

National Adolescent Health and Development Strategy



Family Health Division
Department of Health Services
Ministry of Health
His Majesty's Government of Nepal
2000

NATIONAL ADOLESCENT HEALTH AND DEVELOPMENT STRATEGY



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A Few Words

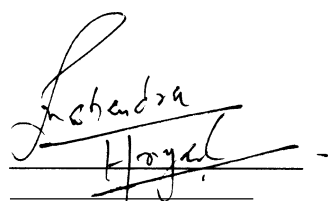
In Nepal, adolescents comprise more than one fifth (22%) of the total population, a proportion which is expected to grow during the years to come due to a high fertility rate and a high proportion of under 15 year olds. The health and development of adolescents is a great concern for the country, as they comprise the future human resources.

Nepal, as a co-signatory in 1994 to the Plan of Action of the International Conference on Population and Development (ICPD), has committed itself to improving the reproductive health status of the people throughout the kingdom. Adolescent reproductive health is one of the vital components of overall reproductive health.

In this regard, an inter-sectoral and integrated approach will be utilized to ensure a wide range of adolescent specific services, information and referrals are available to all adolescents in Nepal.

I hope this National Adolescent Health and Development Strategy will guide HMG and all partner agencies, thus improving the access, coverage and quality of the overall adolescent health and development programmes.

We would like to take this opportunity to express our gratitude to all multi-lateral and bi-lateral GOs, NGOs and other program partners for their continued support.



Mahendra Nath Aryal
Secretary
Ministry of Health

Foreword

His Majesty's Government, Ministry of Health, Department of Health Services is committed to providing reproductive health services throughout Nepal. The Family Health Division in the Department of Health Services has been identified as the focal point for implementation and coordination of the National Reproductive Health Program, which includes adolescent health.

Adolescent health comprises adolescent reproductive health as well as prevention and control of substance abuse, alcohol and tobacco use. It is satisfying to note that the policy as well as implementation level co-ordination has been emphasized in this strategy through the RH Steering Committee and the RH Co-ordination Committee. I believe that utilising these committees will help enhance inter- and intra-sectoral co-ordination and thereby strengthen RH services, including adolescent health, throughout Nepal.

I hope that this National Adolescent Health and Development Strategy document will help MoH, other related line ministries, donors, INGOs and NGOs in the efficient and effective provision of adolescent health services throughout Nepal.



Dr. B.D. Chataut
Director General
Department of Health Services

Preface

The major thrust of health policy in the past was to provide basic health services with an emphasis on primary health care including family planning services. Health for all by 2000 AD" had been the popular slogan for the past two decades. Even into the new millennium any people in Nepal do not have easy access to basic health care services. Among them Adolescents are one of the sizable groups that remain in obscurity of the other groups of people in terms of reproductive health service needs. Adolescent constitute percent of total population. Moreover, the reproductive behaviors of adolescents are speculated to change due to induced hampered exposure to the changes in society particularly the changes in behavior of peers.

The International Conference on Population and Development ICPD held in Cairo in 1994, recognized reproductive health as crucial aspect of overall health which is central to human development and affects everyone individuals, families and communities alike. The ICPD not only emphasized on the human and reproductive rights it emphasized on the life cycle approaches to reproductive health, which encompassed among others the adolescent reproductive health. Nepal is one of the signatory to the ICPD plan of action. It is not only obligatory but also a responsibility to understand the reproductive health problems of the adolescent of Nepal and provide appropriate services to them. In this regard, Ministry of Health has formulated the National Reproductive Health Strategy, which states that adolescent health is one of the major elements of reproductive health.

The Reproductive health Steering Committee (RHSC, a policy level committee) recognized the need to develop an Adolescent Health and Development Strategy and has discussed it in the Reproductive Health Coordination Committee (RHCC). An Adolescent Health (ADH) sub committee was formed to coordinate and assist the development of the Adolescent Health and Development Strategy. In developing the ADH Strategy to develop the Adolescent Health and Development Strategy and thereafter coordinate the adolescent reproductive activities that would evolve in future based on the strategy. Two working groups were also formed one group focussed on health related issues and the other one on non-health issues. As expected, the working groups prepared a preliminary draft of the ADH strategy. In June 2000, a national workshop on adolescent health was conducted by the Department of Health Services in Kathmandu involving representatives from various line ministries. NGOs and other stakeholders including youth leaders. The workshop identified and recommended the scope of adolescent health and development framework and prepared a comprehensive strategy. The strategy also identified the roles and responsibilities of the various stakeholders in identifying important role in fostering ownership. The recommendations of the workshop have been incorporated into the National Adolescent Health and Development Strategy. It is satisfying to note that the Reproductive Health Steering Committee, a high-level policy level committee at the MoH level has endorsed the strategy.

This document outlines His Majesty's Government aim in providing health and development

services for adolescent in Nepal. Furthermore, this document provides guidelines for policy makers, services providers, various line ministries, INGOs, NGOs and private sector organizations, identifying their roles and responsibilities so that they can develop and implement activities within the framework of the adolescent health and development strategy. In this regard, I would like to thank all representatives of line ministries, donor agencies, INGOs and NGOs for their contributions in formulating this strategy.

It is my pleasure indeed to extend my thanks to the WHO South East Asia Regional Office, for its technical and financial support in this important area of RH. In this regard I would like to particularly thank Dr. Suniti Acharya, Advisor WHO/SEARO for her active input in successful achieving the objectives of the workshop but also in her invaluable comments on the earlier draft of this document.

This document is a product of a painstaking and dedicated efforts of a group of professional with varied but related expertise. I would be failing in my duty if I do not acknowledge the dedicated efforts of Dr. Ganga Shakya, Chief of Reproductive Health, Mr. Ajit Pradhan, Chief of Demography/RH Research, Mr. Devi Prasai, Section Officer, Ms. Munu Thapa, RH Advisor GTZ, Dr. Vijaya Manandhar, NOO/WHO, Mr. Tek B. Dangi, Chief of Family Planning, Dr. Nicolette Hutter, Advisor, RH Umbrella Project and others.

I would like to thank Ms. Madhavi Bajracharya, Ms. Deepa Maharjan and Mr. Tika Ram Sedai for their painstaking efforts in preparing numerous drafts of this document.

Last but not the least I would like to extend my heartiest thanks, and gratitude to all the participants of the workshop which developed the Adolescent Health and Development Strategy for Nepal. This document would not have been completed without their invaluable input.



