FIVE-YEAR STRATEGIC PLAN FOR YOUNG PEOPLE'S HEALTH

(2016-2020)

Department of Public Health
Ministry of Health, Myanmar

Foreword

Attaining highest level of health in young people to ensure that every young person's potential is fulfilled is one of the core priorities of Myanmar Health Vision 2030. To this end the national Strategic Plan for young people's health is developed. This requires increasing access to information and services, and creating safe and protective environments for young people to improve their health and wellbeing including health system strengthening, development of human resources for health with skills to engage with young people and provide youth friendly health services, health research and strengthening collaboration with national and international partners. It also entails annual planning and monitoring for effective delivery mechanism and mobilizing necessary resources to achieve the goals and deliver results.

The National Strategic Plan for Young People's Health (2016- 2020) aims at strengthening the existing policy framework and programmes and is based on the following guiding principles;

1. Life-course approach: adolescence is a key decade in the course of life that influences the health outcomes later in life.

2. **Comprehensive approach: It recognizes the** cross cutting health and development needs of young people such as intentional and unintentional injuries and violence, SRH, HIV/AIDS, mental health, substance use, violence, substance use and substance use disorders, infectious diseases and common conditions.

3. **Equity and rights-based approach: focusing on equitable access to services to all adolescents including vulnerable groups and the** recognizing the need to move from aspirations to obligations in fulfilling young people rights for the highest attainable standard of health through the provision of accessible, acceptable and effective health care.

4. **Multisectoral approach:** recognizing cognizant of the fact that holistic development of young people requires multisectoral approach involving education, social welfare. Also address non health issues for the development of adolescents; a multi-sectoral framework needs to be developed. .

5. **Partnership, coordination and joint programming** among stakeholders including UN agencies, professional organizations, civil society organizations and communities and others to maximize resources and to avoid duplication of efforts.

The National Strategic Plan for Young People's Health was developed in a participatory and consultative manner, under the auspices of the Ministry of Health. Throughout the developmental process, key staff from governmental, non-governmental, university, and UN organizations provided insight and feedback.

Acknowledgement

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We appreciate the contributions of all who attended the participatory workshops and provided their expertise and experiences in working with young people towards the development of this Strategic Plan. To ensure continuum of care approach this will feed into the integrated National Strategic for RMNCAH. On behalf of the Ministry of Health, the Department of Public Health and the Health Pormotion and Health Education Division, Adolescent Health Programme, we would like to express our sincere gratitude to those who devoted their efforts in developing this Plan. Particular thanks go to the WHO and the United Nations Population Fund in Myanmar for providing financial and technical support to develop this strategy.

Contents

List of Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ARH	Adolescent reproductive health
ART	Antiretroviral Therapy
ASEAN	Association of South East Nations
AYH	Adolescent Youth Health
CRC	Convention on the rights of the Child
DOPH	Department of Public Health
DTC	Drug treatment center
GSHS	Global School based Health Survey
GYTS	Global Youth Tobacco Survey
HCT	HIV counselling and testing
HE	Health Education
HEB	Health Education Bureau
HIV/AIDS	Human Immune deficiency Virus/ Acquired Immune Deficiency Syndrome
HSS	HIV sentinel surveillance
ICD	International Classification of Diseases
ICPD	International Conference on Population and Development
IEC	Information, Education and Communication
KTV	Karaoke
MANA	Myanmar Anti-narcotics Association
M-CCM	Myanmar Country Coordination Mechanism
MHSCC	Myanmar Health Sector Coordination Committee
MDG	Millennium Development Goals
MMA	Myanmar Medical Association
MMCWA	Myanmar Maternal and Child Welfare Association
MMT	Methadone Maintenance Therapy
MOH	Ministry of Health
MRCS	Myanmar Red Cross Society
MSI	Marie Stopes International

MSF	Medecins Sans Frontieres
MW	Midwives
NCDP	National Comprehensive Development Plan
NGOs	Non-Governmental Organization
NSP	National Strategic Plan
OPD	Out-patient Department
PLHIV	People Living with HIV/AIDS
PWID	People who are Injecting drugs
RH	Reproductive health
RHC	Rural health centre
SARA	Substance Abuse Research Association (SARA)
SC	Save the Children
SH	School Health
STI	Sexually Transmitted Infections
TB	Tuberculosis
TFR	Total Fertility rate
TH	Township Hospital
TMO	Township Medical Officer
UN	United Nations
UNESCO	United Nations Education, Science and Culture Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Fund
UNODC	United Nations Office for Drug Control
VCCT	Voluntary Confidential Counselling and Testing
VHW	Voluntary Health Workers
WHO	World Health Organization
YFS	Youth Friendly Services
YIC	Youth Information Corner

1. Introduction

1.1 Geography and demographic profile

Myanmar covers an area of 676,578 square kilometres and is the westernmost country in South-East Asia. Myanmar shares borders with the People's Republic of China on the north and northeast; with Lao People's Democratic Republic and the Kingdom of Thailand on the east and southeast, the People's Republic of Bangladesh and the Republic of India on the west. 1760 miles of the coast-line is bounded on the west by the Bay of Bengal and on the south by the Andaman Sea. The country is divided administratively into Nay Pyi Taw Union Territory and (14) States and Regions.

According to the Myanmar Population and Housing Census -2014 the total population of Myanmar is 51.4 million, with a population density of 76 per square kilometer. With an annual population growth rate of 0.89%, 70 percent of the population are residing in the rural areas, whereas the remaining are urban dwellers. 65.6% of the population is between the age of 15-64 years, 0-14 year group comprising 28.6% and 5.8% for those over 65 years of age and above. Out of the total population nearly 60% of the population is made up of women and children. There are approximately 16 million young people (10- 24) years in Myanmar which accounts for 28 % of the population.

Myanmar's population is in its last stage of a demographic transition where there is the decline in proportion of those under 15 years of age and increase in the population from 15 to 49 years of age and for elderly population of over 60 years The number of young people increased by 0.6% in 2001-2002, 0.9% in 2004-2005, and about 3.8% in 2007 . This pattern of decline in fertility below replacement level and low dependency ratio and increase in the working age group has been regarded as a demographic window of opportunity. Considering that there are proactive interventions and by proper planning of existing human resources and investment in human capital, job creation to absorb the working age population with relevant skills and knowledge could result in economic growth and increase in GDP per capita.

1.2 Young people's health in international health agenda

Defining terms: The World Health Organization (WHO) defines *adolescents* as those people between 10 and 19 years of age. The great majority of adolescents are, therefore, included in the age-based definition of "child", adopted by the *Convention on the Rights of the Child,*[1]as a person under the age of 18 years. Y*outh* are defined by the United Nations as 15–24 years, and *young people* (10–24 years), is term used to combine adolescents and youth.

Over the past two decades, there has been a spate of reports and advocacy documents,[2345678910 11] declarations[12 13] and milestone publications in academic journals[14 15 16 17] devoted to the health and development of adolescents. There are global goals and targets directed to young people,[18 19 20 21] and adolescents and youth are key to on-going[22 23] and emerging public health agendas,[24 25] to the plans for the International Conference on Population and Development (ICPD) Beyond 2014[26 27] and, increasingly, to discussions about the post-2015 Millennium Development Goals (MDGs).[28 29] There has been attention to adolescents in global public health conferences,[30] and young people have been the focus of several recent United Nations initiatives[31 32 33] and resolutions.[34 35] Progress has been made in generating interest and commitment for adolescent health at global,[36 37] regional[38] and, increasingly, national levels.[39]

The Government of Myanmar is signatory to the Convention on the Rights of the Child , the Programme of Action of the International Conference on Population and Development, the Millennium Declaration and the WHO Global Reproductive health Strategy; and has pledge to undertake appropriate the Millennium Declaration Goals and the United Nations Secretary General's global Strategy for Women's and Children's health ; highlighting the government's commitment to the international development agenda. These agreements have committed governments to protect and promote the rights of young people to reproductive health education, information and care to ensure a healthy transition into adulthood. This policy, in turn, provides direction to the National Health Policy.

1.3 Young people's health in Myanmar

Based on primary health care approach, the Ministry of Health have formulated four-yearly People's Health Plans from 1978 to 1990, followed by National Health Plans from 1991-1992 to 2006-2011. These plans have been formulated within the framework of the National Development Plans for the corresponding period. National Health Plan (2011-2016) in the same vein was formulated in relation to the fifth five years National Development Plan. It is also developed within the objective frame of the short term first five year period of the National Comprehensive Development Plan (NCDP) – Health Sector, a 20 year long term visionary plan (first drafted in 2011) that provides long-term guidance on which further short-term national health plans are to be developed.

The current National Health Plan (2011-2016) is developed around the 11 health program areas, within the context of strengthening the health systems and the growing importance of social, economic and environmental determinants of health. One of the core areas is improving Health for Mothers, Neonates, Children, Adolescent and Elderly as a Life Cycle Approach

The National Strategic Plan for Reproductive Health in Myanmar (2014- 2018) was developed and launched in 2014. This is to ensure an effective and coordinated response to reproductive health needs of women, men, adolescents and youth in Myanmar. An integrated RMNCAH National Strategic Plan is in the process of being developed to ensure streamlining and integration of plans to ensure continuum of care approach with a vision of Universal health coverage in Myanmar by 2030.

National strategic plan on HIV/AIDS for 2011-2016 aims to reduce HIV transmission and HIV-related mortality, morbidity, disability and social and economic impact. Reducing HIV-related risk, and vulnerability among young people is one of the priority intervention.

Ministry of Social Welfare being the focal ministry for preparation of the Youth Policy is in the process of developing a Youth Policy This youth policy will be crucial to sustain the implementation of programmes for young people for effected utilization of available health services.

1.4 Rationale for new strategic plan

Young people aged 15 to 24 years constitute 28% of the country's population. Adolescence is the second decade of life with specific health and developmental needs and rights.[40] It is also a time to develop knowledge and skills, learn to manage emotions and relationships, and acquire attributes and abilities that will be important for enjoying the adolescent years and assuming adult roles.[41,42]

Secondly, emphasis on adolescence in terms of health, education and skills will have profound implications for social and economic development. Over the past years, the economic rationale for investing in young people health has been strengthened from a number of different perspectives.[43,44] The collection and analysis of data on programme and intervention costs have increased,[45,46,47] and some initial efforts have explored cost-effectiveness.[4849] There have also been developments in assessing the economic impact of investing in adolescent health,[50] and there is now a strong economic case to be made for a number of interventions that are implemented during the adolescent years.[51]

Third, healthy, educated, skilled adolescents are an asset and resource, with great potential to contribute to their families, communities and countries. Over the years the there is a growing recognition that adolescents are actors in social change, not simply beneficiaries of social programmes.

