National Strategic Plan on Adolescent and Youth Health (2018-2025)

List of Abbreviations

AA-HA!	Accelerated Action for the Health of Adolescents
ADIC	Alcohol and Drug Information Centre
AYFHS	Adolescent and Youth Friendly Health Service
AIDS	Acquired Immunodeficiency Syndrome
AMOH	Additional Medical Officer of Health
BMI	Body Mass Index
CCP	Ceylon College of Physicians
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CRC	Child Right Convention
DGHS	Director General Health Services
DDG	Deputy Director Generals
DDGPHS 11	Deputy Director General Public Health Services 11
DALYs	Disability-adjusted Life Years
E IMMR	e–Indoor Morbidity and Mortality Register
FGM	Female Genital Mutilation
FHB	Family Health Bureau
EOH & FS	Environment Occupation and Food Safety Unit
GSHS	Global School Health Survey
GYTS	Global Youth Tobacco Survey
GS	Global Strategy for Women's, Children's and Adolescents' Health (2016–2030)
GYTS	Global Youth Tobacco Survey
HD	Hospital Director
HPB	Health Promotion Bureau
HIV	Human Immunodeficiency Virus
RHMIS	Reproductive Health Medical Information System
MCH) Policy	Maternal and Child Health
MHU	Mental Health Unit
MOH	Medical Officer of health
MOMCH	Medical Officer, Maternal and Child Health
MDG	Millennium Development Goals
MOH	Medical Officer of Health
MRI	Medical Research Institute
NGO	Non-Governmental Organizations
NCD	Non-Communicable Diseases
NCoD	Nutrition Coordination Division
ND	Nutrition Division
NSACP	National STD/AIDS Control Programme
NYHS	National Youth Health Survey

PC	Professional Colleges
PDHS	Provincial Director of Health Services
PHI	Public Health Inspector
PHNS	Public Health Nursing Service
PHM	Public Health Midwife
RDHS	Regional Director of Health Services
SMI	School Medical Inspection
SLCCP	College of Community Physicians of Sri Lanka
SLCPSY	Sri Lanka College of Psychiatry
SLCOG	Sri Lanka College of Obstetricians & Gynaecologists
SLCS	College of Surgeons of Sri Lanka
SPHI	Supervisory Public Health Inspector
SPHM	Supervisory Public Health Midwife
STI	Sexually Transmitted Infection
SDGs	Sustainable Development Goals
WIFS	Weekly Iron Folate Supplementation
WHO	World Health Organization

Executive Summary

Five million, nearly one fourth of the Sri Lankan population are adolescents and youth of 10-24-year age group. Adolescents, 10-19 year group, accounts for 16% of the population. Out of adolescents, 70% are school going and 30% non-school going. Youth identified as 15-24 year group consists of 16% of the population[1].

First national strategic plan on adolescent health provided necessary guidance for implementation of adolescent health programme throughout the country for the period of 2013-2017[2]. Second national strategic plan on adolescent and youth health (2018-2025) is developed as an aid for implementing the Sustainable Development Goals (SDGs) related to adolescent and youth within the country. In order to achieve global economic, social and environmental sustainable development by 2030, investing on adolescent and youth health and well-being is recognized as a very important investment. Programming for adolescent and youth health in the health sector in collaboration with other sectors and meeting adolescents' and youths' needs in all aspects is intended through new strategic plan on adolescent and youth health (2018-2025).

The Global Strategy for Women's, Children's and Adolescents' Health (2016–2030) was launched in 2015[3]. It highlights the need for strengthening adolescent health to respond more effectively to adolescents' needs. The Global Strategy with its vision of a world in which every woman, child and adolescent realizes their rights to physical and mental health, identifies adolescent period as the fundamental phase for achieving the SDGs. To ensure implementation of its specific goals related to adolescent health on request from Member States at the Sixty-eighth World Health Assembly in May 2015, UN partners, led by the World Health Organization(WHO), have developed accelerated action for the health of adolescents (AA-HA!)[4]. Present national strategic plan on adolescent and youth health (2018-2025) is developed based on the policy on young persons' health and school health policy of Sri Lanka incorporating interventions identified in global strategy and AAHA! framework adopted for Sri Lankan context.

In early 2016, the Family Health Bureau initiated the development of the national strategic plan on adolescent and youth health for 2018-2025. The National Programme Managers of "school and adolescent health" unit and "adolescent and youth health" are the coordinators for the development of the national strategic plan on adolescent and youth health (2018-2025). Technical Advisory Committee on Young Persons' Health and National Coordinating Committee on School Health provided guidance for this activity. Implementation national strategic plan on adolescent health (2013-2017) through existing school health and adolescent health programmes were reviewed[2].

The national strategic plan for adolescent and youth health (2018-2025) is prepared based on the Maternal and Child Health (MCH) Policy, Reproductive Health Policy, National Youth Policy, National Policy of Health of Young persons, School Health Policy and the National Nutrition Policy.

National strategic plan on adolescent and youth health (2018-2025) is developed with the vision of "Country in which adolescence realize their full potential for growth and development in a conducive and resourceful physical and psychosocial environment to be healthy, safe and happy". It is guided through right-based approach, gender sensitivity, equity and non-discrimination, participation and empowerment of adolescents and youth, non-judgmental approach, respect and dignity of all beneficiaries, privacy and confidentiality, respect for law and order and policies, optimal service delivery to adolescents and youth with universal coverage through building and strengthening essential linkages and focus on accountability.

Goals are based on ending preventable deaths (survive), ensuring health and wellbeing (thrive) and expanding enabling environments (transform). This document provides strategic directions under 12 key areas addressing emerging issues and challenges pertaining to health of the adolescents and youth mainly focusing on the Ministry of Health perspective. The existence of explicit strategies supports homogeneous, sustainable and quality health service to all adolescents and youth in Sri Lanka.

Background

Out of the total Sri Lankan population of 20.4 million, nearly one fourth (5 million) consists of young persons aged 10-24-years. Adolescents identified as 10-19-year age group, accounts for 16% of the population. Out of adolescents, 70% are school going and 30% are non-school going. Youth identified as 15-24 year group consists of 16% of the total population[1].

Adolescent and youth are considered as an apparently healthy group. Yet, it is a time period where they undergo rapid emotional, physical and intellectual transition from childhood to adolescence and to independent adulthood. Though, they get physical maturation by early 10-16 years, maturation of the brain continues up to mid-twenties. They like to experiment new things, yet they are unable to perceive the consequences. This nature of adolescent and youth accounts for premature deaths due to accidents, suicide, violence, pregnancy related complications and other illnesses that are either preventable or treatable. Healthy as well as unhealthy lifestyles established within this period will be continued throughout their life span. Effects of these will extend even beyond adulthood into the next generation. Unhealthy lifestyles such as tobacco and alcohol use, poor dietary habits and sedentary lifestyles, lead to premature morbidity and mortality later in life.

Definitions

Different terminologies are used for denoting certain age categories among adolescents and youth.

Table 1- Definitions used within 10-24-year group

Name	Definition
Adolescence	The period of life between 10-19 years of age
Early Adolescence	The period of life between 10-14 years of age
Mid Adolescence	The period of life between 15-17 years of age
Late Adolescence	The period of life between 18-19 years of age
Teenager	Person aged between 13-19 years
Youth	Person aged between 15-24 years
Young Person	Person aged between 10-24 years

Current Situation

Adolescent and youth mortality

In spite of adolescent and youth appear to be apparently healthy, when considering latest compiled data of Register General Department, there is an adolescent mortality of 45 per 100 000 population and youth mortality of 75 per 100 000 population in 2013[1].

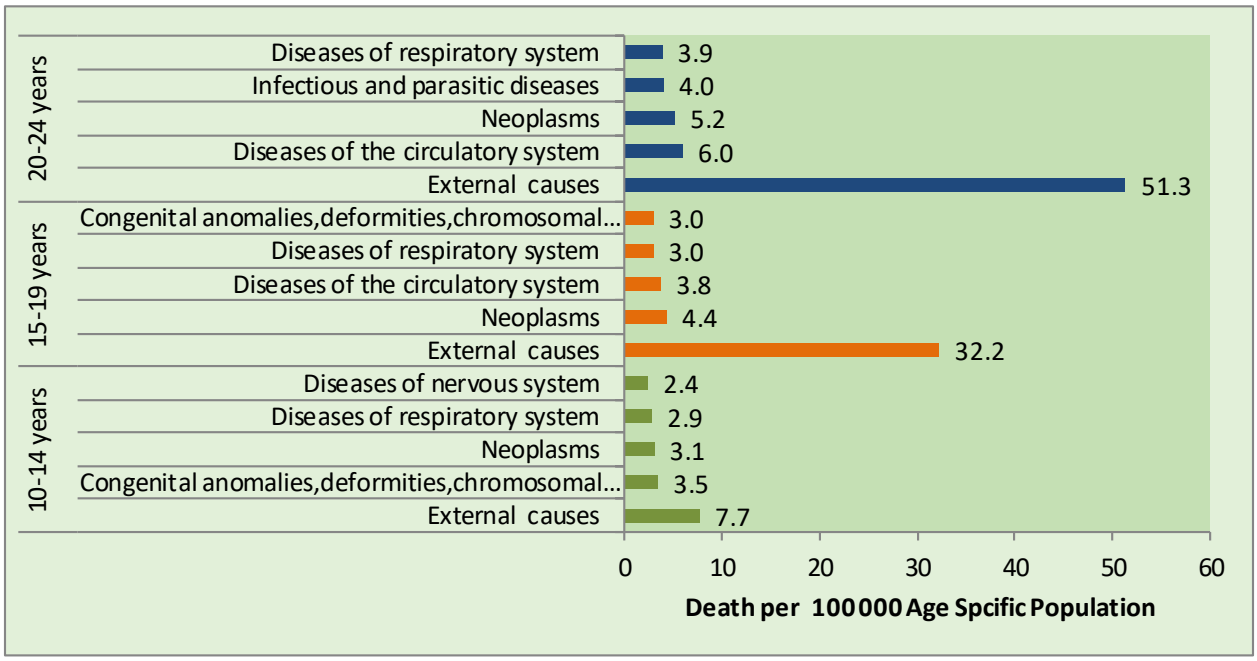

Figure 1- Top five leading causes of deaths among adolescents and youth 2013

Source; Registrar General Department Data (Department of Census 2018)

Among 10-14, 15-19 and 20-24 year groups leading cause of death was external causes (Figure1)

When it comes to the leading causes of hospital admissions, Injury, poisoning and other external causes was cause accounting for highest number of hospital admissions in 2016 according to the e–Indoor morbidity and mortality register (IMMR)[4].

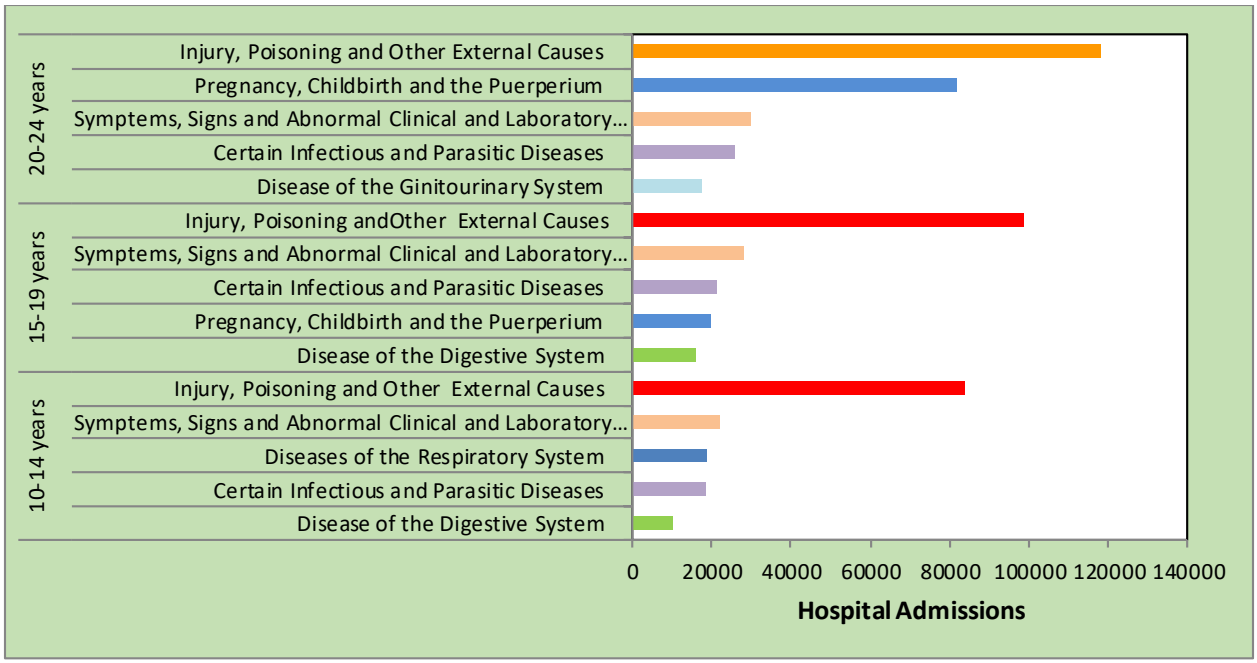

Figure 2- Top five leading causes of hospital admissions among adolescents and youth 2016
Source- e Indoor Morbidity and Mortality Register (Ministry of Health 2018)

Sexual and reproductive health issues

According to the national youth health survey conducted in 2012/2013 among 8820 youth, around 30% reported to have engaged in some sexual activity within past one year. Almost half of the youth were not aware of even basic physiology and common sexual and reproductive health issues. Only 45% had heard of the emergency contraceptive pill[6].