Dr. Laxmi Raj Pathak
Director
Family Health Division

Abbreviation

AAAN	: Advertising Agency Association of Nepal
ADDCN	: Association of District Development Committees of Nepal
ADH	: Adolescent Health
AIDS	: Acquired Immuno-Deficiency Syndrome
ARH	: Adolescent Reproductive Health
CBO	: Community Based Organization
CBS	: Central Bureau of Statistics
CHD	: Child Health Division
CTEVT	: Center for Technical Education and Vocational Training
DDC	: District Development Committee
DHS	: Demographic Health Survey
DoHS	: Department of Health Services
FAO	: Food and Agriculture Organization
FCHV	: Female Community Health Volunteer
FHD	: Family Health Division
FNCCI	: Federation of Nepalese Chambers of Commerce & Industry
FY	: Fiscal Year
GO	: Government Organization
HIV	: Human Immuno-Deficiency Virus
HMG	: His Majesty's Government
ICDP	: International Conference on Population and Development
INGO	: International Non-Governmental Organization
MDC	: Municipality Development Committee
MOE	: Ministry of Education and Sports
MOH	: Ministry of Health
MOIC	: Ministry of Information and Communication
MOPE	: Ministry of Population and Environment
MWSW	: Ministry of Women, Children and Social Welfare
NCASC	: National Centre for AIDS and STD Control
NFHS	: Nepal Family Health Survey
NGO	: Non-Governmental Organization
NMNSS	: Nepal Micro Nutrients Status Survey
NLFS	: Nepal Labor Force survey
NPC	: National Planning Commission
NYCC	: Nepal Youth Coordination Council
RH	: Reproductive Health
RTI	: Reproductive Tract Infection
STD	: Sexually Transmitted Disease
STI	: Sexually Transmitted Infection
UNFPA	: United Nations Population Fund
UNICEF	: United Nations Children's Fund
VaRG	: Valley Research Group
VDC	: Village Development Committee
WHO	: World Health Organization

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A FEW WORDS

FOREWORD

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1. Introduction

1.1. BACKGROUND

Adolescence is the period of physical, psychological and social maturing from childhood to adulthood. Generally, the term "adolescents" refers to individuals between the ages of 10-19 years and the term "youth" refers to individuals between the ages of 15-24 years, while "young people" covers the entire age range, from ages 10-24 years (WHO/UNFPA/UNICEF, 1989). There is growing recognition that because of a combination of biological, psychological and social factors adolescents face many different health risks and problems such as sexually transmitted infections including HIV/AIDS, early and frequent pregnancy, substance abuse, accidents and violence. On the other hand adolescents are usually very energetic and receptive to information that pertains to them and are anxious to become more autonomous in their decision-making. Such curiosity and interest in learning offers great opportunities for improving adolescent health and development.

Adolescence is the period of physical, psychological and social maturing from childhood to adulthood. Generally, the term "adolescents" refers to individuals between the ages of 10-19 years

The health of adolescents is profoundly linked to their development since their physical, psychological and social abilities help to determine their behaviour. Healthy development of adolescents is dependent upon several complex factors: their socio-economic circumstances, the environment in which they live and grow, the quality of family, community and peer relationships, available opportunities for education and employment, and access to health information and services.

Foundations for adequate growth and development for both female and male adolescents and their offspring are laid during childhood and adolescence. For example the rapid growth occurring during adolescence demands extra nutritional requirements. The nutritional status of young girls prior to pregnancy has a tremendous impact on the course and outcomes of pregnancy.

The young people of today are tomorrow's adults. The fertility behaviour of adolescents is a potential determining factor for future population growth in a country. It is of paramount importance that an environment be created and adequate support provided to enable adolescents to develop their full potential and to enjoy a healthy and responsible adulthood.

1.2 SITUATION OF ADOLESCENTS IN NEPAL

In Nepal, adolescents comprise more than one fifth (22%) of the total population. As a result of population momentum the adolescent population will continue to grow for at least twenty years. Existing studies show that nearly half (50%) of 15-19 year old adolescent girls and a fifth (20.6%) of the adolescent boys aged 15-19 years are married (1991 census). According to Nepal Family Health Survey (NFHS), one fourth (24%) of adolescents are already pregnant or mothers with their first child (NFHS, 1996). The contraceptive prevalence rate (CPR) is reportedly only 6.5% among adolescents. The 1996 NFHS also revealed that 50% of adolescent mothers do not receive antenatal care and the majority (90%) of adolescent mothers deliver their babies at home—a trained health worker assists only 14% of these deliveries. There is a higher incidence of anemia, hypertensive disorders, abnormal and premature deliveries and greater fetal demise in adolescent mothers compared to older mothers (Malla, et. al, 1996). Out of all reproductive age suicides, 27.5% were found in the adolescent age group. The Maternal Mortality and Morbidity Study (DoHS, 1998) reports that a significant proportion of maternal deaths (18.9%) occur in the adolescent age group. The nutritional status of adolescents is also of concern. NFHS revealed that 30.6% of girls had a low Body Mass Index (BMI<18.5), which is indicative of a high prevalence of chronic energy deficiency among adolescent girls. According to a study on the nutritional status of adolescent girls conducted in three districts of Nepal, 40% had iodine deficiency and 47.4% had nutritional anemia (New Era, 1994). A majority of adolescents (64%) had their first sexual intercourse when they were between 15-17 years of age. The mean age of first sexual intercourse among males was 16.4 years while among female was 16 years (VaRG, 1999). Of all HIV cases, 13% were found in the 14-19 year age group and 70% of them were female (NCASC 2000). Young people aged 16-19 constituted 22.5% in the total drugs abusers (New Era 1996).

Nearly 40% of adolescents between 10-19 years of age are illiterate. The gross enrolment rate decreases from 86% at a primary education level to 39% and 11% at

Adolescents in Nepal often encounter problem, which include lack of awareness and knowledge about sexual and reproductive health, early marriage, early and frequent child bearing, unsafe abortion, STD/HIV/AIDS, and substance abuse.

lower secondary and secondary education levels respectively (NLSS 1996). Within Nepal, the number of female commercial sex workers is estimated to be 25,000; of them 20% are estimated to be under the age of 16. Twenty three percent of children between the ages of 10 and 14 years and 62.8 % of the 15-19 age group are reported to work in the labour force. Coupled with low school enrolment, especially for girls, and early entry into the labour force, these trends adversely affect the health and development of Adolescents.

Adolescents in Nepal often encounter problems, which include lack of awareness and knowledge about sexual and reproductive health, early marriage, early and frequent child bearing, unsafe abortion, STD/HIV/AIDS, and substance abuse. These problems are often exacerbated by social problems such as poverty, illiteracy, dropping out of school, child labour, gender discrimination, violence and abuses including girl trafficking and prostitution. These problems are further aggravated by poor health seeking behaviour and inadequate access to information and services. Many of these problems not only affect the physical and mental health of adolescents but adolescents' long-term emotional, economic and social well being. Adolescents of disadvantaged groups including disabled, migrant, homeless and other marginalized groups are comparatively more vulnerable and need special attention. It is imperative to acknowledge that most adolescent health issues in Nepal's context are intimately related to socio-cultural and economic factors. There is a clear need for multisectoral actions to address adolescent health and development issues.