The Ministry of Health is committed to promoting and maintaining the health status of youth through Youth Health Project in collaboration with related sectors. Improving their access and utilization of services, information and skills, improving socio-economic conditions and creating an enabling environment are set as main strategies. However, inadequate financial resources, to expand youth programmes, limited capacity of competent educators to conduct life skills and sexuality education, and lack of trained primary health care personnel, turnover of trained young people as peer educators both in urban and rural areas are some of the primary challenges and constraints in effectively implementing and sustaining the adolescent health programme.

The New FIVE-YEAR STRATEGIC PLAN FOR YOUNG PEOPLE'S HEALTH (2014-2018) is based on the experiences and learnings of previous National Strategic Plan on Adolescent health and Development (2009-2013).There is recognition, that despite political commitment and continuous efforts by Ministry of Health and its partners, the status of young people in Myanmar need to be improved further. The Ministry of Health and all line Ministries recognize the need for the improvement in the delivery mechanism and broadening the services package for the young people.

2 Situation analysis

2.1 Health System Infrastructure

The Ministry of Health is responsible for improving the health status of the people and accomplishes this through the provision of comprehensive health services: promotive, preventive, curative and rehabilitative measures. The Union Minister who is assisted by two Union Deputy Ministers heads the Ministry of Health (MOH). The MOH has six departments, each under a Director-General. The Department of Public Health (DPH) the Department of Medical Care (DMC), Department of Health Professional Resources Development and Management (DHPRDM), Department of Food and Drug Administration (DFDA), Department of Medical Research (DMR) Department of Traditional Medicine (DTM). The Department of Public Health is responsible for primary health care and basic health services, nutrition promotion and research, environmental sanitation, maternal and child health services, school health services, health promotion and health education. The Health promotion and Health Education unit headed by a Director is focal to young people's holistic development. The School Health unit also is responsible for in school health.

Maximum community participation in health activities is encouraged. Collaboration with other related government departments and social organizations has been promoted by the MOH. In order to involve the health sector as a whole the MOH is strengthening public private partnership for health. The MOH also has a close collaboration with other sectors to take into account issues that are beyond the scope and capacity of the health sector.

The Township Health System is the backbone of the Myanmar Health System. The Township Health Department provides primary and secondary health care services down to the grassroots level. It usually covers 100,000 to 200,000 populations. Under the Township Health Department, there are Urban Health Centres, School Health Team, Maternal and Child Health Team, one to three Station Health Units and four to five Rural Health Centres (RHCs). One rural health centre covers 20,000 populations and sub centre covers 5,000 populations. In the Township Health Department, the Township Medical Officer (TMO) is the key person managing health care delivery and is also responsible for administration and implementation of health care activities. Each township has four to five Rural Health Centres and each RHC has four sub-RHCs. One Health Assistant, one Lady Health Visitor, five Public Health Supervisors Grade II and five Midwives (MWs) staff each RHC. They are not only responsible for providing public health, disease control and curative health services but also have administrative and managerial functions.

At the village level, voluntary health workers (VHW) provide delivery of and linkages to health services. A midwife located at a sub-rural health centre supervises VHWs - auxiliary midwives and community health workers.

Referral hospitals at the district level with medical specialists including an obstetrician/gynaecologist and a paediatrician provide specialized services to townships under the jurisdiction of the district.

2.2 Coordinating stakeholders

The Ministry of Health collaborates with The Ministry of Education and Ministry of Relief, Resettlement, Ministry of sport and Social Welfare for multisectoral response to holistic health Development of young people. The Department of Education Planning and Training and the Department of Basic Education of Ministry of Education is responsible for primary, secondary and high schools. The teachers are trained to carry out activities on school health including adolescent health, sexual and reproductive health including delivering the life skills curriculum. However, the teachers are not well equipped with teaching skills to relate to young people about ASRH. There is need to build capacity in teaching skills for specific ASRH issues. The Department of Social Welfare under Ministry of Relief, Resettlement and Social Welfare's Child and Youth Division also responds to adolescent health, including out of school children.

2.3 The health status of young people in Myanmar

The main problems faced by young people are intentional and unintentional injuries, consequences of interpersonal violence, risk taking behaviours resulting in sexual and reproductive health problems including unintended pregnancies and its consequences, HIV/AIDS, substance use (tobacco, alcohol and other substances) and substance use disorders, mental health problems, under nutrition and micronutrient deficiencies, and infectious diseases such as tuberculosis, malaria. In addition, many common symptoms such as headache and fatigue, problems such as skin conditions and excessive or painful menstruation are poorly managed. (Please refer the Annex – 1 for detailed description).

2.3.1 Sexual and Reproductive Health

- Overall 7.4 % of adolescent girls age 15- 19 are married.
- Nearly two per cent had their first birth before age 15 and over 25% had their first birth before age 20.
- Among currently married women of at least one contraceptive method is slightly lower among women aged 15-19 and 45-49 than women who are 20-24 years.
- A greater proportion of teenage begin childbearing in rural areas (57%) than in urban areas (47%).

2.3.2 HIV/AIDS among young people

- Myanmar also has one of the most severe HIV/AIDS epidemics in Asia. The HIV prevalence rate for the adult population was 0.53% in 2011 with an estimated 240,000 people living with HIV.
- According to sentinel surveillance, HIV prevalence among youth was as follows:
- Female sex workers aged 15-19 year and 20-24 years were having 5.5% and 7.9% respectively in 2013
- IDUs aged 15-19 year and 20-24 years were having 13.8% and 17.6% respectively in 2014 (GARP Validation Meeting, Nay Pyi Taw, 2015)
- It was 9.1% and 8.6% among men sex with men (MSM) aged 15-19 year and 20-24 years in 2013 respectively.

- Young people (pregnant women aged 15-24 years) was 0.7% in 2012

2.3.3 Nutrition related problems

- A total of 45% of non-pregnant women of reproductive age group and 26% of adolescent school girls being anaemic.
- Nutritional status of adolescent students in 2002 reported that stunting of growth among 37.6% of boys and 30.4% of girls.

2.3.4 Substance use and abuse (tobacco, alcohol and other substances)

- Global School-based Student Health Survey (GSHS) in 2009 showed less than 1% of students reported consumption of alcohol during the past 30 days.
- The Global Youth Tobacco Survey (GYTS) conducted in 2001-2007 revealed that one in five young people use some form of tobacco in Myanmar.
- The prevalence of tobacco use among school going young people as follows: (GYTS 2011)
    - 18.6% currently use any tobacco products (Boys = 30.0%, Girls = 6.8%)
    - 6.8% currently smoke cigarettes (Boys = 13.0%, Girls = 0.5%)
    - 4.2% currently use any other smokeless tobacco products other than betel quid

      (Boys = 6.9%, Girls = 1.4%)
    - 17.4% currently used tobacco products other than cigarettes (Boys = 27.8%, Girls = 6.7%)
    - 13.8% currently use any smoked tobacco products (Boys = 23.5%, Girls = 3.6%)
    - Prevalence of Smoking among male students (13-18 years) was 23.5% and smokeless tobacco use was 15.2%.
- Myanmar remains the second largest opium poppy growing country after Afghanistan, contributing 20% of opium poppy cultivation in major cultivating countries in 2008.
- The Government of Myanmar reports that an estimated 83,000 (2014 IBBS) people inject drugs in the country.

2.3.5 Intentional and unintentional injuries

- Road traffic injury (RTI) is the leading cause of injury among the injuries and it was second major causes next to drowning (50.5%) for deaths among to injuries in Myanmar (2005-2009).
- During 2011, out of all hospital cases for injury are about 21.11% for the 15-19 age group. Total numbers of injury cases were 16,337 cases among which male was 12,172 and female were 4,145 cases (annual hospital statistics report 2010-2011).
- GSHS 2007 found a high prevalence of violence and unintentional injury among school-going children in Myanmar.

- Students who were physically attacked one or more times during the past 12 months 20.8%

- According to Injury Surveillance Report (2010-2013), those in the 15-29 years age group were highest number injured. Transport injury is the leading cause of injury (37% among male and 35% among female). More than 13.5% of children and adolescent were injured in traffic accidents. Injuries at school and sport ground were high for the children under 15 years of age. Among the injuries and death, 40% were between 15-29 years of age. The majority of injuries from assaults were teenagers.

2.3.6 Infectious diseases

- Malaria risk in Myanmar is linked to population mobility induced by economic activity or security, notably development projects including dam construction, mining, logging, road maintenance, and associated migration for work or resettlement.

- Large number of adolescent was reported to be internally migrating for economical reason and they are at greater risk of malaria infection.
- Myanmar is one of the world's 22 high tuberculosis (TB) burden countries, with a TB prevalence rate three times higher than the global average and one of the highest in Asia.

2.3.7 Mental Health

- In Myanmar, neuropsychiatric disorders are estimated to contribute to 9.2%of the global burden of disease (WHO, 2008).

Each year an estimated 20% of adolescents experience a mental health problem: Most commonly the problem is major depression or other disturbances of mood.

2.4 Response to improve health status of young people by Ministry of health

2.4.1 Adolescent health programme

Ongoing activities conducted for adolescent and young people

1. National Standards and Guideline for Adolescent and Youth Health were developed and launched in 2013.

2. A national consultation workshop was held from 23 to 26 July 2013 to prepare for the adaptation of the Adolescent Job Aid in Myanmar context

3. Awareness raising on health messages for young people was done up to achieve positive behaviour change using appropriate and effective media and through peer education and counselling programmes

4. Integration and collaboration with stakeholders and implementing partners at all level for outreach activities, quality youth health services and effective monitoring and evaluation

5. In order to ensure Youth friendly health services a manual for youth friendly health services for BHS was developed and disseminated. It is at importan tto train BHS to provide the required package of health information, counselling, commodities and services either on the spot or through referral. Youth friendly health services were being implemented and expanded beyond 71 townships in 2014 to nationwide.

2.4.2 Sexual and reproductive health programme

In the previous decade, the Reproductive Health Policy and Strategic Plans on Reproductive Health (2004-2008 and 2009- 2013) of the Ministry of Health (MoH) were the national response to the Programme of Action of the International Conference on Population and Development (ICPD PoA) and the United Nations Millennium Development Goals (MDG). Building on this momentum, the newly developed 2014-2018 Strategic Plan will respond, in addition, to the UN Secretary-General's Global Strategy for Women and Children's Health (2010).

An essential package of RH interventions, including adolescent reproductive health for provision at health centres and township hospitals and in the community has been defined to provide continuous care across life stages and from home to hospital. The planned strategies and key activities for effective and efficient implementation of the RH Strategic Plan are (i) strengthening health systems to enhance the provision of an essential package of RH interventions (ii) increasing access to quality, integrated RH services at all levels of care (iii) engaging the community in promotion and delivery of RH (iv) incorporating gender perspectives in the RH Strategic Plan, and (v) integrating RH in humanitarian settings.

