pyi Taw

1. Dr. Thein Thein Htay, Deputy Minister, Ministry of Health
2. Dr. Min Than Nyunt, Director General, Department of Health, Ministry of Health
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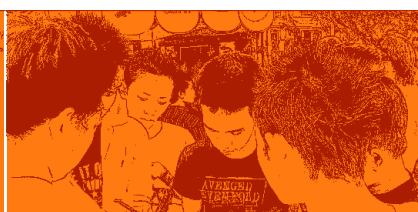
6. Dr. Hla Mya Thway Einda, Deputy Director (Training and BHS), Ministry of Health
7. Dr. Myint Oo, Consultant Orthopaedic Surgeon, Ministry of Health
8. Dr. Chan Nyein Aung, Medical Officer, Department of Health, Ministry of Health
9. Dr. Tun Myint, HD, Department of Health, Ministry of Health
10. Dr. Myo Su Kyi, Medical Officer, Department of Health, Ministry of Health
11. Dr. Khine Nwe Tin, Medical Officer (MCH), Department of Health, Ministry of Health
12. Dr. Aung Tun, Deputy Director (School Health), Ministry of Health
13. Dr. Mya Lay Nwe, Assistant Director, Department of Health, Ministry of Health
14. Dr. Su Su Lin, Medical Officer (MCH), Ministry of Health
15. Dr. Su Mon Myat, Medical Officer (School Health), Department of Health, Ministry of Health
16. Dr. Chaw Su Wai, Medical Officer (NNC), Ministry of Health, Ministry of Health
17. Dr. Khin Sandar Aung, Medical Officer (BHS), Ministry of Health
18. U Aye Yee, Health Education Officer (CHEB), Department of Health, Ministry of Health
19. Daw Su Su Naing, Health Education (CHEB), Department of Health, Ministry of Health
20. Daw Aye Aye Cho, Health Education (CHEB), Department of Health, Ministry of Health
21. Dr. Mon Mon Aung, President, Myanmar Maternal and Child Welfae Association
22. Dr. Thazin Nwe, Secretary, MMCWA
23. Dr. Khin Mar Tun, General Secretary, Myanmar Women Affairs Federation
24. Dr. Khine Soe Win, Project Officer, Youth Development Programme, Myanmar Medical Association
25. So Pyay Oo, Youth Development Programme, Myanmar Medical Association
26. Hninn Nwe Nwe Aung, Youth Development Programme, Myanmar Medical Association
27. Dr. Myo Yar Zar, Project Manager, Marie Stopes International Myanmar
28. Aye Aye Aung, Youth, Marie Stopes International Myanmar
29. Dr. Antonius W.J. van der Velden, International Consultant, Pathfinder
30. Dr. Nyo Nyo Min, National Consultant, United Nations Population Fund
31. Daw Khin Ma Ma Aye, National Consultant, World Health Organization
32. Dr. Josephine Sauvarin, Regional Adviser, Asia and Pacific Regional Office (APRO), United Nations Population Fund
33. Dr. Ne Win, Assistant Representative, United Nations Population Fund
34. Daw Cindy Loo, Programme Assistant, United Nations Population Fund

Annex 3:
List of Working Group Members

1. Dr. Hla Mya Thway Einda, Deputy Director, Department of Health
2. Mr. Antonius W. J. van der Velden, International Consultant, Pathfinder
3. Dr. Nyo Nyo Min, National Consultant
4. Mrs. Phavady Bollen, Technical Officer (HIV/AIDS), World Health Organization
5. Daw Khin Ma Ma Aye, National Technical Officer, World Health Organization
6. Dr. Ne Win, Assistant Representative, United Nations Population Fund
7. Dr. Than Soe, National Programme Associate, United Nations Population Fund
8. Dr. Yan Naing Linn, National Programme Officer, United Nations Population Fund
9. Daw Cindy Loo, National Programme Assistant, United Nations Population Fund
10. Daw Khine Khine Saw, National Programme Assistant, United Nations Population Fund