1.3. RESPONSE TO ADOLESCENT HEALTH ISSUES

Adolescent specific health services were virtually non-existent in Nepal before the International Conference on Population and Development (ICPD) in 1994. However, a few programmes, mostly focusing on drug abuse and HIV/AIDS, have been previously conducted by NGOs. In 1991, HMG/Nepal initiated a HIV/AIDS prevention and control programme in order to address this growing need and concern. With the adoption of ICPD Programme of Action and again in 1995 at the Fourth International Conference on Women in Beijing, the global community resolved to "protect and promote the rights of adolescents access to sexual and reproductive health information and services." Nepal, as a signatory to the ICPD Programme of Action, and other international conferences, is committed to improving the reproductive health of its people. In May 1996, the annual meeting of WHO/South East Asia Region developed a Regional Strategy for Adolescent Health and Development. Nepal participated in its development. The Ninth Five Year Plan and the Second Long Term Health Plan (1997-2017) have emphasised developing special programmes for both population control and reproductive health including adolescent health. This was followed by development of the National Reproductive Health Strategy in 1998, in which adolescent reproductive health was identified as a critical component of the integrated reproductive health package and thus an important indicator of the nation's overall health status.

In addition to these developments, there have been several international conferences in the past few years focusing on youth that have generated awareness and interest about adolescent health and development in Nepal. In order to address adolescent health and development issues and provide standard information and services, it is imperative to develop a comprehensive national adolescent health and development strategy.

2. Goal and Objective

2.1. GOAL

The goal of the National Adolescent Health and Development Strategy is to improve the health and socio-economic status of adolescents.

2.2 MAIN OBJECTIVES

- To increase the availability and access to information about adolescent health and development, and provide opportunities to build skills of adolescents, service providers and educators.
- To increase accessibility and utilisation of adolescents health and counselling services for adolescents, and
- To create safe and supportive environments for adolescents in order to improve their legal, social and economic status.

3. Interventions and Strategies

To achieve the above mentioned objectives, appropriate interventions will be identified and implemented through inter and intra sectoral coordination and collaboration in the following areas to achieve the objective;

- Information and skills,
- Health services and counselling, and
- Safe and supportive environment

The major interventions are:

- *Information and skills,*
- *Health services and counselling, and*
- *Safe and supportive environment.*

Youth participation, inter-sectoral collaboration and co-operation, research, strengthening programme management and gender perspective will be incorporated as integral aspects of the above interventions

The following strategies will be adopted in each area of intervention:

3.1 INFORMATION AND SKILLS

Adolescents need to be empowered with correct, age appropriate and current information and skills to develop and practice responsible behaviours to protect themselves from risks as well as to help them seek appropriate services. Information for parents, teachers and social workers is equally important as they play key roles in adolescent health and development.

Adolescents need to be empowered with correct, age appropriate and current information and skills to develop and practice responsible behaviours to protect themselves

Specific Objectives

- To increase access to culturally acceptable, appropriate and gender-sensitive information by adolescents, parents, educators and service providers including those in disadvantaged or marginalized groups such as disabled, migrants, homeless, and
- To build the skills of adolescents, service providers and educators to promote and participate in providing expanded opportunities for improved adolescent health and development.

Strategies

- Information will be made accessible through formation of committees in schools, health facilities, other vocational/technical institutions, youth clubs/centres, work places, entertainment centres, sports clubs, scout and relevant community based organisations. Existing groups will also be an important channel for disseminating information.
- All channels of mass media including print, electronic and folk media and inter-personal communication will be used to promote adolescent health and development. Partnerships and exchanges of information will be utilised via institutional networking, and
- Skills based training and orientation will be provided to adolescents, educators and service providers.

Activities

- Develop and provide a standard information package on adolescent health and development to adolescents, service providers, parents, educators, decision-makers and the community at large. The components of information and service package are given in Annex 1).
- Provide skills training to service providers and educators on counselling (which also include career development counselling) and management to deal with adolescent health and development problems. This includes skills to foster empathy, listening skills and inter-personal communication skills including peer education skills, as well as management skills including leadership and facilitation.
- Provide training to adolescents on communication, peer counselling, and negotiation skills to develop self-esteem, as well as skills for management of emotions and stress.

3.2 HEALTH SERVICES AND COUNSELLING

Adolescent comprise a special group of the population and hence their health needs should be appropriately addressed by available health care services. Health services and counselling are areas of intervention for improving adolescent health. Adolescent health care services should be adolescent friendly, affordable, accessible, confidential and non-judgmental to improve the access and utilisation health care services by adolescents.

health care services should be adolescent friendly, affordable, accessible, confidential and non-judgmental to improve the access and utilisation health care services

Specific Objectives

- To increase access and utilisation of adolescent friendly health care services in order to reduce the incidence of early frequent and unwanted child bearing, STIs including HIV/AIDS, malnutrition and other medical problems including mental health issues.
- To promote counselling services regarding adolescent health and development.
- To improve the nutritional status of adolescents with particular emphasis on the nutrition of girls, such as meeting protein and energy requirements and providing micro-nutrients such as needs of iron and iodine.

Strategies:

- Integrate adolescent health services into the existing health care delivery system and also develop innovative models for adolescent-friendly health services and provide health care services and counselling irrespective of marital status.
- Involve and establish links with youth clubs, NGOs and the private sector to expand and improve service delivery for adolescents.
- Build linkages with health facilities by establishing and strengthening youth / adolescents clubs in communities and health committee in school and provide health screening and counselling services through school, clubs and other community based organisations.
- Provide micronutrient services and impart education on nutrition and hygiene through schools, youth clubs, health institutions and community based organisations.

Activities

- Conduct adolescent friendly health clinics through existing static and out-reach service outlets.
- Provide training to service providers regarding adolescent friendly services and counselling.
- Develop monitoring and evaluation mechanisms for adolescent health
- Initiate peer-counselling programmes in schools/ clubs and at the workplaces
- Orient employees regarding health and safety measures for adolescent workers.
- Establish and support rehabilitation centers for substance abuse and destitute adolescents.

(Integrated adolescent health service and education package is described in Annex1.):

3.3 SAFE AND SUPPORTIVE ENVIRONMENT

Enabling Environment is necessary to initiate ADH

A conducive, safe and supportive environment is necessary at various levels for undertaking adolescent health and development initiatives. Legal frameworks play an invaluable role in protecting the rights of adolescents.