The following activities are currently undertaken:

- Development of ARH guideline and training manuals
- Advocacy meetings for RH services for local authority, health care providers, community including young people and parents

- ARH Counselling training for Basic Health Staffs
- Safe motherhood and Birth spacing services for youth (peer education, outreach services)
- Youth Information Corners (YIC) in RH townships RHC (71 townships), library, sports, entertainment and health education
- RH Behaviour Change Communication Advocacy and Training by HEB in RH townships
- Development and distribution of training manuals for peer education on ARH

2.4.3 HIV/AIDS programme

The government of Myanmar adopted a National Strategic Plan on HIV and AIDS (2009-2015) that maintains a dual focus on scaling up access to HIV prevention as well as treatment and care. The National Strategic Plan has a vision of achieving HIV-related MDG targets, and aims to reduce HIV transmission and HIV-related morbidity, mortality, disability and social and economic impact. Its objectives are to reduce HIV transmission and vulnerability, particularly among key populations, to improve the quality and length of life of people living with HIV through treatment, care and support, and to mitigate the social, cultural and economic impacts of the epidemic.

Under the leadership of National AIDS Programme, Department of Public Health and in collaboration with social services, and nongovernmental organizations and private sector bodies are officially involved in the provision of services for both in school and out of school young people.

Around half of the young people reached are female. Apart from National AIDS Programme, five organizations are involved in this activity and they are MANA, MMA, MSF (Holland), MSI and Save the children.

A national HIV legal review report was launched which calls for immediate and long term legal reform and capacity building to ensure access to health and HIV prevention and treatment services for people living with HIV (PLHIV) and key affected populations. The report, a collaboration between UNAIDS, the United Nations Development Programme (UNDP), and Pyoe Pin (DFID supported community programme), provides evidence of widespread stigma and discrimination of PLHIV and key affected populations in employment, education and the provision of health care and other services and offers strong recommendations to improve the legal framework and create a more enabling environment for HIV response. The following programmes are being conducted by National AIDS Programme:

Advocacy and aware trainings were conducted for both general population and targeted population including young people an most at risk populations

- Leadership and behaviour change communication trainings are conducted for young key affected populations.
- Trainings of trainers on peer education are being conducted to perform outreach activities among the community.
- To increase synergy on its implementation, MOH and Ministry of Education have jointly collaborated to conduct the health education sessions in the schools particularly focus on adolescent reproductive health.

- Sexual and Reproductive Health trainings are conducted for high school and university students
- Providing services tailored to the needs of young people for counselling and referral services.
- Producing Youth-Friendly IEC materials for HIV by the youth themselves.

2.4.4 Nutrition programme

In accordance with the commitment made at the International Conference on Nutrition 1992, Myanmar formulated the National Plan of Action for Food and Nutrition (NPAFN) in 1994. Coordination meetings for the development of a five- year strategy of NPAFN were conducted and under the leadership of The National Nutrition Centre (NNC). The 2011-2015 Plan was drafted in 2013.

The ultimate aim of the nutrition program is "Attainment of nutritional well-being of all citizens as part of the overall social-economic development by means of health and nutrition activities together with the cooperative efforts by the food production sector".

Adolescent anaemia control activities have been undertaken as follows:

Iron supplementation for adolescent schoolgirls is being provided i.e. one tablet twice a week during the academic term for all middle and high school girls in selected 20 townships.

.For nutrition education, the following activities have been undertaken:

- Encourage consumption of iron rich foods;
- Encourage food habits, which can enhance absorption of dietary iron;
- Discourage food habits, which may inhibit iron absorption.

In addition to the above, other public health measures such as home gardening, birth spacing, personal hygiene and environmental sanitation are being conducted.

2.4.5 Substance abuse control programme

Tobacco:

The Tobacco Control Law on "The control of smoking and consumption of Tobacco Products Law" was adopted on 4th May 2006.

Ongoing activities:

- Ongoing activities:
- Monitoring Tobacco Use and Prevention Policy
- Raising tax for both locally and imported cigarettes by 100%
- Protection from Environmental Tobacco Smoke: The law designates non-smoking areas at public

places. In 2011, the President's office decided to enforce strict prohibition of tobacco use in all government offices' compounds and buildings.

- Awareness raising through advocacy workshop as well as social media such as billboards, warning on tobacco packets and prohibiting tobacco advertisement
- Conducting campaigns for general population with emphasis on preganant women and young people the deleterious effects of tobacco and betel chewing practices.
- Offering help to quit tobacco use
- Training health and education personnel at the state/ region and township levels

Alcohol

Awareness campaigns were conducted to address the harmful use of alcohol among the community and adolescents in particular.

Policies and strategies have been developed for reducing harmful use of alcohol in 2014. Nevertheless, there is no restriction on age limit of alcohol consumption. According to the policies and strategies, the following policies and strategies have been developed. They are:

- Regulating the physical availability of alcohol
- Restriction on sales and production
- Restriction on promotion of sales, including advertising
- Education and enforcing age limit for alcohol consumption.
- Health Education for prevention on the consequences of alcohol
- Community action to avoid drunkenness and alcohol addiction
- Regulating international trade
- Increased in taxation
- Leadership, awareness and political commitment in regulate alcohol consumption.

Illicit drugs

Drug abuse is a disease that is threatening families and the social wellbeing of people and communities. Drug abuse prevention and control programs must be developed and implemented. Myanmar, on her part, is carrying out drug abuse prevention and control programs as a National task.

The Methadone Maintenance Therapy Programme (MMT) has been recommended by most UN agencies – WHO, UNAIDS, UNODC, UNICEF and World Bank to reduce the incidence and spread of HIV infection among PWIDs (People Who Inject Drugs). HIV prevention among PWIDs is a strategic priority in the National Strategic Plan for HIV/AIDS. The goals of methadone treatment include normalizing patients' lives, integrating them back into their family and the community, and keeping them in treatment when

necessary. Methadone patients should be treated as far as possible in the same way as other patients. The methadone maintenance therapy (MMT) programme commenced in early 2006 and in that year 260 people were enrolled. As of August 2014 up to 7,768 patients received MMT from 35 sites. Out of the total patients, 1568 patients are between 15 -24 years. Among 15532 registered drug users (2011-2014), 755 are 15-19 years old and 3034 are 20-24 years old. The Methadone programme has been based on delivering services through specialist drug treatment centres and selected hospitals. Over time it is anticipated methadone will become more readily available, and will enable integration of the treatment of opioid dependence with general medical care. This is important, because many opioid-dependent patients have experienced serious illness, HIV infection or injury as a result of their years of injecting drug use and dependence.

New Drug Dependence Treatment and Methadone Therapy Guidelines have been developed in 2012. Under the coordination of the referral drug treatment centre (DTC), methadone may be dispensed in community-based programmes. This allows for treatment of drug dependence to be normalized and de-stigmatized, and the congregation of large numbers of patients around drug treatment centres will be avoided. With a wider spread of medical and dispensing services, accessibility and choice will be improved. It is also expected that co-location of treatment services for opioid dependence, tuberculosis and HIV will provide efficiencies for patient access and improve adherence with treatment for these common co-morbid conditions.

A new intervention to prevent or delay onset of drug use among school young people will be launched in the early years of this 5 year Strategic Plan period and will be conducted in accordance with the guidelines, principles and practices of UNODC [52] and NIDA.[53]

2.4.6 Mental health programme

Myanmar's mental health policy was last revised in 1995, and The last revision of the mental health plan was in 2006.

includes the following components: (1) organization of services; (2) developing community mental health services;(3) downsizing of large mental hospitals; (4) reforming mental hospitals to provide more comprehensive care; (5) developing a mental health component in primary health care;(6) human resources; (7) involvement of users and families; (8) advocacy and promotion;(9) human rights protection of users; (10) equity of access to mental health services across different groups; (11) financing; and (12) quality improvement and system monitoring.

Mental health care activities were conducted in schools since 2006 as part of managing stress among school children. Two booklets for primary and high school students were produced including factors contributing to mental disorders, major mental disorders and their signs and guidelines to prevent mental disorders. School teachers were trained to be aware of mental health problems among school children and early referral and management. Educational pamphlets on school mental health were produced for primary, middle and high school students

2.4.7 Infectious diseases control programme

Malaria

Malaria is one of the major public health problems in the Republic of the Union of Myanmar. The trend of malaria cases and deaths is on the decline in the recent years but Myanmar has by far the greatest burden of malaria in the GMS. Total 284 out of 330 townships in the country are malaria endemic areas. From 2007 to 2014 there is about 61% reduction of reported malaria morbidity (in 2007 there was 520,887 cases and in 2014 there was 205,658 cases) and during the same period there is about 93% reduction of reported malaria mortality (in 2007 there was 1,261 deaths and in 2014 there was 92 deaths). The reported Pf percent is 69% in 2014.

Though the causes of malaria outbreaks in Myanmar are multi-factorial, but population migration is recorded as the most frequent cause. This may be due to migrant workers coming from endemic areas to non-endemic areas and may be also by the nonimmune migrant workers coming to malaria endemic areas.

Dengue Hemorrhagic Fever

Previously, DF/DHF has been a disease of urban in Myanmar, but since 1998, more cases have been reported in rural areas. In 2011, the distribution of cases was equal in urban and rural area. Causes of increasing cases may be due to: climatic change, rapid urbanization, population migration and improper waste disposal such as tins, plastic wares, unused boats, boat like food containers for cows and pigs, tires& batteries in the house compound etc.

The activities implementing through the country were

1. Strengthening of disease surveillance ,Vector and laboratory surveillance
2. Epidemic preparedness and response
3. Vector Control: Integrated Vector management with other vector borne disease, larval Control with community participation and adult (Mosquito) control
4. Capacity building
    - Training of Medical Officers and BHS staff on effective disease and vector surveillance
    - Training of Medical Officers and BHS on Epidemic preparedness
    - Training of MOs on case management of DHF
5. Advocacy meetings & Community awareness session on DHF prevention & control
6. Intra and Inter-sectoral co-operation
7. Social mobilization
8. Operational research

Tuberculosis

Tuberculosis is one of the major public health problems in Myanmar. It is therefore included as one of the three priority diseases in the national health plan. More than 140,000 TB cases are registered and threatened yearly. Tb cases among young age group accounted for about 13% of total case load in 2014. For advocacy and social mobilization, the following activities are being conducted

- Health education sessions among adolescent integrated with school health activities and community based adolescent and youth health activities including the Youth corner.
- To increase awareness about TB by organizing essay competitions and TB case finding activities during World TB Day week commemorations.