Adolescent fertility rate has remained static over the period of 1975 - 2016 with the figures of 31 and 30 per 1,000 women of 15 -19 years respectively in 1975 and 2016(Figure 3)[1,7,8]. In 2017 years 16708 teenage pregnancies were reported among women under 19 years[8]. National figure for teenage pregnancy rate was 4.6 %.in 2017(Figure 4)[9].

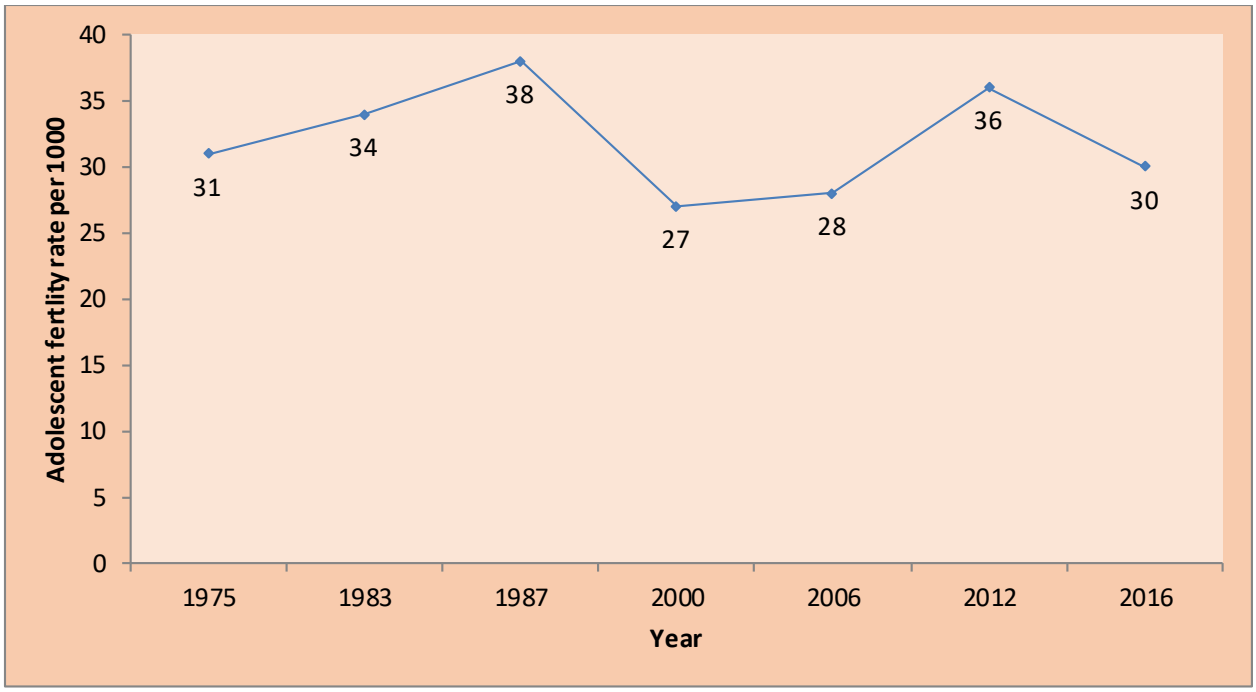

Figure 3-Adolescent fertility rate over 1963-2016

Sources: Department of Census and Statistics 2016; World Fertility Survey (1975); Contraceptive Prevalence Survey (1982), Demographic health Surveys (1987,2000,2006,2016), Census (2012), DHS(2016)

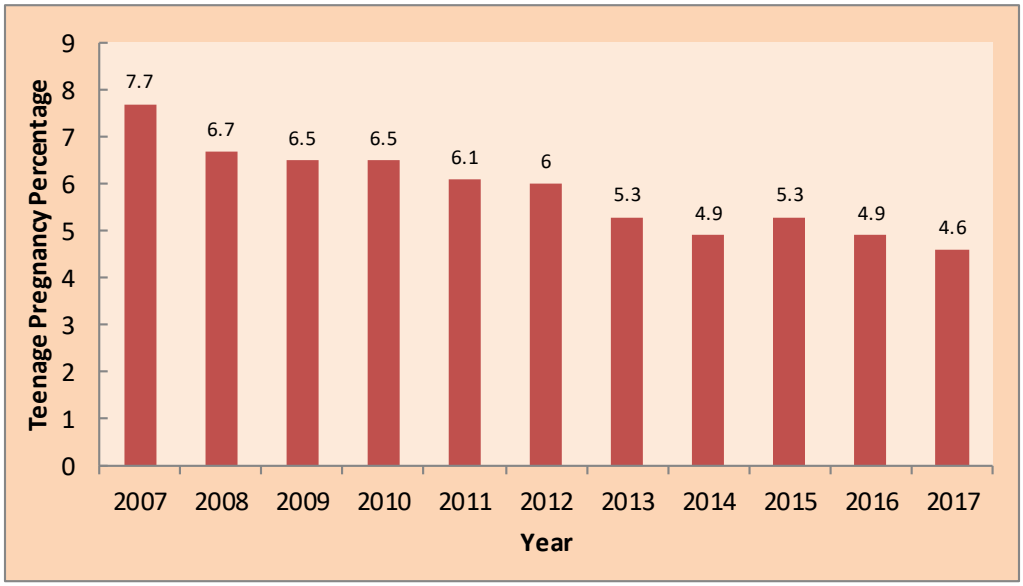

Figure 4-Trend of teenage pregnancies over 2007-2016

Source: RHMIS, Family Health Bureau 2018

Accidents, violence and unintentional trauma

According to morality data from Register General Department and e-IMMR, leading cause of morbidity and mortality among 10-24-year age group is external causes[1,4]. Incompletion of maturation of pre-frontal cortex of their brain until mid- twenties is the scientific basis of increased risk taking.

Global school health survey (GSHS) conducted in 2016 as a school-based survey using a two-stage cluster sample design among 3,262 of students in grades 8-13 of 13-17 years of age in Sri Lanka showed that 43.8% of students engaged in a physical fight one or more times during the 12 months before the survey and 35.6% of students were seriously injured one or more times during the 12 months before the survey[10].

According to the Register General Department data 2013, intentional self-harm accounts for the majority of deaths due to external causes among both 15-19 and 20-24 year age groups (Figure 5). Transport accident was the second highest cause accounting for deaths due to external causes among these two age groups[1].

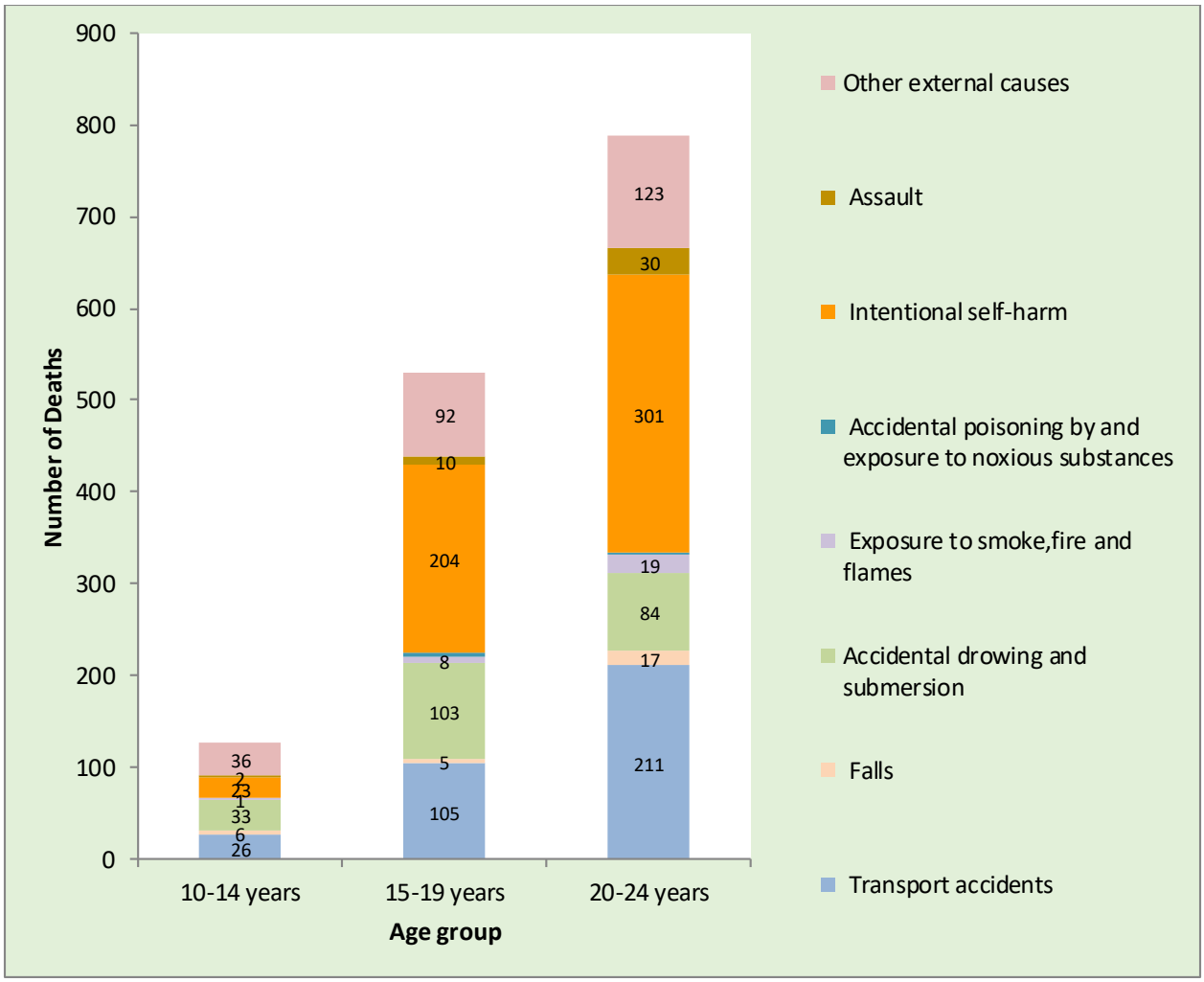

Figure 5-Extenal causes of deaths among adolescents and youth in 2013

Source: Department Census and Statistics, 2018

Substance use

According to the national youth health survey, percentages of ever smoked and ever used alcohol, were at persistently high levels of 16% and 20%, respectively. Sixteen percent had tried other additive substances[6]. The global youth tobacco survey (GYTS) conducted in some nationally representative sample of 1416 adolescents of 13-15 years school going children in Sri Lanka showed that current tobacco use within thirty days was 3.7%. Out of the study sample, 5.7% of students reported that they had smoked one or more cigarettes in their lifetime. When considering their personal lives, 15.3% of students reported that they had one or more parents who smoked, and 14.8% reported having close friends who smoked tobacco. When it comes to

cessation, only 25.0% of current smokers reported that they had received help from a programme or professional to stop smoking[11].

According to GSHS 2016, 15.3% of males and 3.1% of females among 13-17-year-old students currently used any tobacco products (used any tobacco products on at least 1 day during the 30 days before the survey). Out of the group, 42.3% reported that other people smoked in the presence of adolescent on one or more days during the 7 days before the survey[10].

According to GSHS 2016, 5.5 % of males and 1% of females of 13-17-year-old students currently consumed alcohol (at least one drink of alcohol during the 30 days before the survey). Further, 4.6 % of males and 0.8% of females in 13-17-year cohort had ever used marijuana one or more times during their life[10].

Psychosocial issues

Globally mental health problems were estimated to affect 10–20% of children and adolescents, accounting for 15–30% of disability-adjusted life years (DALYs) lost during the first three decades of life[12]

Violence among schooling adolescents has been identified as a global phenomenon which demonstrates a considerable cultural diversity. A descriptive cross-sectional study design carried out among schooling adolescent aged 13-15 years (n=1770) in government schools in district of Gampaha, revealed that involvement of adolescents in violence is through victimization, perpetration or both. The prevalence of being an overall victim for any violent activity at least once within preceding six month was 85.1%[13].

The GSHS shows that a significant proportion of students among 13-17 year (39%) in Sri Lanka had reported been bullied on one or more days in the past 30 days. In general, boys (49%) were more likely to report being bullied than girls (29%). Within this group 6.7% had attempted suicide with in past 12 months and 6.8% made a plan about how they would attempt suicide.

Percentage of students who seriously considered attempting suicide during the 12 months before the survey was 9.4%[10]**.** According to the national youth health survey, nearly 6.5% reported to have seriously considered attempting suicide and 4% had made plans on how they would attempt suicide[6]. Mortality among young person due to suicides was 10.9 per 100 000 in 2013 according to the Registrar General Department data[1].