Specific Objectives

- To form and revise policies and laws as needed to ensure a safe and supportive environment for improved adolescent health and development in the areas of health, education, skill, welfare and rights.
- To explore and utilise the resources in related sectors for adolescent health and development.
- To enhance the use of media, NGOs and community-based organisations (CBO) for advocacy in relation to policy and legislation for ADH

Strategies

- Advocate, orient or reorient relevant sectors to review and reform existing policy and legislation to create a supportive environment for adolescent health and development,

- Strengthen the collaborative efforts between government (relevant line ministries) and NGOs for resource generation and implementation of policy and legal provisions,
- Sensitise parents, teachers and social leaders on needs and issues related to adolescent health and development through IEC and IPC (inter-personnel communication),
- Promote partnership approaches between youth clubs, CBOs and VDCs to explore and use the local resources for adolescent health and development,
- Establish linkages between health facilities and schools, clubs, workplace and vocational/technical institutions to disseminate health information and raise awareness about the available services, and
- Make legal provision to discourage the use of tobacco, alcohol, and other harmful substance by adolescents (by increasing pricing, restricting availability and promoting no smoking areas).

Activities

Policy and legislation level

- Orient Parliamentarians on the policy and legislative needs and issues related adolescent health and development.
- Orient decision-makers, planners and lawyers on implementation of policies and legislation in support of improved adolescent health and development.
- Orient local social and political leaders on ADH.

Family and community level

- To organise community sensitisation meetings with parents, teachers and other influentials on the needs and problems of adolescents.
- Involve adolescents in family, school and social activities and decision making processes to encourage participation and social responsibility.
- Implement literacy programmes for adolescents who are out of school and integrate development of self-esteem and moral values as well as adolescent health and development.
- Organise sensitisation programmes about sexual and other types of exploitation of adolescents.

- Reinforce the requirement for registration and documentation of marriages to control fake marriages.
- Conduct legal awareness programmes at the community level in collaboration with the Nepal Bar Association.

School

- Develop and implement different schemes to increase enrolment and retention of adolescents, particularly girls in school.
- Integrate adolescent health and life skills initially as extra curriculum activities and eventually in the regular curriculum.
- Establish and maintain a healthy environment within schools and build upon the capacity of the schoolteachers to guide & teach about adolescent health and development.
- Build counselling facilities within schools and ensure privacy/confidentiality and link with health facility.

Work Place

- Ensure legal contracts that will protect adolescents from exploitation.
- Ensure fair wages/income.
- Develop safety standards for physical working environments to minimise occupational hazards, including on the job injuries and environmental hazards.
- Reduce physical risks in the non-formal workplace.
- Make provisions for first aid and life saving measures for accidents.
- Build linkage with health care and education facilities.

Disadvantaged groups

- Special programmes should be designed for disadvantaged adolescents, namely disabled, migrants, refugees and homeless adolescents.
- Establish youth information centres for recreational, educational and counselling purposes.

3.4 PROMOTION OF INTERSECTORAL COLLABORATION

The AHD needs multidisciplinary and multi-sectoral initiatives. Linkages with various stakeholders are very important for ensuring adequate resource and allocated for AHD. All related sectors like education, health, population and environment, law and justice, women children and social welfare should make collaborative efforts to address the problems and issues of adolescents. The institutional framework for coordination is given in annex V.

Specific Objectives

- To foster intersectoral coordination and cooperation between various sectors for adolescent health and development at various levels.
- To promote collaborative efforts for adolescent health and development between GOs and NGOs.

Foster intersectoral coordination and cooperation between various sectors for adolescent health and development at various levels.

Strategies:

The existing Reproductive Health Committees will coordinate and support the national Adolescent Health and Development initiatives. There are two committees:

- The National RH Steering Committee (RHSE) is the policy level committee. The Secretary of the Ministry of Health chairs the meeting and other members are: secretaries of the following ministries: Education and Sports, Women, Children and Social Welfare, Local Development, Law and Justice, Population and Environment, representative of planning commission and external development partners. This Committee meets regularly to review progress in RH and identifies areas for intensified program support and provides policy direction on RH.
- The National RH Coordinating Committee (RHCC) is an implementation level committee under the Chairmanship of the Director of the Family Health Division. This Committee meets at least three times annually to review progress and achievements to date in RH and agree on collaborative work plans for all partners. The RHCC may form a separate subcommittee according to the need, like the Adolescent Health Subcommittee, RH Research Subcommittee and Safe Motherhood Subcommittee.

- At the district level, the Health and Population Sub-committee under the DDC coordinates the decentralized plans and programs regarding adolescent health and development. Similarly, district GOs/NGOs and the RH Coordination Committee also coordinate and carry out the activities regarding ADH in the district.

Activities

- Organize regular meetings of focal persons of various ministries for ADH
- Organize meetings of RHSE, RHCC and NGOCC for effective coordination.
- Use and promote the relevant organisations (professional associations: teachers' association, associations of medical professionals, journalists/media representative, legal, advertising, motion picture associations, associations of local bodies such as DDCs, VDCs and municipalities, youth co-ordination councils and the Safe Motherhood Network) by organising orientations and workshops.

(Roles of various ministries and stakeholders are given in annex III)

3.5 RESEARCH IN ADOLESCENT HEALTH AND DEVELOPMENT

Periodic research and studies are necessary for measuring impact and the effectiveness of programs.

Research is an integral part of evidence-based policy development and service delivery. However, the availability of adolescent specific information is limited for designing appropriate policies, plans and programs. Periodic research and studies are necessary for measuring impact and the effectiveness of programs. This is important to ensure the appropriate and optimum use of available resources.

Specific Objectives

- To explore and identify the research gaps in adolescent health and development and conduct relevant research studies on ADH.
- To promote the use of research findings to inform in policy development, programme planning and implementation and programme monitoring and evaluation.

Strategies:

- Collaborate with Nepal Medical Research Council and reproductive health sub committee in conducting and monitoring ADH activities,
- Develop linkages with universities, research institutions and service delivery institutions for collaborative information dissemination and service delivery,
- Develop research capabilities of selected health and development institutions to conduct appropriate research on ADH.

Activities:

- Assess and prioritize research needs on ADH
- Strengthen research institutions.
- Conduct policy, strategic operations and action research in order to better understand the dynamics of access to information and services, health care delivery systems and health care seeking behavior of adolescents.
- Disseminate the findings of research through appropriate information channels to the relevant policy makers, program managers, and other concerned persons and agencies.
- Establish and strengthen operation of a documentation center, and develop a bibliography on ADH.

3.6 YOUNG PEOPLE'S PARTICIPATION

The full and active participation of adolescents and youth is necessary for the success of adolescent health and development initiatives. For, female and adolescents of marginalized groups participation is important because they are in the greatest needs in terms of education and services.

Specific Objective

- To promote the participation of adolescents in program development and implementation processes, including research and promoting the utilization of services.

The full and active participation of adolescents and youth is necessary for the success of adolescent health and development initiatives.

Strategies

- Integrate adolescent health programme with other developmental programmes.
- Promote active involvement of adolescents and young people in the development, implementation and dissemination of information at each level.