For addressing TB among adolescents, the following activities are being conducted:

- contact tracing at TB patient's residence (house, workplace, hostel)
- collection of sputum samples from presumptive TB cases by sputum collection centre
- Identifying suspected cases of TB (presumptive TB) by enquiring about TB signs and symptom in outpatient departments (childhood and adult)

2.5 Response to improve health status of young people by other ministries

2.5.1 School health programme - Life skills education curriculum in schools

The secondary school life skills curriculum (Grade 6 to 11) has been updated since 2006-2007. It covers seven thematic areas - Social Skills, Environment and Sanitation, Disease Prevention and Nutrition, Reproductive Health, HIV/ AIDS and Sexually Transmitted Diseases, Drug use and Emotional Intelligence. However, there's the need of upgrading the skill and knowledge on teaching methodology of teaching sexual and reproductive health.

Age appropriate participatory lessons on sexuality education are prepared with a focus on the development of psychosocial competencies such as critical thinking, decision making, self-awareness, assertive communication for sexual advances and negotiation.

A training of trainer course for Sexual and reproductive health education for teachers from Teacher Education College was conducted in 2012.

- The secondary school life skills school curriculum (Grade 6 and 11) - was developed by UNICEF in collaboration with MOH (NAP & SH)

- Training for lower secondary grades (Grade 6, 7 and 8) has been se rolled out the country. More than 26,130 secondary teachers including 42 school health team members were trained and more than 1,624,000 students are now learning this curriculum.

- To increase synergy on its implementation, the MOH and Ministry of Education have jointly collaborated to conduct the health education sessions in schools particularly to focus on adolescent reproductive health.

2.5.2 Injuries control programme

2.5.2.1 ***Unintentional injuries***

The Injury prevention project has had international road safety literature translated into Myanmar and ethnic languages for use in Myanmar schools. The literature, which includes illustrated books for children, will be included in the curriculum at government schools. Integrating road safety in the school curriculum and in specific university courses in areas such as health sciences had been raised in parliament and is in the process for implementation.

Regional and state level officials mentioned the need for "increased awareness" in the community about the need for road safety. The public needs to be involved in road safety and to be empowered.

2.6 Response to improve health status of young people by NGOs

2.6.1 Marie Stopes International (MSI):

MSI conducted health education sessions at schools, and at tuition and boarding houses. They had advocacy meetings with the local authorities before the health education session and conducted training of trainers before conducting the health education sessions. MSI runs clinics where they provided family planning services, STI treatment and antenatal care. It also provides IEC materials. MSI's main clinic provides clinical services for adults and young people. In addition it runs 6 youth centers and mobile libraries. It also runs Myanmar Red Cross Society (MRCS):

Since 2000, MRCS conducts health education sessions through peer educators, and provides referral to health services. It chose to use a peer to peer approach to reach vulnerable populations who are very mobile. It experiences problems such as drop out of peer educators and transportation costs. . Another challenge is sustainability as these activities are funded by donor agencies.

2.6.2 Myanmar Anti-Narcotics Association (MANA):

There are two youth groups namely MANA Silver Star Youth (MSSY) and MANA Youth Empowerment team (MYET) which are active in advocating about the dangers of narcotics among the young people. MSSY conducts puppet shows to educate using entertainment in high schools, middle schools, elementary schools, monastic schools, townships and villages.

2.6.3 The Substance Abuse Research Association (SARA)

SARA became a legally registered local organization in May 2014 and has been conducting drug abuse prevention activities that target primary school to high school level children and young people. Their preventive approach for onset of drug use places emphasis on developing self-esteem of young people through families, teaching coping skills, drug refusal techniques and choosing friends wisely. In addition, SARA also advocates to the parents on developing close relationships between parents and their children of school going age and early identification of symptoms of mental illness which may lead to onset of drug use if not recognized in a timely manner.

2.6.4 Myanmar Maternal and Child Welfare Association (MMCWA)

MMCWA has two broad approaches - self-reliance funding approach and project funding approach. For the self-reliance approach, in collaboration with Ministry of Education, activities were conducted in basic education schools in 2013. In conjunction with School health and Basic health Departments, MMCWA provided Adolescent Health Education in the BEHS School of Nay Pyi Taw Area, on physical and psychological changes in adolescents, HIV/AIDS, narcotic and drug abuse, nutrition and injuries. In relation to its project funding approach, with the funding from IPPF, the "Speak up Project" for young people was conducted provide the right information on Adolescent Reproductive Health in rural areas.

The main topics addressed were sexual and reproductive health, communication and decision making skills and HIV/AIDS. The activities were advocacy, central-level training of trainers, township-level multiplier training, peer educator training and outreach and monitoring and evaluation.

2.6.5 Myanmar Medical Association (MMA):

MMA carried out training for young people through Youth Development Programme (YDP), including peer educators on HIV/AIDS, adolescent reproductive health and life skills. MMA conducted training in our townships, Pyay, Taunggyi, Taungoo and Pathein.

Apart from training, MMA conducts edutainment programmes and uses the media to disseminate the health information and education to young people. It also operates telephone hot lines separately for males (white) and females (pink), health talks in schools and university. Young people associated with MMA participated in the International Youth Day and the World AIDS Day to raise awareness on adolescent reproductive health and HIV/AIDS reaching a wider range of young people through the country with specific key messages for young people in society.

2.6.6 Save the Children:

Save the Children carries out activities directed at young people in Magwe and Mandalay which started in 2012 till 2015. SC covers both in school and out of school young people. For in school, SC provides health education to young people in universities in Magwe and Mandalay. In Magwe, the organization runs a knowledge centre and library for young people. The organization also provides care for Orphan and vulnerable populations in Magwe, through community based organizations, for psychosocial support and nutrition.

The main focus of SC's work is behaviour change communication e.g. supporting peer education, and conducting awareness raising sessions for the community through traditional and local activities like the Pagoda festival and World AIDS Day, and conducting leadership training programmes for young people, as well as building the capacities of organizations through training on facilitation skills and project cycle management. It also carries out outreach activities to factories, beer shops, KTV and private boarding houses.

The organization provides referral for VCCT and STI treatment to youth friendly general practitioners.

The organization faces challenges - attrition of young people requiring refresher training and the prospect of running out of funds when the project ends in early 2015.

2.7 Opportunities and Challenges

2.7.1 Opportunities

Myanmar has witnessed dramatic and progressive changes over the past few years.. In general, progress has been made towards the attainment of the MDGs, ICPD and other international goals, particularly over the past two and half years. There has been more improvement in some areas while significant challenges remain for some areas.

The Framework for Economic and Social Reforms (2013) noted that Myanmar's health indicators are currently much below those of neighbouring countries and the government will double its commitment in improving health care services and increasing public financing of health in order to meet the health MDGs as soon as possible. The Government of Myanmar recognizes that provision of basic health services is constrained by a lack of access to these services, the poor state of infrastructure, a shortage of health personnel as well as weaknesses in training and gaps in the provision of basic materials and services. Low government investment in the health sector is the root cause of this.

To address these problems the government has already begun increasing the level of expenditure on health both absolutely and as a proportion of the total government budget and will focus on a number of innovative measures in health financing such as a voucher system for maternal and child health care, special funds for destitute mothers, strengthening township-level health financing, and greater cooperation with development partners. Particular attention will be paid to allocating more resources to rural primary health care, communicable disease control and maternal and child health, in view of the acute need to improve health indicators in all these areas. The government endeavours to improve the provision of materials and services to hospitals and expand human resources in line with the newly revised structure of the health departments at the community and primary health care level

The Myanmar Country Coordinating Mechanism (M-CCM) was re-established in 2008. The M-CCM has a mandate to oversee national responses to AIDS, tuberculosis and malaria, and since 2012, also for maternal and child health and health system strengthening. In November 2012 the MCCM was broadened into the Myanmar Health Sector Coordinating Committee (MHSCC) reflecting its multi- sectoral nature with broad participation, including representatives of different government ministries, UN agencies, international organizations, donors, international and local NGOs, private sector and people living with HIV – all of them selected by their own constituencies. The Myanmar HSCC also supports coordination among implementing partners on specific health issues such as HIV/AIDS, malaria; and tuberculosis, health system strengthening, maternal, child and reproductive health and disaster preparedness via technical and strategic groups.

The reproductive, maternal and child health technical and strategy group was formed with three working groups - the Lead Reproductive Health Working Group, the Lead Child Health Working Group and the Lead Birth Spacing/Family Planning Working Group.

For creating employment and opportunities for young people, the Department of Social Welfare has established Youth training schools and has implemented job placement schemes for boys. It has also provided vocational training and assistance in seeking employment based on skills.

For instituting concrete procedures and mechanisms for young people including adolescents to participate in planning and implementation, the Department of Social Welfare has convened youth participation forums which facilitate the participation of children and adolescents in the development of a five year strategic plan on youth. Young people are involved in project design, implementation, monitoring and evaluation for their own projects.

In order to minimize stigma and discrimination towards people living with HIV/AIDS and their families as well as to provide basic and correct information on HIV/AIDS, prevention, treatment , care and support activities are being implemented systematically for the community with special emphasis on men and women of reproductive age.

To create favourable environment for reducing stigma and discrimination, multi-sectoral coordination has been strengthened and legal reform workshops with related ministries, such as the Ministry of Home Affairs, Central Committee for Drug abuse Control, Attorney General's Office and other related sectors has been conducted.

2.7.2 Challenges:

There is a general reluctance to acknowledge the contribution that young people can make in the society- . This is a challenge to develop programmes that respond to the needs of young people. Inadequate financial resources to institute and expand youth programmes, limited capacity of human resources that is limited numbers of teachers competent to conduct life skills and sexuality education and high turnover of trained young people as peer educators both in urban and rural areas affect the quality and sustainability of the adolescent health programme.

Frequent dropouts of trained youth peer educators and volunteers, rapid turnover of focal staff from the government also affect the implementation of activities in the rural areas. There are also gaps in training/ refresher training for basic health staff and young people as there is high mobility, especially among the latter. Finally, young people in work have limited time to participate in youth activities of their interest.

There is lack of accurate data on adolescents' knowledge about contraceptive methods (especially in case of unmarried adolescents); and on adolescents' knowledge on drug use and abuse, alcohol and tobacco.

There is weak collaboration and coordination between different stakeholders involved in adolescent health (YIC, MMA, MRCS, MSI, SC).

There is the need for standardized guidelines and protocols.

Many interventions on adolescent health are small scale and time limited. UNFPA has been supporting CHEB for the last 20 years since establishment of Youth Information Corners. UNFPA is now conducting the YIC assessment and will soon publish the findings. Myanmar has changed politically, socioeconomically and access to internet has posed challenges for young people to be engaged in risk taking behaviours. The findings of this assessment have to be taken into account to strengthen YICs.

Stigma and discrimination for the key affected populations still exist at public health facilities for key affected populations.

There are a number of constraints for the provision of services. STI diagnosis and treatment reach a limited number of adolescents. As a result is many adolescents self-medicate, often with inappropriate treatment regimes, others go to private general practitioners where the quality of service is not regulated.