Nutrition

A nationally representative cross-sectional study conducted on 6,264 adolescents 10 to 15 years of age showed that prevalence rates of underweight, stunting and overweight were 47.2%, 28.5%, and 2.2%, respectively. Further to that, prevalence rates of anemia and vitamin A deficiency were 11.1% and 0.4%, respectively. During the previous 6 months, 10.4% of the study group had usually not eaten breakfast before going to school. Preceding week of the interviews, 24.4% of the children had not consumed green leafy vegetables, 26.6% had not consumed fruit, 19.0% had not participated in physical activities, and 27.5% had watched television for more than 2 hours per day[14].

National nutrition and micronutrient survey conducted in 2012 showed that among 405 adolescents of 10-18 years, 17.3% were stunted, 25.1% were thin, and 4.6% were overweight and 1.4% obese[15].

A cross-sectional study conducted among 7526 secondary school students from 72 secondary schools selected from the 25 districts of Sri Lanka in 2009-2010 showed that anaemia among 470 (6.2%)students and was more common in females (11.1%) than males (5.6%). Median age of the study sample was 16.0 (IQR 15.0–17.0) years. Iron deficiency anaemia was found in 130 (4.6%) out 2794 females and 28 (1.0%) out of 2789 males[16]. Comprehensive nutrition survey among school going children and adolescents of 10-18 years conducted in 2017 by Medical Research Institute (MRI) shows that 8.5% are aneamic (MRI 2018)[17]. Iron deficiency was seen among 22.1% and only 3.7% had anaemia due to iron deficiency. Vitamin A level less 20 µg/dL and iodine deficiency was not found as a public health issue [17].

Further, in this survey conducted among 7700 of 10-18-year school going adolescents, 26.9% were thin, 13.7% were stunted, 7.6% were overweight and 2.2% were obese[17].

A declining trend of low Body Mass Index (BMI) from 42.2% to 24.3% in males and from 27.9% to 16.2% in females was observed in nutrition month data among year 10 students over 2007- 2017 (Figure 6).

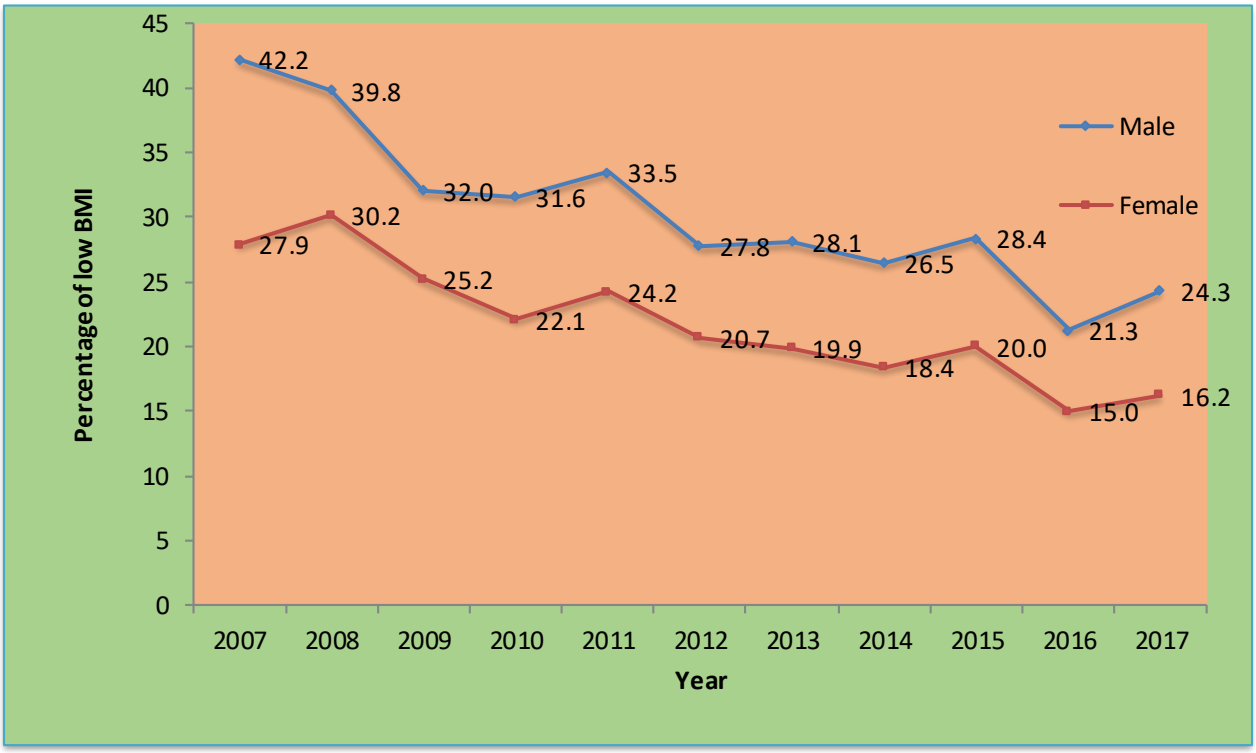

Figure 6-Low Body Mass Index among grade 10 students

Source: Nutrition month data

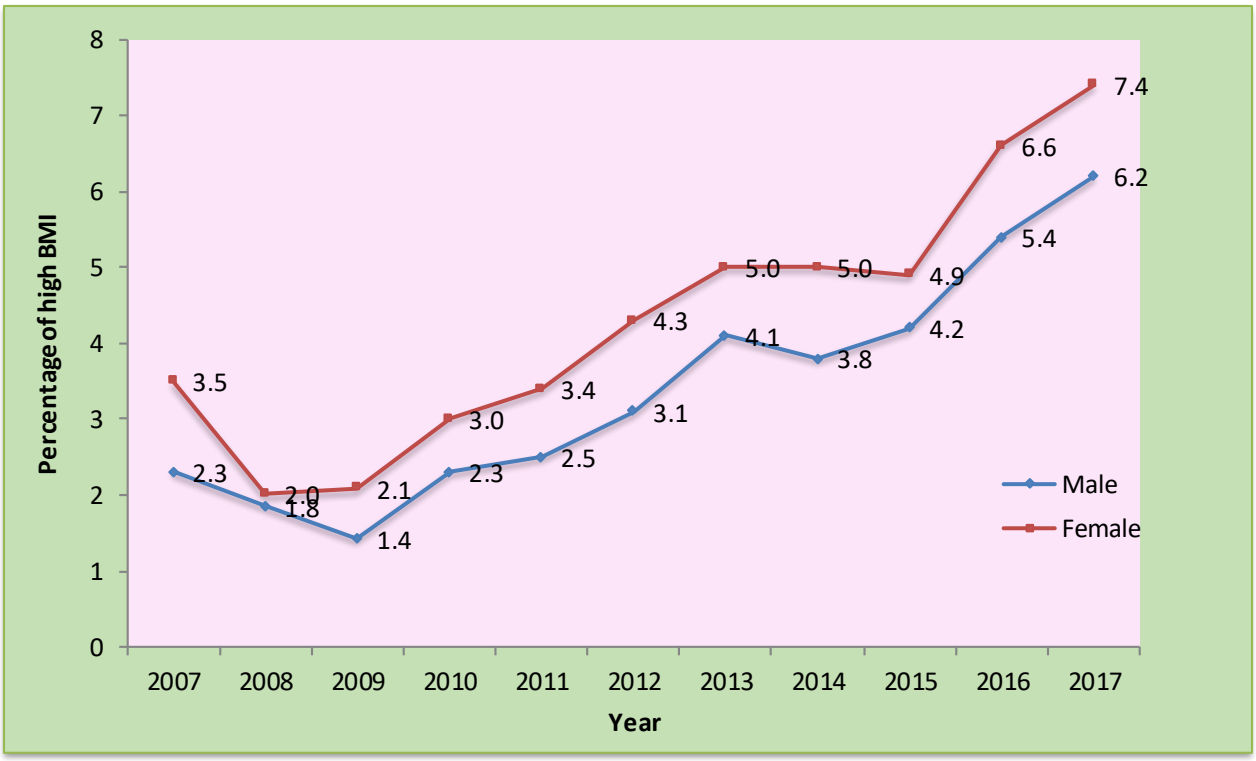

Figure 7 - Overweight and obesity among grade 10 students

Source: Nutrition month data

However, overweight and obesity of the same cohort of grade 10 students showed an increasing trend from 2.3% to 6.2% among males and 3.5% to 7.4% among females over 2007-2017(Figure 7). The preliminary analysis comprehensive nutrition survey among school going children and adolescents of 10-19 years conducted in 2017 by Medical Research Institute overweight and obesity are 7.4% and 2.4% respectively[17](MRI 2018)

Unhealthy lifestyles

Global literature shows that many non-communicable diseases (NCD) are resulted from the behaviors that are established in adolescence, including unhealthy diet, sedentary lifestyle, harmful use of alcohol and tobacco use. This disproportionately affects poor vulnerable and less educated sections of our communities. NCD accounts for pre-mature mortality. Diagnosing NCD among adolescents is at a rising trend. Evidence further emphasize the importance of introducing NCD prevention strategies from an early age. Establishing healthy eating habits, regular exercise and

avoiding risk behaviours among adolescents have been identified as major interventions to overcome this challenge of devastating effects of NCDs among individuals, families, communities and health systems.

According to the GSHS 2016, only 15.5% of students were physically active at least for 60 minutes a day on all seven days during preceding week of the survey. Only 41.5% of students attended physical education classes on three or more days each week during this school year. However, 37.3% have spent three or more hours per day watching television, playing computer games, or talking with friends, when not in school or doing homework during a usual day[10]. According to the national youth heath survey 2012-2013, nearly 50% of males and 75% of females had sedentary lifestyles[6].

In GSHS 2016, percentage of students (13-17 years) who usually consumed carbonated soft drinks one or more times per day during the 30 days before the survey was 26.2%[10]. According to the national youth heath survey 2012-2013, within proceeding week, 44% of the study group reported to have consumed carbonated drinks and 20% had taken precooked food such as sausages and meatballs. Nearly 60% were equipped with mobile phones and 10% tried to use this facility to develop relationships with unknown people[6].

Oral diseases

Oral diseases are a major concern among adolescents. According to the National Oral Health Survey (2003), 40% of 12 year olds and 52% of 15 year olds had dental caries 14. Nearly 50% of 12 year olds and 62% of 15 year olds had dental calculi. Initiation of tobacco/alcohol use and emerging habits such as 'Babul' chewing with frequent consumption of sugar-rich, unhealthy junk-foods has lead to high burden of oral disease among adolescents[18].

Legal framework pertaining to adolescents

Sri Lanka has ratified the Child Rights Convention (CRC) and the Convention of the Elimination of all forms of Discrimination against Women (CEDAW). These international treaties created commitments and harmonize with many provisions set out in the constitution of Sri Lanka.

Sri Lanka is one of the countries that have received international recognition for its policies and laws for provision of free health and education systems without discrimination. Education and attendance at school were made compulsory for children between 5 and 14 years since 1939 by Education Ordinance of 1939. The minimum age identified for employment of children was recognized as 14 years in 1999, by an amendment to the Employment of Women, Young Persons and Children Act (No. 47) of 1956.

Ministry of Labour has the authority to enact laws that prohibit the employment of children in hazardous forms of child labour. The Article 22 of the Constitution on Special Rights for Children provides constitutional guarantees to the right of a child to be protected from abuse.

In Sri Lankan legal system, "child" is defined as persons from birth to 18 years of age and 16 years is generally considered as the "age of discretion" for both boys and girls. The minimum age of marriage under the general law is identified as 18 years. Sri Lanka, being a multi-ethnic, multi-religious society, has certain personal laws which are applicable only to specify ethnic and religious groups and which defer from the civil law[19].

Services for adolescents and youth

All these reflects the need for young people to have adolescent youth-friendly health service (AYFHS) at primary care level. Youth friendly health service concept was introduced in Sri Lanka in 2005. Though around 50 centers were established by late 2008 at hospitals and medical officer of health (MOH) areas, there were only nine youth friendly health service centers that were functioning when youth health component was incorporated into the family health

programme of the Family Health Bureau in the latter half of 2015. Revamping process was initiated under the concept of "Yowun Piyasa" in 2016.

There are three models for Yowun Piyasa. They are 1). Hospital based 2). Field based (at MOH office) 3. Center based (separate center with both health and non-health facilities such as sport, computer, library, etc.)

The issues which led to the failure or closure of youth friendly health service centers were reviewed and the main reasons identified were lack of demand due to unawareness and poor quality of services. The national standards developed in 2005 were reviewed and new AYFHS standards were developed adapting the global standards with WHO support in 2016. New standards would help to overcome these barriers and facilitate the implementation of the AYFHS[20].

In hospitals, AYFHS is provided in a corner away from the crowd and yet, linked to the outpatient department. It has easy accessibility to other health care units and very convenient for the client when referrals are made. Field based centers at the MOH offices are closer to the community. Center based concept is considered as ideal where center provides other facilities such as computers, reading materials, vocational training facilities and recreational facilities in addition to health care services.