Activities:

- Integrate adolescent health programmes with formal and non-formal technical and vocational education programmes and link such programmes with work places/factories;
- Train adolescents and youth on participatory methods such as participatory rural appraisal and participatory learning and action.
- Organise participatory planning workshops and meetings to develop plans and programmes.
- Implement and evaluate ADH plans and programs with full participation of young people;
- Develop youth as programme managers.
- Promote the participation of stakeholders in ADH plan and programmes.

3.7 STRENGTHENING PROGRAMME MANAGEMENT

Adolescent health and development is a new and sensitive subject in the context of Nepalese society, therefore, it needs modern participatory management to address the needs of adolescents adequately. Hence, program management capabilities would be strengthened by orientation and training.

Specific Objectives

- To enhance the management capabilities of the health institutions and program managers on ADH at different levels.

Strategies

- Provide orientation and training to selected service providers and managers;
- Adolescent health and development programmes will be decentralised involving DDC and VDCs.

- Formulate and strengthen adolescent health and development programmes involving relevant sectors.

Activities

- Train service providers and managers on programme management.
- Provide logistic and technical support for service delivery at all levels;
- Establish and operate supportive monitoring, supervision and evaluation mechanisms;
- Establish and integrate quality assurance mechanisms with national health quality control system.
- Develop an adolescent specific health management information system and integrate with HMIS

3.8 GENDER PERSPECTIVE

The country's demographic and disease profile and developmental indicators show the disparity between males and females, suggesting the existence of gender bias against females. Gender analysis in health care reveals males and females have differentials exposure to risk, access to benefits of technology, information, resources and health care, and the realization of rights (WHO, 1998). The health care system recognizes impact of unequal male

and female social dispositions such as power relations in general and specifically on adolescent girl's health risks and health seeking behaviors. The national health program includes gender awareness as one of the major strategies and recognizes the need for gender sensitive, equitable access to quality health services as necessary for the improved health status of the population.

*gender sensitive, equitable
access to quality health
services as necessary for the
improved health status of
the population.*

Objective:

To enhance gender equity and equality in all adolescent health and development initiatives.

Strategy

- Strengthen capacity of planners and implementers to do gender analysis for health care.

- Improve access to the benefits of technology, health care, and information about rights, and resources;
- Enhance capacity of health workers in providing gender sensitive and adolescent centered health services;
- Promote gender sensitive and adolescent centered health research, and generate gender desegregated adolescent health service data.
- Educate children and parents on the benefits of gender equality for health and development;
- Conduct advocacy for gender sensitization through mass media.

Activities

- Involve boys and girls in identifying their health needs;
- Orient policy makers, planners, and managers to gender approaches in data collection, planning, programming and management.
- Outline gender related topics to be included in the curricula at the primary, secondary and tertiary levels of education and in non-formal education packages.

4. Programme Implementation

In order to foster effectively implement ADH programmes, they should be decentralized at various levels and focused on families, communities and adolescents themselves. The VDCs, DDCs and municipalities will be responsible for co-ordinating various sectoral programmes with government, NGOs, INGOs, youth groups, etc. The program will be initiated as a pilot project and extended in phase manner.

4.1 PROGRAM INDICATORS AND OBJECTIVES

Description	Current Status	Objectives	
	Percentage	2002-2006	2007-2011
1. Decrease early age at marriage	45.5%	30%	20%
2. Decrease proportion of child bearing for 15-19 y/o	24 %	18 %	15 %
3. Increase use of family planning methods married	6.5 %	12 %	15 %
4. Increase ANC coverage (1st visit)	49.7 %	60 %	70 %
5. Increase TT coverage (two doses)	40.7 %	50 %	60 %
6. Increase knowledge of STDs and HIV/AIDS (married adolescents aged 15-19)	24.3 %	50%	75%
7. Reduce incidence of nutritional anemia among women <20 years	72%	62%	52%
8. Increase knowledge of alcohol and tobacco hazards	NA*	---	---
9. Decrease % of adolescents among drug abusers	NA*	----	----
10. Increase Gross school enrolment			
Lower secondary	53.4%		
Male	62.2%	84%	94%
Female	44.3%	72%	88%
Secondary	38.7%		
Male	47.5%	51%	59%
Female	30.0%	46%	56%

12. Increase literacy rate			
10-14 y/o:	59.8%		
Male	68.4%	47.2%	77.1%
Female	51.0%	55.5%	57.8%
15-19 y/o:	61.3%		
Male	74.5%	77.3%	78.6%
Female	48.8%	54.4%	57.2%

*Base line information need to be estimated and accordingly objectives to be specified.

4.2 LEVEL OF PROGRAM IMPLEMENTATION

At the family/community level, minimal services are provided with more focus on information, education and awareness creation activities related to adolescent health and development. There will be maximum population coverage at this level. At each higher level, more specialized services will be available.

The program activities at various levels are given in annex III.

Family Level

Community Level

Village and municipality Level

District Level

5. *Priority Setting*

Because of the discrepancy between abundant adolescent needs and scarce available resources, a need to set priority requirements exists. Priority setting at the center will be carried out on the basis of the following criteria:

- Magnitude and severity of the problem,
- Cost effectiveness of the interventions
- Program requirement (human resources, materials, equipment and technology)
- Health and education system capacity
- Cultural/political and legal factors

However, the VDCs and DDCs, with input from adolescent participants, should identify priorities according to the needs of their particular districts and communities.

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Annexes

Annex: I

Adolescent health services and education packages

Adolescent health services and education packages will include the following topics and information:

- Information, education and counselling on human sexuality regarding puberty, marriage, the reproductive process, sexual relationships and responsible parenthood for adolescents in order to develop responsible sexual behaviour among young people
- Information, education, communication, counselling and services about contraception (emphasising the prevention of early and/or unwanted pregnancies and STIs for all sexually active adolescents without discrimination)
- Information, education, counselling and services for safe motherhood (healthy pregnancy, safe delivery and prenatal care including neonatal care and breast-feeding) if adolescent pregnancy can not be or is not avoided
- Information, education and counselling on prevention and management of unsafe abortions as well as complications of abortions
- Information, education and counselling on prevention and management of RTIs, STDs, HIV/AIDS and other reproductive health conditions
- Nutritional information and education emphasising the importance of specific nutritional requirements of childhood and adolescence, especially for girls
- Information, education and communication on communicable diseases.
- Information, services and counselling, on prevention and behavioural change for smoking, alcohol, substance abuse and stress management among adolescents
- Information about life skills, career development and employment opportunities.