There is insufficient information about adolescent health among health care providers, Access to care is varied and limited because of constrained resources and (human, technical and financial), limited capacity to deal effectively and sensitively with adolescents clients, and weakness in inter-sectoral coordination and cooperation.

At the community level, there is limited access to correct information, and to, inappropriate peer and media influence. As a result misconceptions wrong beliefs, low personal risk perceptions, and unhealthy life styles persist. Young people hesitate to use health services even though there is available mainly because of lack of awareness, shyness or embarrassment. Further some have financial constraints, have to cover long distances to health facilities, and are also concerned about the negative/ unsympathetic attitudes of health providers.

Many adolescents are beyond the reach of health facilities. They include migrant adolescents and the large numbers to drop out of school. There are also major, cultural barrier for example – in relation to condom promotion, and sexuality education in school. There are also few employment opportunities and high levels of poverty. .

There is a gap of data for adolescent and youth health as indicators in this area are not yet included in the Health Management information system, with the exception of adolescent birth rate

3 Goals, Objectives and guiding principles

3.1 Goal

The goal of the Strategic Plan for Young People Health is to attain the highest achievable standards of health and development of young people in Myanmar by protecting and fulfilling their rights to information, quality services and protective environments.

The strategies to achieve the goal are:

- **Increase access to information**, from a variety of sources, that is accurate, relevant, consistent and interactive and that helps them demand better health as a basic human right.
- **Increase opportunities to develop life skills**[54] that will help them avoid risk behaviours and improve and maintain their physical and mental health.[55]

  (Note: Young people also need opportunities to develop other skills, for example, livelihood skills and financial literacy skills,[56] and to have access to education, leisure activities and, when appropriate, work.
- **Increase access to and use of health services**, including counselling and commodities, which are acceptable, equitable, affordable, appropriate, effective, and available through a range of channels and delivered in ways that reach marginalized and vulnerable adolescents as well as the general population of young people.

  Safe and supportive environments in which to live, learn and develop. Much needs to be done, ranging from community-level actions, such as providing spaces where adolescents can meet in safety and creating opportunities for them to study, spend leisure time and when appropriate work,[57] to policies and structural interventions that tackle the social determinants of disease and disability. Policies and programmes also need to protect adolescents from harmful physical environments, from exploitation and abuse, from advertising and other promotion of potentially harmful products and from social values and norms that stigmatize or endanger their health.[5859]
- **Increased participation in programming.** Adolescents need to be involved, to contribute, to be actors and partners with adults in the planning, implementation, monitoring and evaluation of interventions to improve and maintain their health and development.[60616263] There is some evidence that this participation not only makes sense but may also improve the impact of programmes.[646566] Adolescents need to be seen as positive resources and assets in their communities, not as troublesome risk-takers.

3.2 Strategic priority areas and program objectives

To implement these aims, the following strategic priorities with relevant objectives have been identified.

1. Improve sexual and reproductive health
    a. Reduce adolescent pregnancy,
    b. Prevent poor reproductive health outcomes in adolescents
2. Prevent and effectively manage HIV
    a. Prevent new HIV infections in young people,
    b. Prevent HIV related mortality and morbidity

3. Improve nutrition

    a. Reduce under nutrition and

    b. Reduce micronutrient deficiencies in young people

4. Decrease substance use

    a. Reduce the prevalence of substance use and

    b. Reduce substance use disorders in young people

5. Prevent unintentional injuries

    a. Reduce the mortality and morbidity from unintentional injuries among young people, in particular from road traffic injuries,

    b. Reduce interpersonal violence, including sexual violence increase access of young people to preventive health and social support services

6. Prevent infectious diseases

    a. Reduce the prevalence of malaria and

    b. Reduce the prevalence of tuberculosis in young people

7. Improve mental health

    a. Promote mental health

    b. Reduce the impact of mental health disorders and difficulties in adolescents' lives

3.3 Guiding Principles and programmatic considerations

The principles and practical considerations that will guide the development, planning and implementation of the Strategic Plan are:

(A) Guiding principles:

Adolescence is a time everyone goes through which offers opportunities and risks: The second decade of a young person's life, which provides an important opportunity to set the stage for health adulthood and to address health problems that have been carried over from childhood.

Not all young people are equally vulnerable: All young people have health-related needs and can experience problems. But some are more vulnerable to health and social problems than others. Some young people may be particularly vulnerable and so have greater needs for a range of services. These young people include those living with disabilities or chronic illnesses; those exploited and abused; and those stigmatized and marginalized because of sexual orientation or ethnicity; adolescents living in remote areas or caught up in social disruption from natural disasters or armed conflicts; those who are institutionalized; those exposed to domestic violence or substance abuse in the family; and adolescents without access to education, health services or social protection. Social norms, especially inequitable gender norms, contribute enormously to health and social problems for girls and women, but also for boys and men. Programmes need to take into consideration the heterogeneity of adolescents and specifically target the most vulnerable to achieve equity in the delivery of interventions.

Development of young people underlies prevention of health problems: Healthy physical, psychological and social developments contribute to adolescent health; conversely, healthy development is affected by poor health.

Young person's health problems have common roots and are interrelated: Many health problems are caused by the same individual and social factors. This means that they can be addressed in a coordinated manner.

The social environment influences adolescents' behaviour and health. What this means is that approaches directed at adolescents themselves need to be combined with approaches directed at the individuals and institutions around them.

(B) Programmatic considerations

Programmes will aim to put adolescents at the centre of their effort. They will aim to address the individual as well as the environmental influences on health. They will aim to deliver complementary interventions as one through multilevel and multisectoral approaches.

Concerted attention: it is increasingly clear that health problems during adolescence are important, preventable but often neglected. For example, sexual and reproductive health problems including maternal mortality and HIV remain a major cause of death and disease. Intentional and unintentional injuries, mental health, substance use, violence are also major causes of mortality during the second decade. Furthermore, much health-compromising behaviour that begin during adolescence have profound consequences for health and development during adolescence and also for long-term well-being—for example, use of

tobacco, alcohol and other psychoactive substances, and unprotected sex.

Building on existing programmes: implementation will be done in accordance with national development policies, national health plans and will build on existing programmes in a co-ordinated manner.

Using life-course approach: Adolescence is a key decade in the life-course that is influenced by by psychosocial changes which render them more vulnerable other decades of one's life. Problems that arise during the first decade of life affect the health and development of adolescents.[6768]. The health problems and health-related behaviours that arise during adolescence shape adult health, with important implications for public health. For example, many of the non-communicable diseases of the adult years arise from behaviours that start, or are reinforced in adolescence, including tobacco use, harmful use of alcohol, unhealthy diets and physical inactivity. The health and development of adolescents, in turn, has significant repercussions not only on their adult health[69] but also on the health of their future children.[70]

Using a rights-based approach: The majority of adolescents are included in the up-to-18 years definition of "child" adopted by the *Convention on the Rights of the Child* (CRC). In addition to General Comment No. 4 on adolescent health and development in the context of the CRC,[71] a new General Comment on Article 24 of the CRC (the right to the highest attainable standard of health) has recently been prepared.[72] Young people are defined as aged 15 to 24 years by WHO.A human rights-based approach to young people's health is important accessibility, availability, acceptability and quality of adolescent health services ensuring that no young person is neglected because of marginalization and discrimination; to agree on universal standards for responding to issues that are often culturally sensitive and controversial, such as sexuality education and informed consent by minors to treatment; and to ensure that young people are listened to and engaged.

Using multisectoral approach: While adolescent health is important in its own right, it also affects many other aspects of adolescents' lives, for example, education and employment. Thus, many sectors have an interest in adolescents being healthy.

At the same time, actions implemented by many sectors are important to young person's health, including employment, housing and the built environment, public recreational areas, public transport, water and sanitation, criminal justice, the media and especially education. Just as adolescent health and nutrition make important contributions to enrolment, retention in school and the ability to learn, education and the physical and social environment in schools have a major impact on adolescents' physical and mental health and the development of health-related behaviours.[73747576]

Partnership, coordination and joint programming: among stakeholders including UN agencies, professional organizations, civil society organizations, local NGOs, and communities and others to maximize resources and to avoid duplication of efforts. Roles and responsibilities of all stakeholders and partners will be clearly defined in planning, implementation, and monitoring and evaluation of the activities in order to increase synergy.

4. Strategies and key activities

Effective implementation of the Strategic Plan for Young People's Health will require a multi-sectoral approach, and the contribution of all actors in the health sector is essential. A number of strategies will be employed for effective implementation of specific interventions targeting the various components of youth health.

4.1 Implementation strategies

The strategies and key activities for implementation are:

I. Strengthening Health System to enhance effective provision of essential package of integrated services for adolescent and youth.

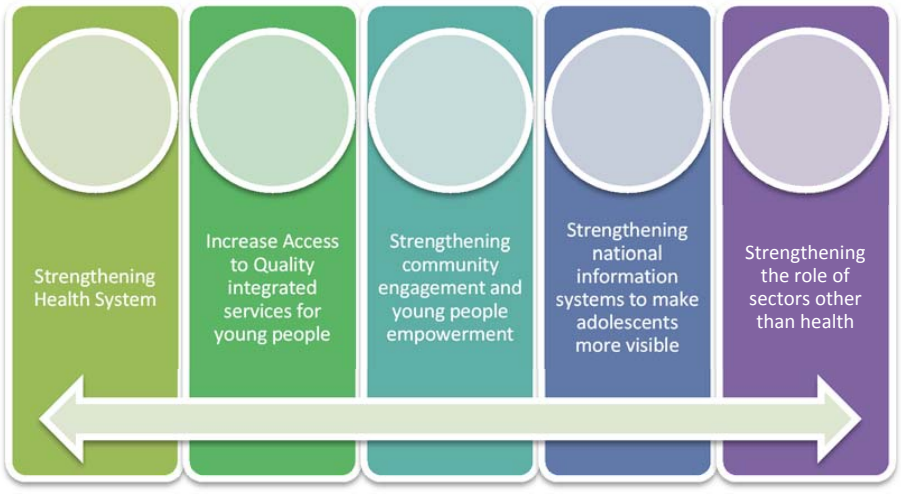
II. Improving health related knowledge and skills among adolescent and young people

III. Strengthening community engagement and young people empowerment to increase their access to and use of services

IV. Strengthening national information systems to make adolescents more visible in policies and programmes

V. Strengthening the role of sectors other than health in promoting young people health and development

The figure below outlines the links between the key strategies and the plan's aims, objectives and overall goal.