Whenever, AYFHS is provided at the MOH office or at non-health institutions, it is linked with the closest health institution. In parallel to AYFHS center, field health component of AYFHS is delivered through field health team under the leadership of MOH. The MOH of the area has the overall responsibility for the adolescent and youth health programme in his or her area. MOH is responsible to take necessary steps to ensure implementation of both clinic and field components of AYFHS according to the national standards in his or her area. At least, one adolescent and youth friendly health clinic session is conducted once or twice a month on a fixed day (e.g. fourth Saturday morning) at MOH office or in a field clinic by the MOH or

additional MOH(AMOH) with the support of public health nursing sister(PHNS), public health midwife(PHM) and other public health staff.

Adequate steps have to be taken to publicize this clinic services among the adolescents and youth at schools, vocational training centers, youth corps, work places etc. Further, awareness should be raised among their parents and public. Young persons are referred to this center from school medical inspection (SMI), domiciliary visits by PHM and awareness sessions at schools or work places by public health inspector (PHI). MOH and the team is responsible for developing partnerships with educational, social service and divisional secretariat sectors as well as with non-governmental organizations(NGOs) helping adolescents with provision of certain facilities. Service provision as well as necessary referral within and out-side the health sectors are provided. Similar to SMI, MOH, PHI and the team has to screen youth attending to youth training centers in the respective area.

PHM has to register adolescents during her home visits and to identify the adolescents who are at risk. She has to refer risk adolescents to MOH. Non-school going adolescents are more vulnerable for risk behaviors and other health problems. Caring for non-school going adolescents is a responsibility of PHM and PHI under the guidance of the MOH and the health team consisting of PHNS, supervisory public health midwife(SPHM), supervisory public health inspector(SPHI). PHI is responsible to raise awareness and referring for necessary services among adolescents and youth at the training centers and working places.

School Health Programme

Around 4,118, 781 children attend schools around the country. Primary school completion rate of these children is 97.9%, while only 98.4% complete up to Grade Nine.

Family Health Bureau is the focal point for school health programme. Central level planning, co-ordination, training, supervision, monitoring and evaluation functions are carried out by the

family health bureau. District level co-ordination was done by the Medical Officer, Maternal and Child Health(MOMCH). The MOH and his/her staff implement the school health programme with the PHI as the person responsible at the grass root level.

School Medical Inspection (SMI) is conducted by the MOH and his staff. In schools with less than 200 students, all are examined at the SMI. In schools with more than 200 students, SMI is conducted for grades 1, 4, 7 and 10. Children with identified defects are attended to, and necessary referrals are made.

The Ministry of Education has included health and physical education and other health related subjects in the school curricula. Sports and other extra-curricular activities are also encouraged in schools to promote physical health. The concept of health promoting schools has been incorporated into school health programme. Health promoting school program is implemented as a joint activity by health and education sectors and teacher counseling services are offered to schools with more than 400 students.

Weekly iron folate supplementation(WIFS) is provided for all the school children in grades 1 to 13. MOH and the team conduct teacher training and educational programs for students on reproductive health, nutrition, NCD prevention and life skills. School Dental Service is provided to children up to 13 years.

Certain aspects of adolescent health component including life skills, nutrition, reproductive hare included in the school curriculum. Ministry of Education has taken initiatives to ensure school attendance unto grade 13 by introduction of practical technological skills component focusing future employments.

Non-school going adolescents

Non-school going adolescents are at a higher risk compared to the school going adolescents. Further, they are a hard to reach category in the community. Addressing the health needs of

the non-school going adolescents has become a great challenge. Several programmes are going on to reach them at various locations and institutions connected with employment, vocational training, youth training centers, universities or other tertiary education centers. Further, several NGOs such as Sarvodaya, Family Planning Association, Red Cross, Plan Sri Lanka, Sewa Lanka, Child Fund, Sumithrayo, Alcohol and Drug Information Center (ADIC) are reaching this group with provision of information, skills and services with varying degree of coverage. However, reaching marginalized groups of adolescents and youth at fragile settings is still found to be a major challenge.

Multi-sectorial involvement

Ministry of National Policies and Economic Affairs and Ministry of Vocational Training and Skills Development ensure provision of a wide range of training opportunities for youth. Ministry of Social Empowerment, Welfare and Kandyan Heritage, Ministry of Women and Child Affairs and Ministry of National Policies and Economic Affairs provide networks of counseling services at the divisional secretariat level with island wide coverage.

Ministry of Health has initiated preliminary discussions with the other ministries under the leader ship of Ministry of National Policies and Economic Affairs for developing muti-sectoral plan on youth health. Plan will be developed with the involvement of adolescents and youth and other relevant stakeholders at all steps.

Other ongoing interventions

Parallel to development of standards on AYFHS, assessment tools, supervisory check list, implementation guide on AYFHS and clinic protocol were developed. Existing AYFHS centers were assessed. Youth health web site (http://yowunpiyasa.lk) was developed and launched. Development of school health policy was initiated by the school health unit of the Family Health Bureau jointly with Ministry of Education. Development of multi-sectoral plan for youth was started under the leadership of Ministry of National Policy Development and Economic Affairs.

With the intension of building a conducive environment to facilitate adolescent health promotion, efforts were taken from ministry of education for making school education compulsory up to grade 13 with introduction of certain carrier guidance component.

A cabinet paper on physical activity in school for obesity prevention was processed and obtained cabinet approval to make one non-competitive sport compulsory at the school. Guidelines for health promoting school was developed and accreditation process was initiated. Implementation of school canteen policy are being strengthened.

Global developments in adolescents and youth health

1. Sustainable Development Goals(SDGs) and Adolescent Health

All 17 goals of SDG are applicable to adolescents. However, goal number 3 and 4 are directly concerned about adolescent health and education respectively.

SDG goals focusing mainly on adolescent and youth health and education;

Goal 3: Ensure healthy lives and promote well-being for all at all ages

Goal 4: Ensure inclusive and equitable quality education and promote life-long learning opportunities for all

Targets of other SDGs that specifically address adolescents:

- Reduce at least by half the proportion of children living in poverty in all its dimensions according to national definitions (Target 1.2).
- Address the nutritional needs of adolescent girls (Target 2.2).
- Ensure that all girls and boys complete free, equitable and quality primary and secondary education leading to relevant and effective learning outcomes (Target 4.1).
- Substantially increase the number of youth who have relevant skills, including technical and vocational skills, for employment, decent jobs and entrepreneurship (Target 4.4).
- Eliminate gender disparities in education and ensure equal access to all levels of education

and vocational training for children in vulnerable situations (Target 4.5).

- Ensure that all youth achieve literacy and numeracy (Target 4.6).
- Build and upgrade education facilities that are child sensitive and provide safe, non-violent, inclusive and effective learning environments for all (Target 4.a).
- End all forms of discrimination on against all girls every-where (Target 5.1).
- Eliminate all forms of violence against all girls in the public and private spheres, including trafficking and sexual and other types of exploitation (Target 5.2).
- Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation (Target 5.3).
- Adopt and strengthen sound policies and enforceable legislation on for the promo on of gender equality and the empowerment of girls at all levels (Target 5.c).
- Achieve access to adequate and equitable sanitation and hygiene for all and end open defecation, paying special attention on to the needs of girls (Target 6.2).
- Achieve full and productive employment and decent work for all young people, and equal pay for work of equal value (Target 8.5).
- By 2020, substantially reduce the proportion of youth not in employment, education on or training (Target 8.6).
- Take immediate and effective measures to eradicate forced labour, end modern slavery and human trafficking and secure the prohibition on and elimination of the worst forms of child labour, including recruitment and use of child soldiers, and by 2025 end child labour in all its forms (Target 8.7).
- By 2020, develop and operationalize a global strategy for youth employment and implement the Global Jobs Pact of the International Labour Organization (Target 8.b)
- Provide access to safe, affordable, accessible and sustainable transport systems for all, improving road safety, notably by expanding public transport, with special attention on to the needs of children (Target 11.2).
- Provide universal access to safe, inclusive and accessible green and public spaces, in particular for children (Target 11.7).
- Promote mechanisms for raising capacity for effective climate change-related planning and

management in least-developed countries and small island developing states, including focusing on youth (Target 13.b).

• End abuse, exploitation, trafficking and all forms of violence against and torture of children (Target 16.2).

Investment on adolescent health is essential to achieve the 17 SDGs with their 169 targets by 2030.

2. Global Strategy for Women's, Children's and Adolescent Health (2016-2030): Adolescent health components[3]

A new global coalition of more than 500 leading health and development organizations worldwide is urging governments to accelerate reforms that ensure everyone, everywhere, can access quality health services without being forced into poverty. The coalition highlight the importance of universal access to health services for saving lives, which is a target within the "Global Strategy for Women's Children's and Adolescents' Health (2016-2030): Survive, Thrive, Transform. WHO's report on Health for the world's adolescents: a second chance in the second decade notes that making progress towards universal health coverage will require Ministries of Health and the health sector to transform how health systems respond to the health needs of adolescents[21].

3. Accelerated Action for the Health of Adolescents Framework ("the Global AA-HA! Framework") [4]

As requested by the 68th World Health Assembly, WHO developed a Global Accelerated Action for the Health of Adolescents Framework ("the Global AA-HA! Framework") in consultation with youth, member States and major partners aligned with the Global Strategy for Women's, Children's and Adolescents' Health (2016-2030). Framework provides guidance to countries and programmes on how to plan, implement and monitor " SURVIVE, THRIVE and TRANSFORM" response to the health needs of adolescents in line with the Global Strategy for Women's, Children's and Adolescents' Health (2016-2030). The AA-HA! guidance provides a systematic

approach for understanding adolescent health needs, prioritizing these in the country context and planning, monitoring and evaluating adolescent health programmes.

Policy guidance for strategic plan for adolescent and youth health (2018-2025)

National Youth Policy was developed in 2014 by Ministry of Youth Affairs and Skill Development with the vision of "development of the full potential of young people to enable their active participation in national development for a just and equitable society". It directs towards building capacity of young people to meaningfully engage in the national development process. Guided by it, National Policy of Health of Young Persons was developed by the Ministry of Health.

The strategic plan for adolescent and youth health (2018-2025) is prepared based on the Maternal and Child Health (MCH) Policy, Reproductive Health Policy, National Youth Policy, National Policy of Health of Young persons, School Health Policy and the National Nutrition Policy. The strategic framework for adolescents and youth (2018-2025) ensures implementation of the youth health strategies identified in the National Youth Policy, the National Policy of Health of Young Persons and School Health Policy the country.

The MCH policy provides directions on strengthening the already established maternal and child health services with a vision of "A Sri Lankan nation that has optimized the quality of life and health potential of all women, children and their families" and its Goal 5 is dedicated to improve health of all children and adolescents.

Furthermore, strategic plan for adolescent and youth health (2018-2025) has linkages with national strategic plan on maternal and newborn health and national strategic plan on child health ensuring lifecycle approach[22, 23].

Sri Lanka is one of the first countries in the South East Asian Region to develop National Standards for AYFHS in 2006 which comprised of five standards. Those five standards were reviewed and revised after ten years and developed a new updated set of eight national standards for AYFHS. The strategic plan for adolescent and youth health (2018-2025), would ensure that AYFHS in the country meeting these national standards for AYFHS.

Rationale and the development of the strategic plan for adolescent and youth health 2018-2025

The present national adolescent and youth health strategic plan 2018 – 2025 is for a period of eight years. The first adolescent health strategic plan for 2013-2017 had a vision "to ensure that adolescents realize their full potential for growth and development in a conducive and resourceful physical and psychosocial environment"[2]. It provided guidance for implementation of evidence-based interventions at national, provincial, district and divisional levels for achieving millennium development (MDG) goals. It addressed adolescent health through five broader sectors in parallel to building blocks of the health system; health sector, human resource development, health service delivery and cross cutting issues. It ensured the smooth implementations of identified evidence-based interventions with the guidance of advisory committee on young persons' health. Though most of the strategies have been implemented, there are gaps in provision of quality care in addressing holistic needs of the adolescents and youth.

In September 2015 at the historic UN Summit, the 17 Sustainable Development Goals (SDGs) of the 2030 Agenda for Sustainable Development were adopted by world leaders with the intention of ending all forms of poverty, fighting inequalities and addressing climate change, while ensuring that no one is left behind over the next fifteen years.

The new goals recognize that ending poverty must go hand-in-hand with strategies that build economic growth and address a range of social needs including education, health, social

protection, and job opportunities, while confronting climate change and environmental protection. All seventeen SDGs are applicable to adolescents.

Adolescent and youth health strategic plan 2018–2025 is developed in order to complete the unfinished agendas of the MDGs and addressing adolescent health rights and the needs with non-discriminations addressing SDGs. This will provide guidance for accelerated implementation of adolescent and youth health programme in the country. It is expected to ensure addressing adolescent and youth health needs to an optimum in order to reach targets of SDGs.

Most of the strategies in this framework cover global strategies on Adolescent Health for 2016-2030 and Global Accelerated Action for the Health of Adolescents Framework ("the Global AA-HA! Framework") [3, 4].

In early 2016, the Family Health Bureau initiated the development of the adolescent and youth health strategic plan 2018–2025. The National Programme Managers of "school and adolescent health" and "adolescent and youth health" units are the coordinators for the development of adolescent and youth health strategic plan 2018–2025. Technical advisory committee on young persons' health and national coordinating committee on school health provided guidance for activity. Existing school health and adolescent health programmes were reviewed.