Annex: II

SELECTED DEMOGRAPHIC INFORMATION ON ADOLESCENT HEALTH

TOPIC	SELECTED STATISTICS	PERCENT	YEAR	SOURCE
<i>TOTAL POPULATION</i>	Population of (10-19) adolescents	5.04	2000	Population Projection
	% (10-19) adolescents among total population	million 22.2%	..	
<i>MARITAL STATUS</i>	% of males aged 10-19 among married population	10.4%	1991	Census
	% of females aged 10-19 among married population	24.4%	..	..
	% of male adolescents aged 15-19 who are married	20.6%	..	..
	% of female adolescents aged 15-19 who are married	45.5%	..	..
	Median age at marriage among women 20-24 yrs	17.1 yrs	1996	NFHS
<i>FERTILITY</i>	% of ever married women 15-19 who have begun child bearing	23.9%	1996	NFHS
	Median age at first birth among women 20-24 yrs	19.9 yrs	..	..
	% of ever married women 20-24 who had a child at age 20	51.6%	..	..
	Age specific fertility for women age 15-19 (per 1000)	132	..	..
	Fertility preference among ever married women age 15-19 - want no more children	6.9%	..	..
	- want to delay next birth for 2 yrs or more	56.1%	..	..
<i>FAMILY PLANNING</i>	% married women age 15-19 currently using FP			
	- any method	6.5%	1996	NFHS
	- any modern method	4.4%	..	..
	Unmet need for FP among married women age 15-19			
	- for spacing	38.9%	..	..
	- for limiting	1.6%	..	..
	- total	40.5%	..	..
% of current married women age 15-19 who know at least 1 FP method	96.6%	..	..

TOPIC	SELECTED STATISTICS	PERCENT	YEAR	SOURCE
<i>SAFE MOTHERHOOD</i>	Among women age 15-19 who had a live birth 3 years preceding this survey - ANC 1 visit coverage by health personnel - TT coverage one dose 2 dose - Place of delivery at health institution at home - Delivery assistance provided trained health personnel TBA Friends/relatives	49.7% 15.0% 40.7% 8.8% 90.7% 13.2% 29.2% 52.3%	1996 ,, ,, ,, ,, ,, ,, ,,	NFHS ,, ,, ,, ,, ,, ,, ,,
<i>ABORTIONS</i>	% of abortions among ever married women age 15-19	5.5%	1996	NFHS
<i>NUTRITIONAL STATUS</i>	% ever married women 15-19 with height <145cm % ever married women 15-19 with BMI < 18.5 % of anemia among women below 20 years	13.3% 30.6% 72%	1996 ,, 1998	NFHS ,, NMNSS DoHS/ UNICEF
<i>MATERNAL MORBIDITY AND MORTALITY</i>	Proportion of all maternal deaths in 15-19 y/o Proportion of RAW deaths due to suicide Proportion of RAW suicide in 15-19 y/o	20.4% 9.5% 27.8%	1998 ,, ,,	DoHS ,, ,,
<i>RTIS/STDs HIV/AIDS</i>	% of ever married women 15-19 who have heard about AIDS % of HIV positive cases aged 14-19 yrs % of commercial sex workers in Kathmandu valley with STDs	24.3% 13% 72%	1996 2000 1998	NFHS NCASC UNICEF
<i>EDUCATION</i>	Literacy among adolescents 10-14 years Total Male Female Literacy among adolescents 15-19 years Total Male Female Gross primary school enrolment rate for 6-10age group (Class 1-5)	59.8% 68.4% 51.0% 61.3% 74.5% 48.8%	1995/1996 1996, vol 1	National Living Standard Survey, CBS Education Information of Nepal 2000

TOPIC	SELECTED STATISTICS	PERCENT	YEAR	SOURCE
	Total	123.9%		MOE
	Boys	140.7%		
	Girls	106%		
	Gross lower secondary school enrolment rate for age group 10-13 y/o (Class 6-8)			
	Total	53.4%		
	Boys	62.2%		
	Girls	44.3%		
	Gross secondary school enrolment rate for age group 14-15 y/o (Class 9-10)			
	Total	38.7%		
	Boys	47.5%		
	Girls	30.0%		
<i>DRUG ABUSE</i>	% of young people age 16-20 among drug users	22.5%	1996		New Era
	% of injecting drug users who started at age 16-20	48.5%	"	"
<i>OTHER SOCIAL AND GENDER ISSUES</i>	Estimated number of female commercial sex workers <16 yrs in Nepal	5000	1998	UNICEF
	Estimated number of street children	30,000	1991	"
	Estimated number of Nepalese girls trafficked to India per year	5000-7000	?	Maiti Nepal
	Estimated number of Nepalese girls <18 working as commercial sex workers in India	60,000	1994	ABC/Nepal
	Labor force participation of children 10-14 age group	32.6%	1999	Nepal Labor Force Survey 1998/99
	- Total	25.9%		
	- Male	39.8%	"	
	- Female			
	Labor force participation of adolescents age 15-19	62.8%	"	
	- Total	58.1%	"	
- Male	67.2%	"		
- Female				

*Note:

$$\text{Gross lower secondary school enrolment rate} = \frac{\text{Number of children attending lower secondary school}}{\text{Number of children aged 10-13 years}} \times 100$$

$$\text{Gross upper secondary school enrolment rate} = \frac{\text{Number of children attending secondary school}}{\text{Number of children aged 14-15 years}} \times 100$$

Annex: III

Program/Activities by Level

FAMILY/INDIVIDUAL LEVEL¹

Activities to increase awareness and improve behaviour in relation to adolescent development and health (ADH) will include:

1. Increase awareness on a broad range of health and development issues of married/unmarried and pregnant/non-pregnant adolescents
2. Increase communication between parents and adolescents on adolescent health and development issues, namely physical, psychological and behaviour changes in puberty, age at marriage and pregnancy, including risk of teenage pregnancy and unsafe abortion, education on sexuality and HIV/AIDS/STD, substance abuse, education of girl child and nutrition, particularly for girls
3. Disseminate information about gender equity and equality

COMMUNITY LEVEL

Activities:

1. Information, education, communication and counselling on a broad range of adolescent issues of married/unmarried and pregnant/non-pregnant adolescents to parents, teachers and community leaders
2. Increase communication between parents and adolescents on adolescent development issues and family life education (namely physical, psychological and behaviour changes in puberty, age at marriage and pregnancy, including risk of teenage pregnancy and unsafe abortion, education on sexuality and HIV/AIDS/STD, substance abuse, education of girl child and nutrition, particularly for girls)
3. Information, education and communication on communicable diseases.
4. Information and service on contraceptive methods as well as distribution of pills and condoms to adolescents in need (who are sexually active)
5. Discussions of ADH issues in mothers group meetings through trained female community health volunteers and other social workers.
6. Establish and promote adolescent/youth centres in the community to support adolescent issues and promote peer-education in formal and non-formal settings and make access to the information on health and career development.
7. Information about gender equity and equality.
8. Promote positive and moral values among adolescents.
9. Promote school enrolment and retention of students, especially for girls.
10. Disseminate information about life skills, career development and employment opportunities.