4.2 Key activities for implementation of the five strategies

The following priority actions are proposed alongside each of the five key strategies:

I. Strengthening Health System to enhance effective provision of essential package of AYH services	
1. Reinforce an enabling policy environment for young people health and development	1.1 Examine and potentially revise current policies on age of consent and confidentiality of health services for young people to ensure access to services, including flexibility to allow mature minors to consent for services.
	1.2 Review national laws and policies to include provisions so that they do not restrict the provision of health services to young people;
	1.3 Make sure policies state the obligation of facility staff to provide services to all young people irrespective of their ability to pay, age, sex, marital status, schooling, race/ethnicity, sexual orientation or other characteristics
	1.4 Develop guidelines and standard operating procedures to guideline health service providers in applying these policies
2. Ensure the availability of adolescent competent workforce	2.1.Develop/revise and implement competency based training programmes in young people's health in pre-service and continuous professional education in adolescent health information, counselling, diagnostic, treatment and care for priority conditions;
	2.2. Include competencies in young people's health and development in job descriptions as relevant, and ensure that objectives, responsibilities, authority and lines of accountability within job descriptions include a focus on adolescents.
	2.3.Define the skill mix in young people's health care of health teams at different levels of health care system, identify district staffing needs, and deploy staff to facilities to ensure the necessary skill mix
	2.4 Conduct assessments in districts to identify training needs in young people's health and development at district level, and conduct competency based in-service trainings in young people's health
3. Improve basic infrastructure, supply and technology to ensure the provision of essential package of AYH services	3.1.Develop or review, as appropriate, lists of equipment ,medicines and supplies that facilities need to enable the provision of the essential package of AYH services
	3.2. Conduct assessments to determine gaps in the availability of equipment required to provide the essential package of Young people's health services, and ensure timely supply and maintenance.
4. Ensure the financing of the of essential package of AYH services	4.1 Negotiate allocation of funds from the national budget to ensure the provision of the essential package of Young People's Health services
5. Implement the national service standards on adolescent and youth health care, and monitor the compliance with standards	5.1. Develop and disseminate national service standards and tools to monitor the implementation of national service standards on young people's health care
	5.2.Include feedback mechanism from young clients in each health facility and Set up a system to reward/recognise highly performing health care providers
6. Set up a system for supportive supervision in adolescent health care	6.1.Develop/adapt tools for supportive supervision, and distribute them to districts and facility managers
	6..2 Supportive supervision of peer education programmes by health facility providers

II. Improving health related knowledge and skills among adolescent and young people	
1. Ensure the availability evidence-based tools for health care providers to Improving health related knowledge and skills among adolescent and youth	1.1. Develop/adapt evidence-based tools for young people's health information and healthy skills.
	1.2 Conduct training for health care providers on these interventions
	1.3. Ensure that these tools are included in teaching/learning materials and activities.
2. Ensure the availability of IEC materials for adolescents	2.1 Develop/adapt IEC materials and media including social media for young people covering a range of topics including SRH/HIV, mental health, nutrition, TB and malaria, drug and alcohol prevention etc.
	2.2 Conduct training peer counsellors to utilize these health education materials effectively
3. Ensure quality peer education and outreach to adolescents and youth	3.1 Develop/adapt tools for peer education and distribute them to districts and facility managers
	3.2 Conduct session among young people to enhance their life skills
III. Strengthening community engagement and young people empowerment to increase their access to, and use of, services	
1. Engage communities to increase their support for adolescents' use of health services	1.1.Raise awareness of community leaders (school, other sectors, religious leaders, local authorities, parents) on young people's health through Communication for development
2. Implement parenting programmes in collaboration with non-governmental organisations	2.1. Implement parenting programmes to improve adolescent sexual and reproductive health, developing family bonding and taking care of young person's self-esteem.
	2.2 Teach parents on methods to strengthen their young people' coping mechanisms and social relationships skills.
3. Strengthen young people participation in the planning, monitoring and evaluation of services	3.1 Inclusion of adolescents in the national adolescent health working group under the MHSCC mechanism, township health committee and health facility committees
	3.2Capacity building of youth organizations to increase their participation in policy and programming
	3.3 Inclusion of young people in programming e.g. advocacy, outreach, referral, peer education, social media, local communication
	3.4Develop feedback mechanisms for young clients on YF services and protocols for young people's role in monitoring and supervision of services
	3.5 National coordination of peer education programmes, training of master trainers, guidelines on supervision/support by teachers/health providers

IV. **Strengthening national information systems to make adolescents more visible in policies and programmes**	
1. Ensure a focus on adolescent health in national Health Management Information System (HMIS)	1.1.Review health management information system (HMIS) to ensure first 25 years of life are disaggregated by sex and 5-year age groups
	1.2.Ensure that national reports on cause-specific utilization of services include a focus on young people
	1.3.Ensure that other national reports (e.g. DHS, quality of care evaluations etc.) have a focus on young people
2. Strengthen availability of strategic information on adolescents and youth health	2.1.National young people's health surveys
	2.2.Inclusion of young people's health indicators in national surveys
	2.3.Operations research on adolescent and young people's health interventions
	3.1 Collect data of school drop-outs disaggregated by age and sex, to understand the reasons such as pregnancy, marriage etc.
V. **Strengthening coordination and legislation, and the role of sectors other than health in promoting adolescent health and development**	
1. Improve collaboration and coordination within health sector	1.1 Develop institutional mechanisms to ensure the collaboration and coordination within health sector
	1.2 Appoint adolescent and youth focal points within health department, state/regional, and township
2. Improve collaboration and coordination between health and other sectors in key area of strategy implementation	2.1.Develop institutional mechanisms to ensure the collaboration and coordination of health with other sectors in matters of young people's health
	2.2.Health sector to disseminate data – disaggregated by age and sex – on various aspects of adolescent health, and advocate for use of data to inform relevant policy and programme development by other sectors
	2.3Engage NGOs, non-state actors and society to take active role in the implementation plan for adolescent and youth health and strengthen their involvement in young people's health activities.

4.3 Key Targets

A national planning consultation was conducted to identify the current status of the adolescent health and the health services targeting those health issues. The stakeholder involved in the adolescent health activities; have participated in this consultation programme. In addition, in-depth interviews were conducted among the health service personal involved in implementing these programmes. The strength and weakness and the opportunities and challenges identified.

Based on these background the target for this national strategic plan was selected. These targets were identified to guide efforts, and to enable the evaluation of the NSPYPH.

Strategic priority areas and program objectives	**Targets**
1. Improve sexual and reproductive health	
a. Reduce adolescent pregnancy,	Reduce adolescent fertility rate from 20 per 1000 in 2014 to 10 per 1000 in 2018 (2014 census)
	Increase contraceptive prevalence rate among sexually active young people from 38% in 2014 to 52% in 2018
	Reduce MMR among young pregnant mother
b. Prevent poor reproductive health outcomes in adolescents	Improve the proportion of all pregnant mothers who received antenatal care services (at least one visit) from 74% to 85% in 2018 and Percentage of all pregnant women receiving antenatal care (at least 4 visits) from 66.9 % to 80% in 2018
2. Prevent and effectively manage HIV	
a. Prevent new HIV infections in young people,	Increase proportion of young people with correct knowledge of SRH and HIV/AIDS
Prevent HIV related mortality and morbidity	increase the coverage of HIV testing among young key population
3. Improve nutrition	
a. Reduce under nutrition	Reduce underweight (BMI <18.5 kg/m2) among adolescent by 30%
	Reduce obesity among adolescent (13-15 years) from 5% to 3% by 2018
b. Reduce micronutrient deficiencies in young people	By 2018 reduce the prevalence of Anaemia among pregnant woman from 26% in 2014 to 20%
4. Decrease substance use	
a. Reduce the prevalence of substance use and	Reduce by 10 % the prevalence of smoking tobacco among 13-15 year old boys by the end of 2020 from baseline 23.5% in 2011
	Reduce by 10% the prevalence of smokeless tobacco (betel chewing) use among 13-15 year old boys by the end of 2020 from baseline 15.2% in 2011

	Delay the onset age of drug use among adolescent
b. Reduce substance use disorders in young people	Reduce by 10% the prevalence of illicit drug use among 15 to 19 years old
5. Prevent unintentional injuries	
a. Reduce the mortality and morbidity from unintentional injuries among young people, in particular from road traffic injuries,	To reduce half of the mortality and morbidity of Road Traffic Injury by the end of 2020
b. Decrease the acceptability and tolerance of all forms of interpersonal violence, in particular against adolescent girls	Reduce the gender based violence among adolescent
6. Prevent infectious diseases	
a. Reduce the prevalence of malaria and DHF	By 2016 at least 90% of the people in all malaria risk villages in 284 malaria endemic townships and 100% of population living in artemisinin resistance containment areas, are protected against malaria by using insecticide treated nets/ long-lasting insecticidal nets complemented with another appropriate vector control methods, where applicable.
	Reduce malaria morbidity to 60% in 2016 from the 2007 baseline
	Reduce mortality by 75% in 2016 from 2007 baseline
	Reduce DHF morbidity by 25% in 2020 from 2010 baseline
	Reduce DHF mortality by 50% in 2020 from 2010 baseline
b. Reduce the prevalence of tuberculosis in young people	Reach the interim target of halving tuberculosis deaths and prevalence by 2015 from the 1990 baseline
	Achieve at least 70% of case detection treatment success rate 85% by using DOTS
7. Improve mental health	
a. Promote mental health	5% (in 2017) of schools have implemented mental health promotion programmes after the 3 year School based mental health promotion project, from the baseline of 0% in 2014
b. Reduce the impact of mental health disorders and difficulties in adolescents' lives	Increased awareness raising for suicide prevention among young people

4.4 Strategies to implement interventions

The strategies identified to implement intervention plan could be broadly grouped in following manner:

A. Community based interventions
    - **Adolescent clubs (AC):**

B. Facility based interventions
    - **Adolescent friendly clinic (AFC):**

C. Convergence within health sector and with other sector
    - **National steering committee for adolescent health (NSCAH):**
    - **Township steering committee for adolescent health (TSCAH):**

A steering committee will be formulated at national and district levels to review, strengthen and monitor adolescent health activities at each level. They will also coordinate non heath sectors to ensure their involvement in adolescent health activities.