Strategic plan was developed with the contribution of a wide spectrum of stakeholders including the Director General Health Services(DGHS), Deputy Director Generals(DDGs), Health care workers in adolescent and youth health from the hospitals and the field, members from the Professional Organizations, relevant national programme managers from the Family Health Bureau and adolescent and civil society groups to understand the existing gaps in the adolescent and youth health programme and the important aspects that should be addressed in the next strategic plan. Latest evidence-based strategies were reviewed in global context and followed the interventions identified in Global Strategy for Women's, Children's and

Adolescents' Health 2016 -2030 and Global Accelerated Action for the Health of Adolescents Framework ("the Global AA-HA! Framework")[3,4]. With the consensus of DGHS and all relevant stakeholders final draft was developed.

This document provides strategic directions under 12 key areas addressing emerging issues and challenges pertaining to health of the youth mainly focusing on the ministry of health perspective. The existence of explicit strategies supports homogeneous, sustainable and quality health services to all adolescents and youth in Sri Lanka as identified in the National AYFHS Standards .

Higher level policy makers in the Ministry of Health, Ministry of Education, Ministry of National Policy Development, Ministry of Social empowerment, Welfare and Kandyan Heritage, Ministry of Skills Development and Vocational Training, Ministry of Women and Child Affairs and other ministries, national level program planners, program managers at provincial, district and divisional levels and all relevant stakeholders including developmental partners are considered as the target audience of this document.

Guiding Principles

This document was prepared based on the following guiding principles:

- Right-based approach
- Gender sensitivity and equality
- Equity and non-discrimination
- Participation and empowerment of adolescents and youth
- Non-judgmental approach, respect and dignity of all beneficiaries
- Privacy and confidentiality
- Respect for law and order and policies
- Optimal service delivery to adolescents and youth with universal coverage

Vision:

Country in which adolescents and youth realize their full potential for growth and development in a conducive and resourceful physical and psychosocial environment to be healthy, safe and happy.

Mission:

To ensure adolescents and youth are empowered with knowledge, attitudes, skills and opportunities for optimum development in a safe, supportive and promotive environment at home, school and community which facilitate healthy transitions into adulthood and provided quality health care.

Goals:

Adolescents and youth receive timely and effective health promotion, prevention, and care services through integrated health systems and inter-sectoral collaboration.

Goals are based on following concepts:

1. Survive - End preventable deaths
2. Thrive- Ensure health and well-being
3. Transform - Expand enabling environments

Goals of the adolescent and youth health programme of the country

Note: The ultimate goal of a programme is to reduce mortality, morbidity and improve nutritional status and wellbeing. Therefore, the goals for adolescent and youth health programme are selected based on the indicators of morbidity, mortality and nutrition and wellbeing.

1. Reduce mortality among young persons(adolescents and youth) due to accidents(transport, falls and drowning) from 18.5 (in 2013) to 12.0 per 100 000 by 2025- **Source: Department of Census and Statistics 2018**

2. Reduce mortality among young persons(adolescents and youth) due to suicides(intentional self harm) from 10.9(in 2013) to 5.0 per 100 000 by 2025- **Source: Department of Census and Statistics 2018**
3. Reduce the prevalence of wasting(thinness) among adolescents from 26.9 % to 18% by 2025 **Source: MRI 2018**
4. No further increase in overweight and obesity among adolescents (<7.6% and 2.2%)- Source MRI
5. To reduce adolescent fertility rate from 30/1000 to in (2016) to 25/1000 by 2025
6. To prevent new infections of HIV/STI among young persons by 2022: **Source: National STD/AIDS Control Programme**
7. To reduce the prevalence of anaemia among adolescents from 8.5% to 5.0% by 2025 **Source: MRI 2018**
8. To increase the percentage of adolescents /youth who perceived to be in happy mood from 83% to 90 % by 2025 (NYHS 2012-2013)[5]

Evidence based interventions to improve health and wellbeing of adolescents

According to the Global Strategy for Children's Women's and Adolescent's health and accelerated action for the health of adolescents framework ("the global AA-HA! framework") the following evidence-based interventions have been identified to improve the health and wellbeing of the adolescents and youth.

Positive development

1. Promotion of healthy behaviour (e.g. nutrition, physical activity, no tobacco, no alcohol ,no substance use) through AYFHS, school health, hygiene and nutrition interventions and multispectral initiatives

Unintentional injury

2. Prevention of injuries- GS1

3. Assessment and management of adolescents who present with unintentional injury, including alcohol-related injury- GS2

Violence

4. Prevention of violence- GS3
5. Prevention and response to child maltreatment- GS4
6. Prevention of and response to sexual and other forms of gender based violence - GS5

Sexual and reproductive health, including HIV

7. Comprehensive sexuality education- GS6
8. Information, counseling and services for comprehensive sexual and reproductive health including contraception- GS7
9. Prevention of and response to harmful practices such as female genital mutilation and early and forced marriage- GS8
10. Pre-pregnancy, pregnancy, birth, post pregnancy, abortion (where legal), and post abortion care (all 48 evidence-based interventions) as relevant to adolescents- GS 9
11. Prevention, detection and treatment of sexually transmitted and reproductive tract infections, including HIV and syphilis- GS 10
12. Voluntary medical male circumcision in countries with generalized HIV epidemics- GS 11.
13. Comprehensive care of children living with, or exposed to, HIV - GS 12

Communicable diseases

14. Prevention, detection and treatment of communicable diseases, including tuberculosis - GS 13
15. Routine vaccination- GS 14
16. Prevention and management of childhood illnesses, including malaria, pneumonia, meningitis and diarrhea- GS 15

17. Case management of meningitis- GS 16

Non-communicable diseases, nutrition and physical activity

18. Promotion on of healthy behaviour (e.g. nutrition, physical activity, no tobacco, no alcohol or no drugs)- GS 17
19. Prevention, detection and treatment of non-communicable diseases- GS 18
20. Prevention, detection and management of anaemia, especially for adolescent girls. Iron supplementation on where appropriate- GS 19
21. Treatment and rehabilitation of children with congenital anomalies and disabilities- GS 20.

Mental health, substance abuse and self-harm

22. Care for children with developmental delays- GS 21
23. Responsive care-giving and stimulation- GS 22.
24. Psychosocial support and related services for adolescent mental health and well-being- GS 23.
25. Parent skills training, as appropriate, for managing behavioural disorders in adolescents- GS 24
26. Prevention of substance abuse- GS 25
27. Detection and management of hazardous and harmful substance use- GS 26
28. Prevention of suicide and management of self-harm/suicide risks- GS 27

Conditions with particularly high priority in humanitarian and fragile settings

29. Nutrition; disability and injury; violence; sexual and reproductive health; water, sanitation and hygiene; and mental health interventions.

Key: AIDS = acquired immunodeficiency syndrome; FGM = female genital mutilation; GS = Global Strategy for Women's, Children's and Adolescents' Health (2016–2030) (11); HIV = human immunodeficiency virus; STI = sexually transmitted infection.

Objectives of the adolescent and youth health programme of the country

Based on the list of evidence-based interventions, availability of the data and sensitivity of the indicators, the following are identified as the programme objectives.

1. To reduce consumption of carbonated drinks among adolescents and youth from 44% to 34% by 2025 (NYHS): Promotion of healthy diet
2. To increase the proportion of adolescents engage in physical activity (60min) from 28% to 35% by 2025 (GSHS2017): Improve physical activity
3. To reduce alcohol (current) use among adolescents /youth from 5.3% to 3% by 2025 (NYHS): Prevention and control of Alcohol consumption
4. To reduce smoking (current) among adolescents and youth 9% to 5% by 2025 (NYHS): Prevention and control of smoking
5. To reduce current use of addictive drugs among adolescents from 2.7% to 1.5% by 2025 (GSHS): Prevention of Substance abuse
6. Increase the coverage of weekly iron folic acid supplementation for school going adolescents from 77.2% to 85% by 2025(MRI): Prevention and control of anaemia
7. Increase the percentage of grade 12 children receiving comprehensive sexual and reproductive health education to 85% by 2025 (HMIS): Sexual and reproductive education
8. To reduce the percentage of adolescents subjected to bullying from 38.5% to 30% by 2025: Psychosocial development
9. To reduce the percentage of adolescents subjected to physical violence from 35% to 25% by 2025: Prevention of Violence
10. To reduce the percentage of girls getting married before 18 years from 12% to 8% by 2025 (DHS): sexual reproductive health services
11. To increase the percentage of parents/ guardians understand the problems of adolescents from 62.6% to 75% by 2025 (GSHS): Parenting
12. To reduce the percentage of adolescents who attempted suicide from 6.8% to 4% by 2025 (GSHS): Suicide prevention

13. To establish at least one adolescent and youth friendly health service center in each MOH area: Health services
14. To make all health care facilities adolescent and youth friendly: Health services

Strategic directions

To achieve the above mentioned programme goals and objectives, twelve strategic directions are identified in the adolescent and youth health strategic plan for2018 – 2025:

- Ensure leadership, governance, financing and accountability for adolescent and youth health
- Strengthen positive development of adolescent and youth
- Strengthen health system to cater for adolescent and youth health
- Promote psychosocial wellbeing of adolescents and youth
- Ensure optimal level of nutrition, physical activity, hygiene and sanitation
- Ensure access to sexual and reproductive health (SRH) education and services
- Prevent adolescents and youth from substance abuse
- Prevent accidents, injuries and violence among adolescents and youth
- Enhance community involvement to improve health of adolescents and youth
- Enhance service provision in humanitarian and fragile settings
- Strengthen capacity , partnership and networking among all stakeholders
- Strengthen research, monitoring and evaluation

Strategic direction 1

To ensure leadership, governance, financing and accountability for adolescent and youth health

Rationale

When it comes to the priority in financing, adolescent and youth health has not been given due recognition though investing on adolescents has been proven as a huge investment for the development of the country. There is the need of addressing this gap by having streamlined the flow of funds and other resources at all levels starting from national, provincial, district and

divisional levels. Further, to that ensuring having good leadership and governance with policy guidance for adolescent and youth health programme and enacting necessary laws and regulations for adolescent getting best possible health care is needed for uplifting the adolescent and youth health in the country. Hence, effective planning should be strengthened at all levels. In this process, identifying social factors operating on adolescent and youth is vital. Finding effective interventions is a huge challenge to be met. Lack of accountability is one of the other barriers for improving adolescent and youth health programme as a country. The critical role of government sectors, civil society organizations, academia, the business community, media, funders and other stakeholders in holding each other and governments to account for adolescent and youth health outcomes has to identified and strengthened. Therefore, strategies are identified to overcome all these aspects ensuring sustainability.

Strategies

1. Ensure the mechanisms to provide policy guidance to adolescent and youth health programme at all levels
2. Enact laws, regulations and policies to ensure protective, supportive and healthy environment for adolescents and youth
3. Ensure evidence-based planning and implementation and adequate funding for adolescent and youth health programme at all levels
4. Ensure mechanisms to understand and find effective ways to address social factors that contribute to adolescent and youth health
5. Strengthen accountability of government sectors, civil society organizations, academia, the business community, media, funders, other stakeholders and young persons on adolescent and youth health outcomes

Strategy Direction 1

To ensure leadership, governance, financing and accountability for adolescent and youth health

Strategy 1.1

Ensure the mechanisms to provide policy guidance to adolescent and youth health programme at all levels

Major activities

1.1.1 Advocate for a high-level steering committee chaired by President's Secretary/ prime minister to strengthen the multi-sectoral coordination to improve adolescent and youth health

1.1.2 Continue the conduction of National Steering Committee/ Technical Advisory Committee for Young Persons' Health and National Coordinating Committee School Health regularly

1.1.3 Establish district/ provincial level coordinating committees on young persons' health

1.1.4 Advocate for a single inter-ministerial plan, budget and monitoring and evaluation framework for adolescent and youth health

1.1.5 Advocate for development of infrastructure of all schools to address students' physical needs to promote learning of all students including institutionalized children and differently abled students

Strategy 1.2

Enact laws, regulations and policies to ensure protective, supportive and healthy environment for adolescents and youth

Major activities

1.2.1 Advocate and support for reviewing and updating existing policies and regulations to ensure that they are supportive and promotive for adolescent and youth health programme

1.2.2 Advocate and assist the implementation of the recommendations of the report on "Review of Laws, Regulations and Policies of Adolescent Sexual and Reproductive Health"

1.2.3 Advocate, revise and assist in implementation of child protection laws and policies including laws on abuse, corporal punishment, bullying and violence

1.2.4 Advocate and assist the implementation of the existing law and regulations on substance use including tobacco, alcohol and illicit drugs

Strategy 1.3

Ensure evidence-based planning and implementation and adequate funding for adolescent and youth health programme at all levels

Major activities

1.3.1 Develop tools with sensitive indicators to review the implementation status and achievements related to adolescent and youth health

1.3.2. Incorporate the planning for adolescent and youth health programmes to annual plans

1.3.3 Advocate for relevant policy makers and higher administrative authorities to get adequate funds for adolescent and youth health initiatives through a separate budget line including national and provincial level

Strategy 1.4

Ensure mechanisms to understand and find effective ways to address social factors that contribute to adolescent and youth health

Major activities

1.4.1 Identify the most risk groups of young persons with regard to social factors affecting health

1.4.2 Develop and implement targeted programs based on evidence with regard to vulnerable and marginalized adolescent and youth

Strategy 1.5

Strengthen accountability of government sectors, civil society organizations, academia, the business community, media, funders, other stakeholders and young persons on adolescent and youth health outcomes

Major activities

1.5.1 Include adolescent and youth health indicators into routine RHMIS and monitoring mechanism

1.5.2 Ensure participation of all stakeholders and adolescent and youth in developing plans programming, monitoring and evaluation of implementation

1.5.3 Establish a monitoring system to review the incidences related to adolescent and youth, reported in mass media

1.5.4 Advocate for establishing an arbitrary body for school going children rights

Strategic direction 2

Strengthen positive development of adolescent and youth

Rationale

Development of the young person is the basis of improving adolescent and youth health in a country. Health promoting concept is being implemented through school system as a joint activity between Ministry of Health and Ministry of Education. However, it is still not up to the expectation of the country. Hence, strengthening the programme is a timely need. In addition, around 20 000 youth are involved in vocational and other trainings. Therefore, it is essential to have health promotion concept implemented at all training centers for adolescents and youth. Initial steps of training the instructors of these training centers were carried out as a joint activity.