VILLAGE AND MUNICIPALITY LEVEL

Activities:

1. Develop VDC, MDC level plans and programmes for ADH services and education and implement in collaboration with health institutions, schools, Community Based Organisations (CBOs), etc.
2. Provide adolescent friendly health services and counselling, including referrals
3. Conduct family life education at clinics, which address parent/adolescent communication, age at marriage and pregnancy, nutritious food and education to adolescents, particularly to adolescent girl;
4. Organise school health programmes for health screening and linking with services and the teaching of life skills;
5. Referral to higher level health care facilities for services which are not available at lower level facilities
6. Promote school enrolment and retention of students, especially girls
7. Disseminate information about life skills, career development and employment opportunities

DISTRICT LEVEL

Activities:

1. Develop, implement, monitor and evaluate district level plans and programmes for adolescent health and development in collaboration with health and development institutions, schools, CBOs, etc.
2. Provide a wide range of adolescent friendly services in collaboration with health sector organisations such as District Health Office, District Hospital and NGO's
3. Foster intersectional co-ordination at district level
4. Mobilise resources at the district level to support adolescent health and development programs.

Annex: IV

Roles and Responsibilities of Stakeholders Safe and Supportive Environment:

A. Social Recognition

Strategies and Intervention	Lead Agencies	Supporting Agencies	Indicators
Empowerment of adolescents through: <ul style="list-style-type: none"> - IEC - Skill development - Reproductive rights and legal provisions 	MOE/MOPE	MOH, NYCC, Youth organisation, Scouts, NGOs, INGOs, MOPE, MoHome, MWSW, Min. of Law, NRCS	No. and types of activities
Empowerment of parents, family, community and teachers through: <ul style="list-style-type: none"> - Sensitisation - Capacity building - Dialogue - Counselling 	Nepal Youth Co-ordination Council	MoH, MoE, NGOs, INGOs, Donor agencies, teachers associations, NRCS, schools, independent resource centers	No. and types of activities
Mobilisation of media for positive role models to spread messages and increase self-esteem and moral values	Min. of Information and Communication	MOH, MOE, Advertisement Association (AAAN), Motion Picture Association, Journalists Association	Change in types and quality of messages No of programmes with positive messages
Mobilisation and involvement of adolescents	MOE	MOH, NYCC, Youth organisation, Scouts, NGOs, INGOs, MOPE, Home Ministry, MWSW, Min. of Law, NRCS	Increase in involvement of adolescents in planning and implementation process

Roles and Responsibility of Stakeholders Safe and Supportive Environment:

B. Prevention of Early Marriage

Strategies and Interventions	Lead Agencies	Supporting Agencies	Indicators
Correct discrepancies and provide uniformity between legal, social and health related messages	MWSW Safe motherhood Network, MOH	Min. of Law, MoH, women's organisations, AAAN	No. of discrepancies corrected
Advocacy to increase legal age at marriage by consent and narrow the gap between male and female age at marriage	MWSW, Safe motherhood Network,	MoH, MoPE, Population Council, advocacy groups, FPAN, PAN, Nepal Bar Association, NGOs/INGOs	Increased age at marriage
Advocate for changing parental attitudes and norms concerning early marriage	Association of DDC of Nepal(ADDCN), Association of VDCs	Various associations, Journalist Association, NGOs, MoH, Ministry of Communication, FCHV and mothers group	Change in opinion (opinion survey)
Increase enrolment and retention of girls in schools	MoE, MWSW	ADDCN, VDC Associations, housewife organisation, political parties	Increase enrolment and retention of girls

Roles and Responsibility of Stakeholders Safe and Supportive Environment:

C. Labour and Poverty

Strategies and Interventions	Lead Agencies	Supporting Agencies	Indicators
Ensure and enforce child rights (including adolescent rights)	MWSW	MoH, MoL, NGOs, SOS, other child specific NGOs, INGOs	Governments' follow up report
Equal opportunities and uniformity in wages for male and female adolescents	Ministry of Labour	Ministry of Industries, MWSW, Trade Unions, FNCCI	Male and female ratio in employment sees changing trends
Promote safety, security and health care at workplace	Ministry of Labour, Trade Unions, MWSW	NGOs/INGOs (related to child welfare), SWC	No. of programmes
Promote programmes that integrate work and education for disadvantaged adolescents	Ministry of Labour, MOE, Ministry of Women, Children and Social Welfare, Social Welfare Council	CTEVT, vocation training centres, private training and consulting organisations	No. of training
Provide vocational training and enterpreuternship training with the aim of self-employment	Ministry of Education	CTEVT	Employment rate of adolescents

Roles and Responsibility of Stakeholders Health Services and Counselling:

Strategies and Interventions	Lead Agencies	Supporting Agencies	Indicators
Develop innovative models: <ul style="list-style-type: none"> • Link work place to health facility • Orient employers • Link school health programmes to health facilities (PHC) 	MOL, MOW & Social Welfare MOH MOE	MOH, MOL, MOW and Social Welfare MOH	No. of workplaces linked with health facilities
Involve youth clubs, NGOs and private health sector: <ul style="list-style-type: none"> • Establish youth information centres • Form community based clubs for Kishories • Mobilise scout and sport groups • Mobilise Junior Red Cross 	MOH Youth Clubs MOE NRCS	MOE, MOWC&SW Ward, community, VDC and health sector organisations MOH MOE, MOH	No. of NGOs and private sector organisations involved in adolescent health and development No. of youth information centres No. of adolescent education groups, scout groups, sport groups and Junior Red Cross groups
Service provision: <ul style="list-style-type: none"> • Train health care providers in counselling and adolescent friendly services, both pre-service and in-service • Strengthen adolescent program management capacity 	Public and private universities, CTEVT, MOH,/DHS MOH/DHS	MOH, universities, NGO/INGO, Hospitals Donors, NGOs, INGOs	No. of health service providers who have received orientation on how to provide adolescent friendly services