These strategies identified will help to implement intervention to achieve the programme objectives (Exhibit -1)

Exhibit -1 : Table showing the objectives and targets and the approaches selected in the Young People's health strategic plan

Target groups and approaches	Young People's clubs (AC)					Young People friendly clinic (AFC)			Community participation for YP health			
	in school			Out of school								
Strategic priority areas and program objectives	Years 10-14	Years 15-19	Years 20-24	Years 10-19	Years 20-24	Years 10-14	Years 15-19	Years 20-24	Parents	Other Sectors	Other ministries	NGOs
1. Improve sexual and reproductive health												
a. Reduce adolescent pregnancy												
b. Prevent poor reproductive health outcomes in adolescents												
2. Prevent and effectively manage HIV												
a. Prevent new HIV infections in young people												
b. increase their access to HIV testing and counselling												
c. increase the access for young people living with HIV to comprehensive care and support services												
3. Improve nutrition												
a. Reduce under nutrition												
b. Reduce micronutrient deficiencies in young people												
4. Decrease substance use												
a. Reduce the prevalence of substance use												
b. Reduce substance use disorders in young people, and increase access to harm reduction strategies for young people who inject drugs												

5. Prevent unintentional injuries												
a. Reduce the mortality from unintentional injuries among young people, in particular from road traffic accidents,												
b. Decrease the acceptability and tolerance of all forms of interpersonal violence, in particular against adolescent girls												
c. increase access of young people to preventive health and social support services												
6. Prevent infectious diseases												
a. Reduce the prevalence of malaria and												
b. Reduce the prevalence of tuberculosis in young people												
7. Improve mental health												
a. Increase awareness about mental health problems in young people												
b. increase access to school based mental health services and programmes												

5 Over view of planning and implementation

The MOH has developed a five-year strategic plan for young people's health. The strategic plan will be disseminated to other national stakeholders for advocacy and collaboration. MOH will coordinate with other stakeholders for collaboration for AH. The MOH will also do the costing and budget allocation at national level. Training programmes will be organized for national health staff from different government departments.

An implementation plan will be developed at the national level for a two-year period at a time. It will consist on actions for at the national and district levels. Training packages, national standards of adolescent services, and tools to apply them will be developed at this stage. A monitoring and supportive supervision mechanism would be developed and incorporated in to the implementation plan.

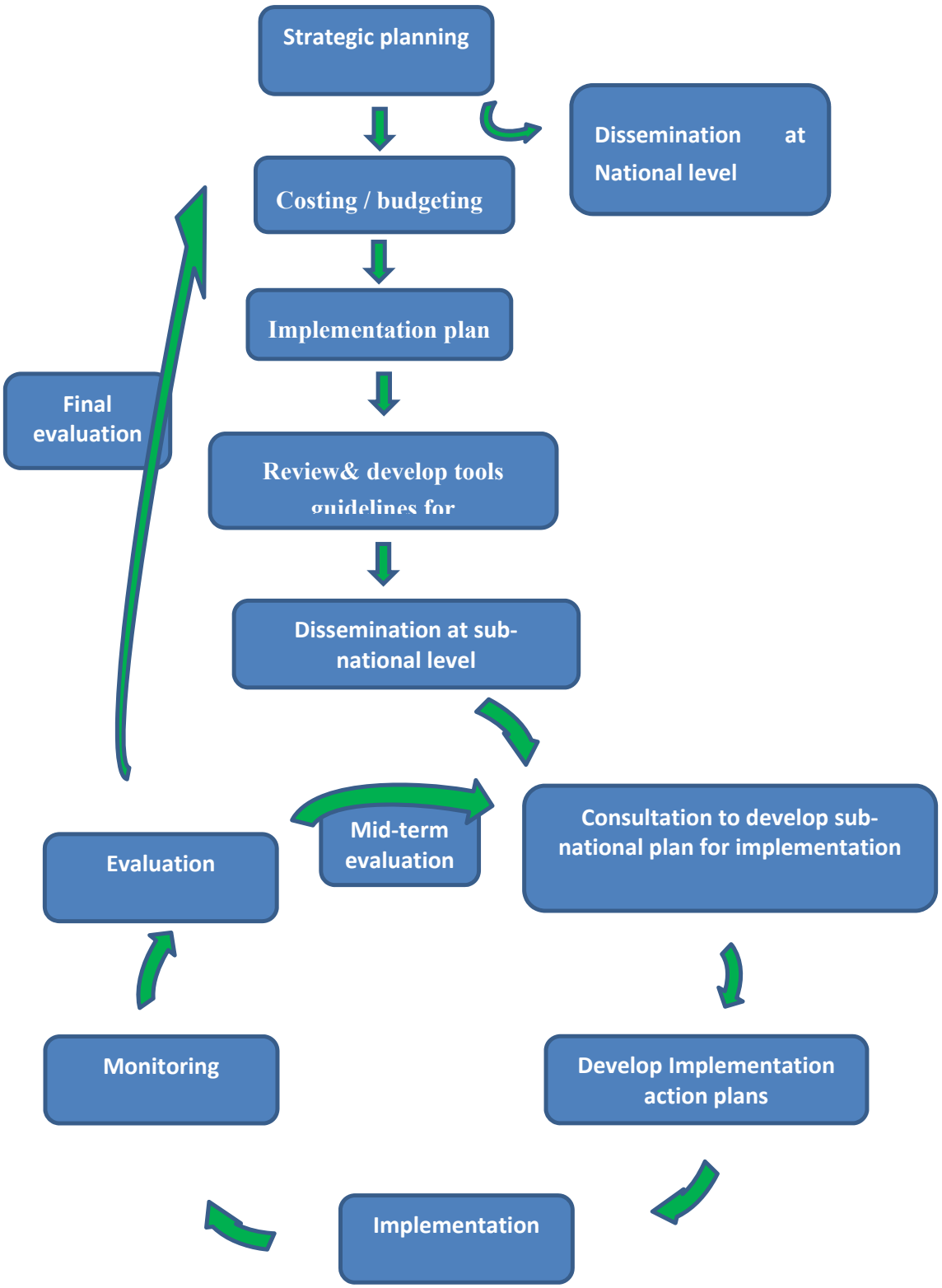
A situation analysis to identify the issues related to adolescent and young people's health and the interventions being delivered by various sectors and stakeholders will be carried out at township/ district level. Based on this, priorities will be identified and township/district level targets set, keeping the feasibility and resource availability in consideration. The five-year national strategic plan for young people's health will be used as the guide to select the priority objectives and interventions at each level. The Implementation plan will be for 2 years and will involve all relevant stakeholders and sectors, in order to address cross cutting issues. Costing and budget allocation for the implementation plan will be developed to ensure the participation of other sectors.

As mentioned above, training packages, national standards of adolescent services, quality of care tools and informational/educational materials will need to be developed at the national level. Resources to establish and strengthen the implementation of interventions will need to be identified. Training programmes for township/ state level health staffs will need to be organized.

The implementation will need to be carried out in the planned manner and the staff will be trained to monitor the progress and provide supportive supervision.. At the end of each 2 year period a systematic evaluation will be conducted to ascertain progress and at 4th year an evaluation will be conducted to reviewing the implementation of the national strategic plan as a whole. An overview of the planning and implementation flow is given in the following - Exhibit 1.

Exhibit -1:

Flow diagram showing the activities involved in planning and implementing the YPH programme



6 Essential Package of interventions to improve young people's health

To contribute to achieving the goal and specific objectives of the NCPYPH, key effective interventions organized in packages across the continuum of care will be employed. The interventions are based on services and interventions currently recommended in WHO's guidelines[1]. Existing services will be strengthened and will be used as entry points for new interventions, looking for maximum synergy. The essential interventions will be delivered to provide continuous care from home to primary and referral level care.

Table 1:The health interventions for adolescents that will be delivered at Young People friendly clinic (YPFC) at various level of care are detailed in

Health issue	Intervention	Primary health care (Rural health SC, RHC, MCH centre)	Township level (Station Hospital and Township Hospital)	State/ region
SRH	General care in the home during pregnancy		√	√
	Birth and emergency planning	√		
	Danger signs in pregnancy	√		
	Post-abortion care	√		
	Support during labour and childbirth		√	
	Postnatal care and hygiene of the mother and newborn		√	
	Family planning counselling	√	√	
	Breastfeeding	√	√	
	Nutrition counselling (for very thin adolescents)	√	√	
	Ensure the linkage with the community and health care providers (AMW, BHS) and proper referral	√		√
	Care and support in pregnancy, childbirth and postpartum period for adolescent mother and newborn infant including confirmation of pregnancy, information on the importance of utilizing skilled childbirth attendance / care, routine and	√	√	√
	Post abortion care	√	√	
	Contraception – Information and advice/counselling and peer education on safe sexual behaviour, prevention of unwanted pregnancy and STI and HIV	√	√	
	Prevention and management of Sexually Transmitted Infections (STIs)	√	√	
	Peer education and outreach activities in the catchment area according to national guidelines	√	√	
	Youth friendly RH services/RH service delivery corner for adolescents and youth in the health facility with provision of educational materials, supplies and equipment and RH commodities		√	√
	Capacity building health care providers on attitude toward YP friendly services in non-judgemental, confidential manner		√	√
	Develop proper referral pathway to seek quality health care for young people	√	√	
	Capacity building health care providers on attitude toward youth friendly services in non-judgemental, confidential manner	√	√	√
	Collaboration with university / high school for awareness raising and service provision of SRH for in school young people	√		√
	Awareness raising campaign/ youth forums about SRH	√	√	√
	Collaboration with relevant stakeholders and service providers in SRH	√	√	√
	Review and revise comprehensive sexuality education (CSE) , develop	√		√

Health issue	Intervention	Primary health care (Rural health SC, RHC, MCH centre)	Township level (Station Hospital and Township Hospital)	State/ region
	training manuals on SRH in line with current local context			
HIV	HIV counselling and testing	√	√	√
	PMTCT	√	√	√
	ART treatment		√	√
	Condom information and services	√	√	√
	Prevention education and life skill training/ sexuality education	√	√	
	Data recording and reporting	√	√	√
	Linkage with SRH services and treatment	√	√	√
	Communication package/IEC development			√
	Advocacy to stakeholders	√	√	√
	Assessment and Research	√	√	√
	Development of Standard and Guidelines			√
Nutrition	Intermittent iron and folic acid supplementation	√	√	√
	- Health education to adolescents, parents and caregivers on balanced and healthy diet, physical activity	√	√	
	- Growth assessment (BMI-for-age) assessment using WHO growth curves for school-aged children and adolescents	√	√	
	- School based interventions (School lunch programme, School gardening)	√	√	
	- Home gardening programme	√		
Substance use	Assessment and management of alcohol use and alcohol use disorders		√	□
	Assessment and management of drug use and drug use disorders		√	□
	Health Education of adolescents regarding drug use and drug use disorders		√	□
	Teaching of coping mechanisms, stress management methods, resisting peer pressure, social relationship skills.	√		
		√	√	√
Tobacco	Cessation support and treatment including management and prevention of tobacco use and second hand smoking exposure in pregnancy, psychosocial interventions for tobacco use cessation in pregnancy and protection from second-hand smoke in pregnancy (smoke-free homes)	√	√	√
Violence and Injury Prevention	Assessment and management of adolescents that present with unintentional injuries		√	
	Assessment and management alcohol-related unintentional injuries		√	
	First-line support when an adolescent girl disclose violence	√	√	
	Health education on intimate partner violence	√	√	
	Identification of intimate partner violence	√	√	
	Care for survivors of intimate partner violence		√	√
	Clinical care for survivors of sexual assault including first-line support, emergency contraception, HIV post-exposure prophylaxis, post-exposure prophylaxis for sexually transmitted infections and psychosocial interventions		√	
Malaria	Awareness raising campaign	√	√	√
	Malaria testing	√	√	√
	Assessment and classification of febrile adolescents	√	√	√
	Malaria treatment	√	√	√
Tuberculosis	Health education and awareness raising	√	√	√
	Training	√	√	√
	TB suspect referral	√		
	TB diagnosis and treatment		√	√
Mental	Management of conditions related to stress including post-traumatic		√	√