Use of mobile phones and computers and surfing on internet among adolescent and youth is becoming the culture. This is generally seen everywhere and was reflected by national level surveys such as national youth health survey 2012-2013. Establishing a system with online protection is a timely need of the country. Meanwhile, having e health and m health interventions for catering health needs of adolescent and youth is proven to be an effective intervention in global context.

Strategies

1. Ensure health promotion at schools and training centers
2. Ensure online protection of adolescents and youth
3. Ensure adolescent and youth participation in all levels of the AYFHS programme

4. Establish e health and m health interventions for health education for adolescents and youth
5. Ensure provision of school education up to grade 13 for all adolescents

Strategy Direction 2

Strengthen positive development of adolescent and youth

Strategy 2.1

Ensure health promotion at schools and training centers

Major activities

2.1.1 Evaluate all the schools and other educational institutions for status of health promotion and accredited based on evaluation

Strategy 2.2

Ensure online protection of adolescent and youth

Major activities

2.2.1 Advocate for enacting regulations on restricting certain web sites

2.2.2 Educate parents on online protection of the adolescent and youth

Strategy 2.3

Ensure adolescent and youth participation in all levels of AYFHS programme

Major activities

2.3.1 Facilitate adolescent and youth participation and involvement in programme design, implementation and monitoring and evaluation of AYFHS

Strategy 2.4

Establish e health and m health intervention for health education for adolescents and youth

Major activities

2.4.1 Explore the potential of adolescent e-health and m-health interventions focused on particular issues such as chronic illness management, tobacco cessation and sexual reproductive health with a variety of approaches

Strategy 2.5

Ensure provision of school education up to grade 13 for all adolescents

2.5.1 Strengthen monitoring school dropout closely at schools

2.5.2 Strengthen follow up of school dropouts at the field by public health staff

Strategic direction 3

Strengthen health system to cater for adolescent and youth

Rationale

AYFHS are initiated in Sri Lanka as early as 2005. However, at present there are only 30 functioning centers all over the country. MOHs are supposed to conduct at least one AYFHS clinic per month in their area. However, young persons do not perceive the need of getting services from these clinics. Though having a separate center dedicated for adolescents and youth with recreational, reading, computer, carrier guidance and health services at one service delivery point is identified as the best concept in global context, it is not logistically feasible to make available such centers through out the county due to resource constraints. Considering global and regional evidence, for streamlining these services, next option is to introduce adolescent and youth friendly concept at all health service facilities. Though, health staff is presently been trained on AYFHS, need of increasing capacity of all health care providers should be ongoing with incorporation of latest evidence-based teaching and learning strategies. School health programme provides health screening and vaccination for all school-going adolescents.

In the process of strengthening the capacity building of the health care providers, existing trainer manual on adolescent and youth health was revised. Participant manuals and training packages are being developed. Sensitization of non-health category working with young persons was initiated with training of teaching instructors for youth and officers attached to the divisional secretariat offices. Yet, there is the need of strengthening the ongoing training.

Meanwhile health system has to be strengthened on health promotion at schools, training centers and working places for the wellbeing of adolescents and youth. Strengthening services for adolescents and youth as per expectations and standards are essential.

Strategies

1. Streamline the AYFHS
2. Improve the capacity of health staff to deal with health issues among adolescents and youth
3. Improve the capacity of non-health staff to deal with health issues among adolescents and youth
4. Strengthen the health promotion at schools including school health services to cater for adolescents and youth
5. Strengthen the services for adolescents and youth with chronic diseases and behavioural issues

Strategic Direction 3

Strengthen health system to cater for adolescent and youth health

Strategy 3.1

Streamline the AYFHS

Major activities

3.1.1 Strengthen all health care provision points for adolescents and youth for adolescent and youth friendly service provision

3.1.2 Establish the AYFHS centers using appropriate models in selected locations and implement according to the standards and protocols on AYFHS

3.1.3 Create demand for the AYFHS through school health programme, outreach and other relevant activities

3.1.4 Strengthen the referral system for adolescent and youth health issues

3.1.5 Conduct regular review to strengthen AYFHS at institutional, district and national level

3.1.6 Prepare all sectors of the health system to cope with adolescent and youth health needs in emergencies and disasters

Strategy 3.2

Improve the capacity of health staff to deal with health issues among adolescents and youth

Major activities

3.2.1 Review and revise the basic and in-service curricula for medical officers, nurses, PHMs and PHIs to incorporate the knowledge, attitudes and skills for identification and management of adolescents and youth health issues

3.2.2 Adopt new methodologies to teach sensitive subject areas related to adolescents and youth health

3.2.3 Strengthen the training of the health care workers using orientation programme on adolescents and youth health (AYFHS centers, other service delivery points such as outpatient departments)

Strategy 3.3

Improve the capacity of non-health staff to deal with health issues among adolescents and youth

Major activities

3.3.1 Incorporate adolescent and youth health module into the curriculum of youth training institutions and vocational training institutions

3.3.2 Review and revise curricula incorporating adolescent and youth health for the training curriculums of teaching instructors

3.3.3 Strengthen the training of the non-health workers working with adolescents and youth using orientation programme

3.3.4 Adopt new methodologies to teach sensitive subject areas related to adolescents and youth health for young persons

Strategy 3.4

Strengthen the health promotion at schools including school health services to cater for adolescents and youth

Major activities

3.4.1 Advocate for health promotion policies and to establish resource centers in schools

3.4.2 Review, revise and strengthen school oral health services

3.4.3 Advocate for dental trauma prevention and management through school oral health services

3.4.4 Strengthen the counseling services and referral pathways for identified health and psychosocial issues in schools

Strategy 3.5

Strengthen the services for adolescents and youth with chronic diseases and behavioral problems

Major activities

3.5.1 Strengthen the identification, appropriate referral, treatment, follow up and rehabilitation of adolescents and youth with congenital abnormalities and disabilities, chronic diseases, learning difficulties behavioral problems

Strategic direction 4

Promote psychosocial wellbeing of adolescents and youth

Rationale

It is very important for the health development of the adolescents and youth, to have psychosocial wellbeing. They have to have life skills to face the challenges in the modern world. Life skill development is incorporated into the school curriculum and teachers are trained on this jointly by education and health ministries. However, research-based evidence shows that their life skills are not up to the expected standards. Suicide and attempting suicides are still a major issue. Bulling and violence are very much common. All these reflect the need of strengthening life skills of adolescents and youth and ensuring bulling free, safe, supportive environment in schools, training centers and universities. Empowering adolescents, youth, teachers, parents and community in promoting mental health wellbeing and timely identification of mental health conditions are to be strengthened. Several psychological conditions start within adolescent period. Hence, streamlining suicide prevention, stress management and early identification of psychological conditions are essential. There are counselors at certain schools and youth training centers. Yet, it is necessary to strengthen these services. Replacing teacher counselors with trained non-teacher counselors to increase quality and coverage of the services is a timely need.

Strategies

1. Strengthen the life skills among adolescents and youth
2. Ensure early identification and appropriate management of adolescents and youth with physical, mental and psychosocial issues
3. Empower parents, teachers and students to promote psychosocial wellbeing
4. Ensure safe, supportive environment at home, school, community and other institutions free from bulling, violence and abuse
5. Streamline interventions for suicide prevention, anxiety and stress management

Strategic Direction 4

Promote psychosocial wellbeing of adolescents and youths

Strategy 4.1

Strengthen the life skills among adolescents and youth

Major activities

4.1.1 Advocate ministry of education for active participation of students in school extracurricular activities e.g. health clubs, team games, spiritual and other activities

4.1.2 Incorporate life skill development to school and other curricula (e.g. higher education, youth and vocational training)

4.1.3 Promote positive social interactions within all school communities and training centers

Strategy 4.2

Ensure early identification and appropriate management of adolescents and youth with physical, mental and psychosocial issues

Major activities

4.2.1 Introduce a suitable screening tool to identify developmental delays and psychosocial issues among adolescents and youth through school health programme

4.2.2 Strengthen the counseling services in schools and other settings

4.2.3 Streamline the referral pathways for identified issued

4.2.4 Establish a hot line/ web-based platform to help adolescents and youth

4.2.5 Advocate for strengthening care for adolescents and youth with identified developmental delays

Strategy 4.3

Empower parents, teachers and students to promote psychosocial wellbeing

Major activities

4.3.1 Incorporate parenting skills on adolescent care to teacher training curricula

4.3.2 Educate community on parenting at suitable parent teacher gatherings/ using audio visual aids

4.3.3 Introduce parenting skills training, as appropriate, for managing behavioural disorders in adolescents through health and educational sectors

4.3.4 Promote Publishing positive case studies on good parenting

4.3.5 Develop information education and communication (IEC) material on parenting for adolescents and youth

4.3.6 Develop material for adolescents and youth on how to manage stress, time, critical thinking, decision making and carrier guidance (audio visual aids, Instagram posts etc.)

Strategy 4.4

Ensure safe, supportive environment at home, school, community and other institutions free from bulling, violence and abuse

Major activities

4.4.1 Advocate for increasing opportunities for aesthetic and recreational activities in school timetable and at home and community

4.4.2 Advocate for adolescents and youth friendly school and training center with supportive and safe environment, free from bullying, violence and abuse

4.4.3 Advocate for no bulling and no violence policies and regulations and procedures to prevent bulling, violence and abuse in schools and institutions

4.4.3 Train teachers to recognize and counsel students regarding bulling, violence and abuse

4.4.5 Establish a reporting mechanism at schools and other institutions regarding bullying and violence

Strategy 4.5

Streamline interventions for suicide prevention, anxiety and stress management

Major activities

4.5.1 Advocate for legislation to restrict the access to pesticides, firearms, medications and other commonly used modes of attempting suicide and safe storage and disposal of pesticides

4.5.2 Establish sustainable and long-term surveillance system on deliberate self harm and attempting suicide in order to strengthen prevention, intervention and treatment

4.5.3 Establish adequate, prompt and accessible treatment for substance use and mental disorders with the objective of reducing the risk of suicidal behavior

4.5.4 Establish guidelines for media highlighting the importance of avoiding detailed descriptions of suicidal acts, sensationalism, glamorization and oversimplification and use of responsible language

4.5.5 Establish online suicide prevention strategies or short messenger service including self-help programmes and professional help

4.5.6 Conduct awareness campaigns to reduce stigma, promote help seeking and access to care with special focus on vulnerable groups

4.5.7 Capacity building of the gatekeepers on identifying adolescents and youth at risk and referring at-risk individuals for treatment

4.5.8 Establish helplines that adolescents and youth can access in crisis e.g. with peer assistance.

4.5.9 Capacity building of primary health-care workers to recognize depression, suicide risk, substance use disorders and other mental health issues

4.5.10 Establish a strong follow-up system and support for adolescents and youth discharged after suicide attempts in the community

Strategic direction 5

Ensure optimal level of nutrition, physical activity, hygiene and sanitation

Rationale

All necessary details of healthy options of diet, physical activity, hygiene and sanitation are included in school curriculum. Yet, environment at schools, homes and community are not having options enabling healthily choices. In spite of having school canteen guideline, school canteens are still not up to the expected standards. Fast food places with unhealthy food are within walking distance from the schools. Media advertise unhealthy food options using adolescents for promoting these food items. National youth health survey 2012-2013, reflected that sedentary lifestyles as a major issue among adolescents and youth. Adolescents and youth are more on screen watching television, using mobile phones and computers. They do not perceive the consequences of physical inactivity. Though it is made compulsory to have outdoor physical activity sessions at schools, it is not being implemented as expected. Still there are pockets within our community that do not meet required standards of hygiene and sanitation. Hence, it is necessary to strengthen the knowledge and skills of the adolescents and youth on these aspects further to create an enabling environment.

Strategies

1. Create an enabling environment to promote healthy eating
2. Improve knowledge and skills of adolescents and youth on healthy eating
3. Strengthen comprehensive school nutrition services
4. Strengthen early identification and management of nutritional issues
5. Create an enabling environment to promote physical activity
6. Improve hygiene and sanitation

Strategic Direction 5

Ensure optimal level of nutrition, physical activity, hygiene and sanitation

Strategy 5.1

Create an enabling environment to promote healthy eating

Major activities

5.1.1 Advocate strengthening regulatory mechanisms for advertisements on food and beverages

5.1.2 Advocate for improving food labeling to facilitate healthy choices e.g. Front of pack labeling, traffic light systems, healthy logos, etc.