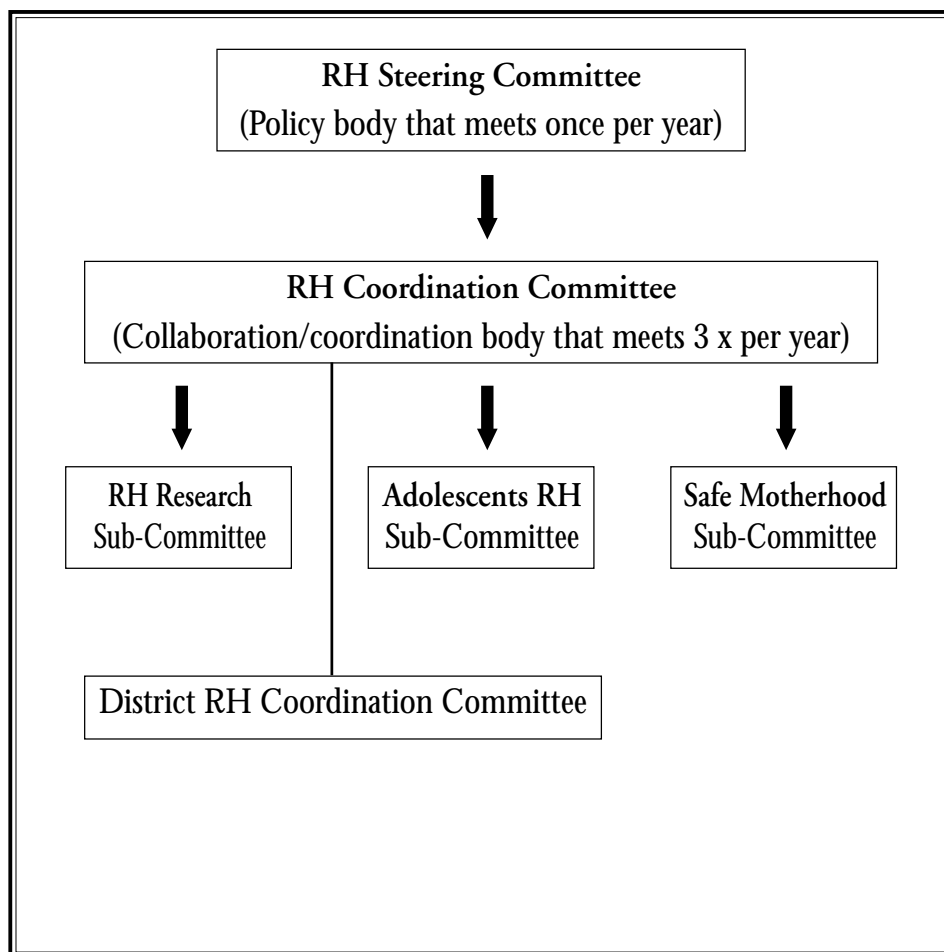
Provision of contraceptive care and nutritional services to adolescents from all existing public and private health institutions without discrimination	MOH/DHS	Donors, NGOs, INGOs and private institutions	% ANC/PNC coverage % of delivery conducted by skilled worker % adolescent clients served % TT coverage % Iron supplements
Provision of ANC, PNC and EOC at PHC and district hospitals	MOH/DHS	Donors, NGOs, INGOs	No. of referral cases; guidelines produced, distributed and used for contraception among adolescents
Adolescent focus on existing HIV and STD cases, as well as TB programs	MOH/DHS., National AIDS Centre	NGOs, INGOs, UNAIDS	Availability of policy documents, number of adolescent served; No. and type of material for advocacy and IEM produced
Programmes for prevention of substance abuse among adolescents	MOH./FHD, Mental Health, AIDS Project	MOE	No. of programmes; service statistics
Special programme targeted at adolescents for prevention of anaemia, malnutrition and de-worming: link to school health	MOH	MOE	No. of school and health facilities providing such programmes; No. of adolescent beneficiary

Roles and Responsibility of Stakeholders Information and Skills:

Strategies and Interventions	Lead Agencies	Supporting Agencies	Indicators
Incorporate practical life skills & RH topics in the current curricula of teacher, students & health workers in formal & non formal education	MOE	MOH & other relevant donors INGOs, NGOs, MOPE	Developed modified curricula
Develop/enhance the communication and dissemination skills of teachers and service providers	MOE & MOH		Programmes developed and implemented
Develop specific information packages based on gender, religion and socio-economic background to address the informational needs of adolescents	MOH	MOWD, MOE, MOPE, MLD, Donors, NGOs, INGOs	
Advocate and promote gender understanding of adolescent biological, physical, social and developmental needs among and to parents, guardians, teachers and communities	MOE	MOWD, MOH, MOLD, MOPE, Adolescent/Youth groups	
Dissemination of adolescent friendly information using appropriate and effective media	MOIC	MOH, MOE, MOPE, associations, local clubs	
Establish/promote access to adolescent-friendly information through different forums (e.g. youth centres, youth clubs, schools)	Youth Development Division/MOE	MOH, MOPE, health institutions, social organisations	
Involve and empower adolescents in all stages of programme development, implementation and M & E Research adolescent health and development issues	NPC MOH, MOE, MOPE	Adolescent/Youth groups NHRC, other research agencies	

Annex: V

Institutional framework



Annex: VI

General Indicators for Adolescent Health and Development

Adolescent Empowerment Indicators

Indicator	Flow/Source	Level
1. Literacy rate of Adolescent (Boys and girls)	Census/Survey	National/District
2. Enrollment of Adolescent girls and boys at school (primary and secondary)	Census/Survey MOE	National/District
3. Percentage of adolescent who have knowledge on adolescent health	Survey	National/ District
4. Percentage of Adolescents competent in on vocational and managerial skills.	Annual Report of MOE	National/District
5. Age of women at first marriage (average)		
6. Percentage of Adolescent Marriage	Census/Survey(DHS)	National/District

Service Delivery Indicators

Indicator	Flow/Source	Level
1. Utilization of Adolescent Health Services /counseling	HMIS Record	At all levels
2. Contraceptive prevalence among adolescents age 15-19	HMIS	At all levels
3. Percentage of adolescent pregnant mothers who had ante-natal care	HMIS tool/DHS Survey	At all levels
4. Percentage of abortion among adolescents		
5. Percentage of adolescent deliveries attended by trained personnel	HMIS tool/DHS Survey	At all levels
6. Percentage of adolescent mother receiving post-natal care	HMIS tool/DHS Survey	At all levels
7. No. of health facilities providing adolescent health services (as per national guideline) by type of health facilities	DHO/PFAD/HMI DD	National/District
8. Percentage of obstetric complication and STD cases among adolescent referred and managed	HMIS tool	District
9. Percentage of adolescent who are anaemic and received iron folate	Program Report	District

Quality of Care Indicators

Indicator	Flow/Source	Level
1. The method continuation rate of family planning acceptors among adolescent	HMIS/Record follow-up	National/District
2. Percentage of adolescent mothers who had at least four ante-natal visits	HMIS record	At all levels
3. Percentage of service providers and educators who are trained on adolescent health and development	Training Reports	
4. Availability and adherence of guidelines and protocols regarding different elements of reproductive health at different levels	FHD/RHD	At all levels
5. Regular updating of knowledge and skills of service providers	NHTC/FHD	National/District
6. Availability of adolescent friendly service facilities	HMID/FHD divisions	District/National

Impact Indicators

Indicator	Flow/Source	Level
1. Adolescent age specific fertility rate (15-19 age group)	Periodic survey	National/Regional
2. Percentage of adolescent child bearing (15-19 age group)	Periodic survey	
3. Maternal mortality ratio among 15-19 age group	Periodic survey	National/District
4. Prevalence of anemia among adolescent	HMIS record	National/District