Health issue	Intervention	Primary health care (Rural health SC, RHC, MCH centre)	Township level (Station Hospital and Township Hospital)	State/ region
health	stress disorder			
	Management of emotional disorders		√	√
	- Depressive episode			
	- Depressive disorder			
	- Anxiety disorder			
	Management of behavioural disorders		√	√
	Management of children with developmental disorders including parent skills training :		√	√
	- Intellectual disability		√	√
	Pervasive developmental disorders (including autism)		√	√
	Management of other significant emotional or medically unexplained complaints:		√	√
	Somatic symptoms (somatoform disorders)		√	√
	Management of self-harm/Suicide including emergency care, psychosocial treatment and advice		√	
			√	
Community level education programme	Information provision to adolescents and their parents/careers on	√	√	
	Healthy eating			
	Physical activity			
	Sexual activity			
	Emotional well-being			
	The use of tobacco, alcohol and other substances			
	Unintended injuries			
	Violence and abuse			
School Health	Provide ToT for teachers on skill-based health education by BHS at least once a year at all school	√	√	
	Provide IEC materials	√	√	
	Increase access to Health services	√		
	Establish school-based Health room/ corner	√	√	
	Conduct health examination for students at least once a year	√	√	

7 Monitoring and Evaluation

7.1 Monitoring progress of the Strategic Plan

The district / township health authorities should develop a system of supportive supervision to improve programme implementation. It should review the progress at monthly intervals / at per determined schedules and provide feedback to the relevant stakeholders. Through monitoring and evaluation, progress towards and achievement of expected results will be measured and assessed.

Impact, outcome and output indicators for the Strategic Plan are outlined in Table 2. Data for monitoring of the Strategic Plan will be obtained from several sources and will require close co-ordination with the respective responsible entities. These include the Health Management Information System, hospital statistics, central and regional government reports and township implementation reports. National surveys and special studies (e.g. HIV and STI surveillance surveys by NAP, Global school-based student health survey) carried out periodically will also yield information on impact and outcome indicators. Efforts will be made to include age and sex disaggregated data in the forthcoming Demographic Health survey.

Table 2: The programmatic indicators to track progress of the plan

The progress on the priority area of the strategic plan will be tracked and followed up using following indicators.

Priority areas	Outcome indicator	Output indicators	Means of verification
1. Improve sexual and reproductive health			
a. Reduce adolescent pregnancy,	Adolescent birth rate	Percentage of adolescents with correct knowledge on complication and risks of early pregnancy	Periodic surveys like MICS
		Proportion of married adolescent using modern method of contraception	Periodic surveys like MICS
	Prevalence of Adolescents who have begun child-bearing		
	Skilled Attendant at birth		
	Contraceptive prevalence rate among sexually active young people	Percentage of adolescents with correct knowledge of at least one modern method of contraception	Periodic surveys like MICS
		Condom use at first sexual intercourse among adolescents	Periodic surveys like MICS
	Unmet need for family planning among youth	Demand for contraception satisfied among adolescents aged 15-19 years	Periodic surveys like MICS
	First sex before age 15		
b. Prevent poor reproductive health outcomes in adolescents	Proportion of adolescent pregnant mother who received antenatal care services	Number of antenatal care visits among adolescent pregnant mothers	Periodic surveys like MICS
		Proportion of adolescent pregnant mother who received antenatal care from any skilled service provider	Periodic surveys like MICS

Priority areas	Outcome indicator	Output indicators	Means of verification
	Maternal mortality		
	Health Service Utilization by adolescents		
2. Prevent and effectively manage HIV			
a. Prevent new HIV infections in young people,	proportion of young people with correct knowledge of SRH & HIV/AIDS	Comprehensive knowledge about HIV/AIDS	Periodic surveys like MICS
	Condom Use at last higher-risk sex	Sexual intercourse and condom use among never married adolescents	Periodic surveys like MICS
	Young Peopleliving with HIV		
	Mortality *due to HIV*		
b. increase their access to HIV testing and counselling, and	Coverage of prior HIV testing among adolescent girls	Self-reported prevalence of sexually-transmitted infections (STI)	Periodic surveys like MICS
		Percentage of adolescents aware of at least one symptom of RTI/STI	Periodic surveys like MICS
3. Improve nutrition			
a. Reduce under nutrition	Underweight (BMI <18.5 kg/m2) among adolescent	Percentage of health workers working with adolescents having correct knowledge on balance diet	The Global School-based Student Health Survey (GSHS)
	Reduce the obesity / Overweight among adolescent (13-15 years)	Percentage of adolescents with correct knowledge on nutritional deficiencies	The Global School-based Student Health Survey (GSHS)
b. Reduce micronutrient deficiencies in young people	Prevalence of anaemia among pregnant woman	Percentage of primary health workers working with adolescents having correct knowledge on nutrition issues among adolescent	The Global School-based Student Health Survey (GSHS)

Priority areas	Outcome indicator	Output indicators	Means of verification
4. Decrease substance use			
a. Reduce the prevalence of substance use and	Prevalence of smoking tobacco among 13-15 years of age boys	Proportion of adolescents currently smoke cigarettes	The Global School-based Student Health Survey (GSHS)
	Prevalence Alcohol use among 13-15 years of age boys	Proportion of adolescents currently using smokeless tobacco products	
	Prevalence of tobacco / smokeless tobacco use among 13-15 years of age boys		
	Prevalence Illicit drug use among 13-15 years of age boys	Percentage of adolescents with correct knowledge on health problems with illicit drug use	
b. Reduce substance use disorders in young people, and increase access to harm reduction strategies for young people who inject drugs	Proportion of adolescent with symptoms of dependence to drug use	Percentage of primary health workers working with adolescents having correct knowledge on substance use disorders among adolescent	Special survey
5. Prevent unintentional injuries			
a. Reduce the mortality from unintentional injuries among young people, in particular from road traffic accidents,	Morbidity of Road Traffic Injury	Percentage of adolescents with correct knowledge on methods of prevention of Road Traffic Injury	Special survey
	Mortality *due to Road Traffic Accidents (RTA)*		
b. Decrease the acceptability and tolerance of all forms of interpersonal violence, in particular against adolescent girls	Percentage of married adolescents who have experienced physical violence from their spouses in past 12 months	Percentage of adolescent girls who agree that a husband is justified in hitting or beating his wife for at least one specified reason	Special survey
	Mortality *due to Interpersonal Violence (IPV)*		
6. Prevent infectious diseases			
a. Reduce the prevalence of malaria and	% People in high and moderate risk villages in 52 priority townships are protected against malaria by	Proportion of households reached with ITN/long lasting insecticides treated nets among those live in high risk area.	Age disaggregation of malaria data (10-19yrs, 20-24yrs)

Priority areas	Outcome indicator	Output indicators	Means of verification
	using ITN/long lasting insecticides treated nets complemented with another vector control method whenever feasible	No of long lasting ITN/ITN distributed by years	Age disaggregation of malaria data (10-19yrs, 20-24yrs)
	Malaria morbidity ratio	Proportion of hospital out of all that are fully equipped to treat malaria among high risk areas.	Age disaggregation of malaria data (10-19yrs, 20-24yrs)
	Malaria mortality ratio	Proportion of death review conducted by hospital teams out of all hospital with mortality due to malaria	Age disaggregation of malaria data (10-19yrs, 20-24yrs)
b. Reduce the prevalence of tuberculosis in young people	TB deaths and prevalence	Percentage of adolescents with correct knowledge of symptoms of tuberculosis	Age disaggregation of tuberculosis data (10-19yrs, 20-24yrs)
	case detection and treatment success rate of using DOTS	Proportion of OPD patients given sputum samples for TB screening of TB	Age disaggregation of tuberculosis data (10-19yrs, 20-24yrs)

7. Improve mental health			
a. Increase awareness about mental health problems in young people	% of schools have implemented MH promotion programmes	Proportion of schools implemented mental health program out of all schools with secondary level classes	The Global School-based Student Health Survey (GSHS)
		Proportion of schools with counsellor teachers out of all schools with secondary level classes	The Global School-based Student Health Survey (GSHS)
b. increase access to school based mental health services and programmes to prevent suicide	Suicide rate among adolescent	Proportion of schools that have conducted coping skill trainings for adolescent students out of all schools with secondary level classes	The Global School-based Student Health Survey (GSHS)

Efforts will be made to include the data gaps related to adolescents and young people disaggregated by age and sex for separate programmes in the national HMIS and in the forthcoming surveys, where appropriate.

An internal review will be carried out by the DOPH on an annual basis with the key stakeholders and partners, including governmental and non-governmental organizations, to review the implementation of the Strategic Plan.

Interventions on the provision of information and services to young people are delivered by NGOs in several townships. These NGOs will be asked to align their monitoring systems to include indicators that are collected by the Health Information Management System, i.e. linking programme/project monitoring to existing data collection and reporting systems.

Quality and coverage measurement surveys will be conducted to assess the implementation of national service standards on adolescent and youth health care.

7.2 Mid-term Review and Final Evaluation

For the Mid-term Review, data will be collected and analyzed to assess programme, and management issues and budget expenditure. The findings and critical analysis will facilitate evidence-based decision-making with a view to inform the continued implementation of the Strategic Plan for the remaining years. A mid-term review should be planned at completion of 2 years of implementation. In addition to the above mention indicators, a qualitative assessment should be carried out to collect information about the extent to which the implementation has progressed so far and what elements have been obstacles and drivers of success to its implementation.

A final evaluation should be conducted at the end of 4 the year to determine whether the interventions have had an impact and whether the implementation of the programme has been successful. The relevance, performance effectiveness and efficiency of the Strategic Plan will be established and areas for programme improvement identified. This will be carried out by an external agency in 2018 and will guide the development of the subsequent Strategic Plan for Young People Health and Development. Information on impact indicators will also be obtained from national surveys e.g. the census and the Demographic and Health Survey which are planned in the coming years.

7.3 Dissemination of data and reports

Policy briefs based on annual reports will be prepared on a biennial basis summarizing the findings, noting good practices, operational research on the issues related to young people's health will be disseminated to policy makers, programme managers and scientific community as well as researchers and the young people themselves.

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