5.1.3 Advocate for inclusion of legislation on healthy food into food act

5.1.4 Advocate for introducing pricing systems to increase price of unhealthy foods and reduce the price of healthy foods

5.1.5 Advocate for implementation of the healthy canteen policy in schools and extend the implementation to universities, vocational training centers, etc.

5.1.6 Advocate for educating on healthy eating at schools, training centers and in the community

Strategy 5.2

Improve knowledge and skills of adolescents and youth on healthy eating

Major activities

5.2.1 Develop social marketing campaign to promote healthy eating, physical activity and healthy life styles targeting both young persons and parents

5.2.2 Advocate Ministry of Education to include lessons on healthy eating, nutrition, nutritional assessments, physical activity and gardening to school curricula

Strategy 5.3

Strengthen comprehensive school nutrition services

Major activities

5.3.1 Establish and implement standards for meals provided in school

5.3.2 Strengthen implementation of healthy canteen policy at schools, sport facilities, training centers and youth work places

Strategy 5.4

Strengthen early identification and management of nutritional issues

Major activities

5.4.1 Scale up the establishment of facilities at schools, universities and vocational training centers for enabling nutritional self- assessment

5.4.2 Introduce yearly medical assessments adolescents and youth at universities and other training centers

5.4.3 Scale up and streamline the weekly iron folic acid supplementation at schools and seek the possibility of extending to other institutions

5.4.4 Strengthen nutrition clinics at MOH offices and hospitals as referral centers

5.4.5 Establish family-based, multi-component, lifestyle and weight management services for adolescents and youth with the involvement of multi-professional teams

Strategy 5.5

Create enabling environment to promote physical activity

Major activities

5.5.1 Introduce " walk for health" concept to schools and other institutions e.g. Step count competitions, walking school bus, etc.

5.5.2 Streamline the regulations on time allocated for physical activity in schools

5.5.3 Advocate to have adequate facilities at school premises, youth training centers, workplaces and public spaces for enabling physical activity during recreational time for all adolescents and youth including disabled

5.5.4 Increase the awareness among adolescents and youth, their parents, caregivers, teachers and health professionals on healthy body size, physical activity, correct sleeping behaviours and appropriate use of screen-time

5.5.5 Promote regular, structured sports activities among adolescents and youth while ensuring the linkages with physical activity, sports and health

Strategy 5.6

Improve hygiene and sanitation

Major activities

5.6.1 Advocate for adequate toilet facilities (for girls and boys separately) with continuous water supply and cleaning mechanism in school, training centers and universities

5.6.2 Advocate for availability of safe drinking water in schools, training centers and universities

5.6.3 Advocate for provision of hand washing facilities at schools, training centers and universities

Strategic direction 6

Ensure access to sexual and reproductive health (SRH) education and services

Rationale

Age appropriate SRH components are already included in school curricula from grade six onwards. However, teaching of these components are not being carried out as expected. Though teaching staff have knowledge, they do not have adequate skills to impart it to the students due to barriers that they have identified themselves. Addressing these barriers and streamlining SRH education through schools as well as other youth training programmes are very much essential.

SRH services are operated throughout the country through field and curative health services. These services consist of provision of SRH services for adolescents as well. PHM has a role to register adolescents and to identify those at risk and refer them to MOH or AYFHS clinic at hospitals. However, adolescent fertility rate still shows an increasing trend. Coverage of services are not up to the standard. Hence, strengthening service availability and increasing awareness on existing services is a timely need.

In spite of service availability and SRH education, there is a group of adolescents who get pregnant during the teenage period. They too have right for health, education and protection. Formal and non-formal education has to cater the educational need of this group as well. Further, they should be supported to have a safe childbirth with an assurance of social support such as safe homes.

Strategies

1. Streamline the age appropriate SRH education through school and other curricula
2. Strengthen the SRH services for adolescents and youth
3. Ensure formal education for teenage pregnant adolescents

Strategic Direction 6

Ensure access to SRH education and services

Strategy 6.1

Streamline the age appropriate SRH education through school and other curricula

Major activities

6.1.1 Implement the policy on compulsory comprehensive SRH education at grade 12

6.1.2 Advocate for implementation of the policy on compulsory basic age appropriate components of SRH education from grade 6 upwards

6.1.3 Review and revise school curricula and other curricula based on new evidence on SRH

6.1.4 Develop and implement educational package through media and other means of communication used by adolescents and youth

6.1.5 Introduce educational material on SRH in sign language and brail language

Strategy 6.2

Strengthen the SRH services for adolescents and youth

Major activities

6.2.1 Review and revise the existing laws and regulations to remove barriers for adolescents and youth to access SRH services e.g. legalizing termination of pregnancy for under 16 year pregnant category with unwanted pregnancies

6.2.2 Empower health workers to deal with SRH issues and provision of family planning for adolescents and youth with the assurance of privacy, confidentiality and dignity

6.2.3 Continue provision of quality care on pre-pregnancy, pregnancy, childbirth, post-partum and post abortion as relevant to adolescents

6.2.4 Strengthen prevention, detection and treatment services for STI and HIV

6.2.5 Establish facilities for SRH specific counseling and guidance at health facilities for adolescents and youth

6.2.6 Advocate law-implementing authorities and child care officials on the need of respectful care and the confidentiality maintenance in issues related to adolescents and youth

6.2.7 Advocate for establishing safe home facilities for teenage pregnant mothers as appropriate

6.2.8 Strengthen the SRH services for adolescents and youth with special need and socially deprived e.g. prisoners, war affected groups, with special needs, etc.

6.2.9 Strengthen the services for child abuse cases

6.2.10 Advocate child protection authority to prevent perpetrators having chances to engage in abusing children continuously by having a registry of perpetrators and keeping them away from jobs related to children

Strategy 6.3

Ensure formal education for teenage pregnant adolescents

Major activities

6.3.1 Advocate for having legislations and policies enabling pregnant adolescents continuing education

Strategic direction 7

Prevent adolescents and youth from substance abuse

Rationale

Certain social determinants and risk factors existing in the community make adolescents and youth more vulnerable for tobacco, alcohol and other addictive substance use. Peer pressure and lack of life skills are the main reasons for adolescents and youth becoming addicts. Empowering adolescents and youth with life skills are in cooperated into school curriculum. Yet, adolescents and youth do not have enough skills to overcome such challenges. There is an emerging need to empower adolescents and youth with life skills to say “no” to tobacco, alcohol and addictive substances. Ensuring implementation of necessary legislations to prevent availability of tobacco, alcohol and addictive substances is essential.

The need of strengthening supportive services for quitting and rehabilitation for the addicted group is vital. Need of introducing evidence based innovative approaches at all levels to achieve these targets is imminent.

Strategies

1. Empower adolescents and youth to "say no" to tobacco, alcohol and addictive substances
2. Reduce the affordability of tobacco and alcohol
3. Ensure banning advertising tobacco and alcohol
4. Strengthen services available for quitting and rehabilitation from tobacco, alcohol and addictive substances

Strategic Direction 7

Prevent adolescents and youth from substance abuse

Strategy 7.1

Empower adolescents and youth to "say no" to tobacco, alcohol and addictive substances

Major activities

7.1.1 Establish peer groups and train them with relevant skills

7.1.2 Conduct regular and effective mass-media campaigns to raise the awareness of the hazards of addictive substances

7.1.3 Advocate to promote the entertainment media, cinema and drama as smoke and alcohol-free

7.1.4 Advocate for implementation of policies, laws and regulations on tobacco, alcohol and other addictive substances

7.1.5 Educate the parents, teachers and general public on addictive substances

7.1.6 Advocate for implementation of smoke free environment at school, work place and public transport

Strategy 7.2

Reduce the affordability of tobacco and alcohol

Major activities

7.2.1 Advocate to reduce affordability for tobacco products by increasing tobacco excise taxes

7.2.2 Advocate restricting alcohol availability and affordability by reducing demand through taxation and pricing

Strategy 7.3

Ensure banning advertising tobacco and alcohol

7.3.1 Advocate to enforce comprehensive bans on tobacco advertising, promotion and sponsorship, including, internet, social media and cross-border advertising.

7.3.2 Advocate to regulate the marketing of alcohol to adolescents; raise awareness and support for policies; and implement interventions for the harmful use of alcohol

Strategy 7.4

Strengthen services available for quitting and rehabilitation from tobacco, alcohol and addictive substances

Major activities

7.2.1 Establish medical services to support quitting and rehabilitation from tobacco, alcohol and addictive substances

7.2.2 Educate all non-smokers not to start smoking; strongly advise all smokers to stop smoking, and support them in their efforts; and advise individuals who use other forms of tobacco to quit (e.g. Toolkit for delivering the 5A's and 5R's in brief tobacco interventions in primary care for more specific guidance)

Strategic direction 8

Prevent accidents, injuries and violence among adolescents and youth

Rationale

According to e IMMR of the country, external causes are the leading causes of morbidity and mortality among adolescents and youth. These include accidents, injuries and other external causes. Violence is increasingly reported among this group in spite of all legal and social restrictions. It is important to ensure accident and injury free environments at home, schools, training centers and public places in parallel to skill development to avoid accidents and

injuries. Improving life skills should be strengthened in order to reduce violence among adolescents and youth while ensuring mental and physical wellbeing of the victimized adolescents and youth. Proper management of injuries and accidents have to be strengthened further.

Strategies

1. Ensure accidents and injury free environment for adolescents and youth
2. Ensure proper management of injuries and accidents among adolescents and youth
3. Ensure reduction of violence among adolescents and youth
4. Strengthen surveillance system and monitoring of accidents, other injuries and violence

Strategic Direction 8

Prevent accidents, injuries and violence among adolescents and youth

Strategy 8.1

Ensure accidents and injury free environment for adolescents and youth

Major activities

8.1.1 Advocate for education of laws and regulations to reduce road traffic accidents among adolescents and youth e.g. Helmet policy, policies related to three-wheeler driving, etc.

8.1.2 Advocate for setting the legal age for allowing alcohol consumption to 21 years

8.1.3 Advocate for a graduated licensing system such as first an extended learner period involving training and low-risk, supervised driving; then a license with temporary restrictions; and finally, a full license

8.1.4 Advocate for infrastructural engineering measures for road network (e.g. speed humps, mini-roundabouts, designated pedestrian crossings, road lighting or surface treatment and one-way street and traffic calming measures)

8.1.5 Advocate for setting vehicle safety standards

8.1.6 Use case studies to educate adolescents and youth regarding accident and injury prevention

8.1.7 Set standards on playgrounds, swimming pools and sports complexes at schools and strengthen the implementation

8.1.8 Advocate raising the awareness on road safety rules, regulations and laws through school curriculum

8.1.9 Implement community campaigns to ensure road safety and prevent other accidents such as drowning and falls

Strategy 8.2

Ensure proper management of injuries and accidents

Major activities

8.2.1 Introduce compulsory training on First Aid for adolescents and youth through schools, universities and vocational training centers using Red Cross, St. Johns, Scouting etc.

8.2.2 Strengthen the emergency management services at hospitals

Strategy 8.3

Ensure reduction of violence among adolescents and youth

Major activities

8.3.1 Advocate for legislations for reducing access to and misuse of firearms and explosive substances

8.3.2 Advocate for deploying police resources in areas where crime is prevalent

8.3.3 Advocate raising the awareness on road safety rules, regulations and laws regarding the violence and abuse to school curriculum

8.3.4 Advocate to implement and enforce of laws: ban violent punishment at schools and workplaces, criminalizing sexual abuse and exploitation of children

8.3.5 Strengthen parent and caregiver support through home visits, community approaches and comprehensive programmes

8.3.6 Conduct life skill training programmes for adolescents and youth including anger management

8.3.6 Advocate to implement response and support services for adolescents and youth engaged in violence (e.g. screening and interventions, counseling and therapeutic approaches, programmes for juvenile offenders and foster care interventions)

Strategy 8.4

Strengthen surveillance system and monitoring of accidents, other injuries and violence

8.4.1 Advocate strengthening injury surveillance

8.4.2 Establish a surveillance system for violence

8.4.3 Conduct regular monitoring of accidents and violence

Strategic direction 9

Enhance community involvement to improve adolescent and youth health

Rationale

Advocacy to have recreational and sports activities in the community has been initiated. Yet, there is a need to strengthen the availability of such facilities in the community while ensuring safety. Community involvement is very important in taking such initiatives. Media advertise all unhealthy foods and drinks irrationally. Hence, it is essential to ensure that media act responsibly for the betterment of adolescents and youth rather than targeting only on income generation through irrational advertising.

Adolescence is a time of significant growth and development in the brain. Unused connections in the thinking and processing part of adolescent brain are 'pruned' away while used connections are strengthened. This process of brain maturation begins in the back of the brain. The front part of the brain, the prefrontal cortex, is the last part to mature. It is the decision-making part of the brain, responsible for your child's ability to plan and think about the consequences of actions, solve problems and control impulses. Changes in this part continue into early adulthood.

As prefrontal cortex is still developing, adolescent might rely on a part of the brain called the amygdala to make decisions and solve problems more than adults do. The amygdala is associated with emotions, impulses, aggression and instinctive behaviour. It is very important that parents, teachers and community should understand this scientific basis of adolescent behavior. Parents, teachers and the community need several skills to handle this group. Enhancing parenting skills to improve health of adolescents and youth is still a major challenge.

Strategies

1. Ensure availability of recreational and sport activities
2. Ensure responsive media exposure
3. Enhance parenting to improve health of adolescents and youth

4. Ensure supportive, safe environment in the community

Strategic Direction 9

Enhance community involvement to improve health of adolescents and youth

Strategy 9.1

Ensure availability of recreational and sport activities

Major activities

Advocate for providing recreational and sports activities at community level

Strategy 9.2

Ensure responsive media exposure

Major activities

9.2.1 Support in establishing responsible media behaviour that facilitate in reducing adolescent and youth risk behaviors

Strategy 9.3

Enhance parenting to improve health of adolescents and youth

Major activities

9.3.1 Strengthen the parental knowledge on the needs of adolescents and youth

9.3.2 Improve the capacity of parents on parenting adolescents and youth

9.3.3 Strengthen the marginalized groups of parents with specific life skills

Strategy 9.4

Ensure supportive, safe environment in the community

Major activities

9.4.1 Ensure environment is free from bulling, violence and abuse

9.4.2 Strengthen relationships and social wellbeing through community activities

Strategic direction 10

Enhance service provision for adolescents and youth in humanitarian and fragile settings

Rationale

Universal health care coverage including preventive, promotive, curative and rehabilitative health care without discrimination have to be ensured for adolescents and youth. There are pockets of socially deprived subcultures, war affected communities and key populations among adolescents and youth throughout the country. In such sub-cultures it is very important to identify priorities and to design and implement focused interventions. Deployment of essential interventions in an emergency has to be ensured. Therefore, it is very much needed to streamline the provision of health services for adolescents and youth in such humanitarian and fragile settings. This includes ensuring of both physical and psychological wellbeing of adolescents and youth in fragile settings as well as educational and recreational facilities.

Catering for sexual and reproductive health needs and psychological first aid for needy adolescents and youth is very important.

Strategies

1. Strengthen identification of priority needs and focused interventions for adolescents and youth in humanitarian and fragile settings
2. Ensure deployment of essential health interventions for adolescents and youth in an emergency in humanitarian and fragile settings
3. Streamline the provision of health services for adolescent and youth in humanitarian and fragile settings
4. Improve recreational facilities and educational facilities to support psychosocial wellbeing of the adolescents and youth in humanitarian and fragile settings
5. Ensure provision of psychological first aid and first-line management of mental, neurological and substance-use conditions of the adolescents and youth in humanitarian and fragile settings

Strategic Direction 10

Enhance service provision for adolescents and youth in humanitarian and fragile settings

Strategy 10.1

Strengthen identification of priority needs and focused interventions for adolescents and youth in humanitarian and fragile settings

Major activities

10.1.1 Develop and use a health and humanitarian risk assessment approach for adolescents and youth in humanitarian and fragile settings

Strategy 10.2

Ensure deployment of essential health interventions for adolescents and youth in an emergency in humanitarian and fragile settings

Major activities

10.2.1 Adapt, implement and coordinate the use of minimal initial service package in an emergency (E.g. In the fields of nutrition, disability, violence, SRH, sanitation, hygiene and mental health)

Strategy 10.3

Streamline the provision of health services for adolescent and youth in humanitarian and fragile settings

Major activities

10.3.1 Establish medical screening of adolescents and youth of marginalized populations E.g. In conflict affected areas and those undergone physical or sexual violence

10.3.2 Strengthen community based psychosocial support for marginalized groups of adolescents and youth

Strategy 10.4

Improve recreational and educational facilities to support psychosocial wellbeing of the adolescents and youth in humanitarian and fragile settings

Major activities

10.4.1 Advocate for promotion of recreational activities and restarting of formal or informal education and carrier development among marginalized adolescents and youth

Strategy 10.5

Ensure provision of psychological first aid and first-line management of mental, neurological and substance-use conditions among adolescents and youth in humanitarian and fragile settings

Major activities

10.5.1 Strengthen capacity building of health care workers on psychological first aid and first line management of mental, neurological and substance-use conditions among adolescents and youth in humanitarian and fragile settings

10.5.2 Improve facilities available for psychological first aid and first line management of mental, neurological and substance-use conditions among adolescents and youth in humanitarian and fragile settings

Strategic direction 11

Strengthen the capacity, partnership and networking among all stakeholders working on adolescents and youth

Rationale

Adolescents and youth health is a sector that need to be addressed with partnership with other ministries, NGOs, adolescents and youth. National level steps for development of a multisector action plan is already initiated with the leadership of National Policy and Development Ministry. Adolescents and youth involvement have to be ensured at all steps and at all levels in adolescent and youth health initiatives. For that it is vital to strengthen the capacity, partnership and networking among all stakeholders, adolescents and youth.

Strategies

1. Strengthen capacity, partnership and networking among all stakeholders, adolescents and youth

Strategic Direction 11

Strengthen capacity, partnership and networking among all stakeholders, adolescents and youth

Strategy

11.1 Strengthen capacity, partnership and networking among all stakeholders and adolescents and youth

Major activities

- 11.1.1 Advocate to establish and develop a single inter- ministerial plan, budget, monitoring and evaluation framework for adolescents and youth
- 11.1.2 Strengthen the intra and inter sectorial committees including private sector, professional and NGOs, media and adolescent and youth groups
- 11.1.3 Establish partnership with private sector, NGOs, community-based organizations and youth groups to improve adolescent and youth health
- 11.1.4 Involve young persons in all steps of planning and implementation

Strategic direction 12

Strengthen research, monitoring and evaluation on adolescents and youth health services

Rationale

HRMIS system collects data of number of adolescents, adolescents at risk, adolescents referred and adolescent deaths. Yet, data is incomplete when it comes to adolescents and youth. Details of patients seen at AYFHS system is monitored at the central level. However, there is a strong need to strengthen the information system to provide evidence for planning and monitoring. Monitoring and reviewing at institutional, divisional, district and provincial levels have to be strengthened in parallel to national level. Further, timely reporting of adolescent deaths in IMMR and register general data have to be ensured.

Research evidence is very much needed for necessary planning and introduction of new innovative interventions.

Strategies

1. Strengthen the information system on adolescent and youth health to provide evidence for planning and monitoring
2. Strengthen research and develop evidence based interventions on adolescent and youth health

Strategic Direction 12

Strengthen research, monitoring and evaluation on adolescents and youth health services

Strategy 12.1

Strengthen the information system on adolescent and youth health to provide evidence for planning and monitoring

Major activities

12.1.1 Strengthen the routine information systems and monitoring frameworks integrating adolescents and youth health indicators with necessary reviewing and revising to get correct data

12.1.2 Conduct regular reviews and monitoring at all levels to share best practices and identify the existing gaps

12.1.3 Conduct periodic external evaluations of the adolescents and youth health services

Strategy 12.2

Strengthen research and develop an evidence based interventions on adolescents and youth health

Major activities

12.2.1 Identify priority areas and advocate for conducting relevant research on adolescents and youth health

12.2.2 Incorporate adolescents and youth health indicators to national health surveys (DHS, MICS)

12.2.3 Test interventions on parenting and peer group involvement

Bibliography

1. Department of Census and Statistics, Sri Lanka.Population and Housing [Internet]. [cited 2018 Apr 29]
Available from: http://www.statistics.gov.lk/page.asp?page=Population and Housing

2. Family Health Bureau. National Strategic Plan Adolescent Health (2013 - 2017). Published [Internet]. 2013; Available from: ile:///C:/Users/MAC/Downloads/national_strategic_plan_final_part1-3.pdf

3. World Health Organization. The global strategy for women's, children's and adolescents health. United Nations [Internet]. 2016;108[cited 2018 Apr 22].
Available from: http://www.who.int/life-course/partners/global-strategy/en/

4. World Health Organization. Global Accelerated Action for the Health of Adolescents (AA-HA!) Guidance to Support Country Implementation [Internet]. 2017. 9 p. [cited 2018 Apr 29].
Available from: http://apps.who.int/iris/bitstream/10665/255415/1/9789241512343-eng.pdf?ua=1

5. Medical Statistics Unit, Ministry of Health, Nutrition and Indigenous Medicine, Sri Lanka, e Indoor Morbidity and Mortality Register. Colombo; 2018

6. Family Health Bureau, Ministry of Health, Nutrition and Indigenous Medicine, Sri Lanka. National Health Youth Survey 2012/2013 Sri Lanka [Internet]. Colombo; 2015[cited 2018 Apr 27].
Available from: http://www.fhb.health.gov.lk/web/index.php?option=com_phocadownload&view=category&id=57:adolescent-and-youth-health&Itemid=150&lang=en#

7 Department of Census & Statistics, Ministry of Policy Planning and Economic Affairs,Sri Lanka. Census of Population and Housing 2012 [Internet]. Colombo; 2015 [cited 2018 Apr 29]. Available from: http://www.statistics.gov.lk/PopHouSat/CPH2011/Pages/Activities/Reports/FinalReport/FinalReportE.pdf

8. Department of Census & Statistics, Ministry of Policy Planning and Economic Affairs, Sri Lanka. Demographic and Health Survey Sri Lanka 2016 [Internet]. Colombo; 2017 [cited 2018 Apr 29].
Available from: http://www.statistics.gov.lk/social/DHS_2016a/FIST PAGE_&_CONTENTS.pdf

9. Family Health Bureau, Ministry of Health, Nutrition and Indigenous Medicine, Sri Lanka. eRHMIS - electronic Reproductive Health Management Information System [Internet].

2018 [cited 2018 Apr 29]. Available from: http://erhmis.fhb.health.gov.lk/erhmis/dhis-web-commons/security/login.action

10. Global School-based Student Health Survey Sri Lanka 2016 Fact Sheet [Internet]. [cited 2018 Apr 29]. Available from: http://www.who.int/ncds/surveillance/gshs/SRH2016_fact_sheet.pdf

11. Global Youth Tobacco Survey 2015 [Internet]. [cited 2018 Apr 29]. Available from: http://www.searo.who.int/tobacco/data/gyts_sri_lanka_2015_factsheet.pdf

12. Kieling C, Baker-Henningham H, Belfer M, Conti G, Ertem I, Omigbodun O, et al. Child and adolescent mental health worldwide: evidence for action. Lancet (London, England) [Internet]. 2011 Oct 22 [cited 2018 Apr 29];378(9801):1515–25. Available from: http://www.ncbi.nlm.nih.gov/pubmed/22008427

13. Wijeratne MP, Seneviratne R, Gunawardena N, Østbye T, Lynch C. Descriptive study of the psychosocial and physical environments of school in relation to violence among adolescents in the Gampaha District of Sri Lanka. Sri Lanka J Child Heal [Internet]. 2015 Sep 12 [cited 2018 Apr 29];44(3):138. Available from: https://sljch.sljol.info/article/10.4038/sljch.v44i3.8009/

14. Jayatissa R, Ranbanda RM. Prevalence of Challenging Nutritional Problems among Adolescents in Sri Lanka. Food Nutr Bull [Internet]. 2006 Jun 15 [cited 2018 Apr 29];27(2):153–60. Available from: http://journals.sagepub.com/doi/10.1177/156482650602700206

15. Jayatissa R, Gunathilaka MM, Fernando DN. National nutrition and micronutrient survey part i: anaemia among children aged 6-59 months and nutritional status of children and adults [Internet]. Colombo; 2013 [cited 2018 Apr 29]. Available from: https://www.unicef.org/srilanka/MNS_Report-28.02.2013.pdf

16. Allen A, Allen S, Rodrigo R, Perera L, Shao W, Li C, et al. Iron status and anaemia in Sri Lankan secondary school children: A cross-sectional survey. [cited 2018 Apr 29]; Available from: http://journals.plos.org/plosone/article/file?id=10.1371/journal.pone.0188110&type=printable

17.

18 Ministry of health care and nutrition, Sri Lanka. National Oral Health Survey Report. 2002/2003.

19. Goonesekara,Senanayake and de Silva(2012),Using Human Rights to Adolescent Sexual and Reproductive Health of Youth and Adolescents, Report of Sri Lanka Field Test,WHO and Ministry of Health,Sri Lanka

20. Family Health Bureau, Ministry of Health, Nutrition and Indigenous Medicine, Sri Lanka. Standards for Quality Health Services for Adolescents and Youth in Sri Lanka [Internet]. Colombo:
Available from:
http://fhb.health.gov.lk/web/index.php?option=com_phocadownload&view=category&id=57:adolescent-and-youth-health&Itemid=150&lang=en

21. World Health Organization, Health for the world's adolescents: A second chance in the second decade [Internet]. World Health Organization; 2015 [cited 2018 Apr 30].
Available from: http://www.who.int/maternal_child_adolescent/documents/second-decade/en/

22. Family Health Bureau. National Strategic Plan Maternal and Newborn Health (2017 - 2025). Family Health Bureau; 2018.

23 Family Health Bureau. National Strategic Plan on Child Health (2017 -2025) Family Health Bureau; 2018.

.