Highlights

Child and Adolescent Health and Development
Progress Report 2006–2007
The greatest preventable risks faced by newborn babies and children under five in low-income countries are low birth weight, newborn illness, childhood diseases and malnutrition. For adolescents aged ten to 19 years, some of the main health risks are HIV and too-early pregnancy, as well as substance use and mental health problems.

Focusing on these major challenges, we are engaged in research, supporting the use of that research for policy change and programme implementation, and monitoring the results of evidence-based approaches in countries.

Taking a public health perspective, we aim both to strengthen health systems and to empower communities and families. Our goal is to protect and improve the health and well-being of children and adolescents, contributing to the achievement of the Millennium Development Goals (MDGs).

To date, we have supported 30 countries to develop national child survival strategies that are the basis for uniting all stakeholders to work towards a common goal and purpose.

In 2006–2007 we celebrated the tenth anniversary of the Integrated Management of Childhood Illness (IMCI) strategy.

Now introduced in more than 100 countries around the world, IMCI is still relevant and still addresses the major killers. Having analysed the results of the latest research, and recognizing the need to accelerate policy change and programme implementation for the high risk newborn period, we expanded IMCI to cover the management of illness and care of infants from the first day of life. In order to address the need for training on the treatment and care of children with HIV, we developed a complementary course for care of children with HIV within IMCI and also for care of children with HIV and AIDS in referral facilities.

As appropriate feeding is central to child well-being, we finalized a five-day course to provide health workers with skills for counselling mothers on breastfeeding, complementary feeding, and feeding when the mother is infected with HIV. This integrated training has already been introduced in 30 countries.

CAH has one of the largest research programmes in WHO. In 2006–2007, we have supported research and updated recommendations on giving children iron supplements in malaria-endemic areas, and on the safety and efficacy of zinc supplements for young children.

To prevent illness and death in the first week of life, we are carrying out research on postnatal visits in the home by community health workers (CHW) who introduce key prevention and care messages and actions to the mother. We are also developing CHW training materials for the community management of illness in newborns and older children, and the promotion of key practices to maintain health.

In 2006–2007 landmark progress was made in the area of early childhood development with the publication of a Lancet series which brought to the world’s attention the huge loss of potential from malnutrition in early childhood. Similarly, the Joint Statement on the community-based management of severe acute malnutrition which we published with UNICEF, the World Food Programme and the UN System Standing Committee on Nutrition, makes treating severe malnutrition in the community possible, giving the prospect of better development for millions of children.

In the field of adolescent health, in 2006–2007 we marked the tenth anniversary of the call made by WHO, UNFPA and UNICEF for Action for Adolescent Health.

In the 1980s and 90s WHO played a key role in putting adolescent health and development on the public health agenda. Looking back, it is extraordinary that so little attention had previously been paid to this group, who represent an estimated one-fifth of the world’s population.

Times have changed. Governments, UN organizations and NGOs are now more and more aware of the reasons why they should be concerned about what happens during adolescence: for the present, for the future, for this generation and the next. From the HIV pandemic to the non-communicable diseases that confront governments around the world, what happens during adolescence is key to responding effectively to the problems that they face.

In 2006–2007 we have focused our efforts on strengthening the response of the health sector to adolescent health, and specifically the stewardship role of ministries of health in four key areas:

- gathering and using strategic information;
- developing supportive, evidence-informed policies;
- scaling up the provision of health services and commodities; and
- strengthening action in other sectors and civil society.

In 2006–2007, we generated evidence for programmatic action, developed and tested methods and tools to support those actions, built capacity for their implementation, and supported and documented results in countries. Using HIV and reproductive health as entry points, we supported ten ‘focus’ countries to strengthen their health sector’s response to adolescents’ needs in these and other areas. We have worked in ways that not only resonate with ministries of health and other partners in the health sector, but that also build on the organizational priorities set by WHO’s Director-General: particular attention to Africa; a focus on health issues that affect young women; and efforts to strengthen the system that provides the services that adolescents need to improve their health and development.

We recognize that partnerships are essential to moving forward in this challenging area. We work closely with other departments within WHO, with UN agencies (especially UNICEF, UNFPA, and the World Bank), with key development partners including bilateralis, NGOs and professional associations, as well as many collaborating centres. WHO is hosting the Partnership for Maternal, Newborn and Child Health and we are an active member working together with them to meet MDGs four and five.

We are heading into a new biennium which will present new challenges. 2008–2009 will be the first two years of WHO’s new Medium-Term Strategic Plan. Over the past two years we have succeeded in turning global attention to the need for much greater focus on achieving MDGs 4, 5 and 6 and the need to strengthen health systems. We must now sustain that pressure and deliver on key promises to improve the health and development of the world’s children and adolescents.
Newborns in IMCI

The Integrated Management of Childhood Illness (IMCI) strategy is being continually improved and extended – not just to more countries and communities, but also to cover more specific needs. Based on a study that covered close to 9 000 young infants in six countries, we have identified a small set of clinical signs that selects newborns with severe illness requiring hospitalization. These have been used in improving the IMCI guidelines for clinical assessment of children aged 0–2 months.
**Infant Feeding Indicators**

In 2006–2007 we continued work with partners to develop simple, valid and reliable population-level indicators to assess infant and young child feeding practices. We hosted a consensus meeting in November 2007 which resulted in a document entitled “Indicators for assessing infant and young child feeding practices”. It presents eight core and seven optional indicators for assessing feeding practices in children aged 0-24 months.

### Core indicators

1. Early initiation of breastfeeding
2. Exclusive breastfeeding under six months
3. Continued breastfeeding at one year
4. Introduction of solid, semi-solid or soft foods
5. Minimum dietary diversity
6. Minimum meal frequency
7. Minimum acceptable diet
8. Consumption of iron-rich or iron-fortified foods

### Optional indicators

9. Children ever breastfed
10. Continued breastfeeding at two years
11. Age-appropriate breastfeeding
12. Predominant breastfeeding under six months
13. Duration of breastfeeding
14. Bottle feeding
15. Milk feeding frequency for non-breastfed children

**HIV and Infant Feeding**

Should a mother breastfeed if she is infected with HIV? We have reviewed the results of research and found that exclusive breastfeeding during the first six months of life carries a lower risk of HIV transmission than “mixed” feeding. Stopping breastfeeding early can lead to other health-risks for the child, unless an acceptable, feasible, affordable, sustainable and safe alternative is available. To ensure widespread awareness and use of this information, we have worked with partners to develop a “Consensus Statement” on HIV and infant feeding, and technical guidance has been updated to reflect the best available evidence.

**NEWBORNS**

Over the past two years, we have gained new evidence for the health advantages of breastfeeding and making recommendations for its practice. We can say with full confidence that breastfeeding reduces child mortality and has health benefits that extend into adulthood. Exclusive breastfeeding for the first six months of life is the recommended way of feeding infants, followed by continued breastfeeding with appropriate complementary foods for up to two years or beyond. To support more mothers and infants around the world to practise exclusive breastfeeding, we have created a five-day course for lay health workers, along with all the necessary training materials and guidelines on how to counsel mothers about the feeding of infants and young children. We have also produced a guide for programme managers on how to plan and implement national programmes for infant and young child feeding.
**OVERVIEW**

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**IMCI coverage and evaluation**

Since 1996, we have supported the implementation of the Integrated Management of Childhood Illness (IMCI) strategy. To date, IMCI has been introduced in more than 100 countries around the world. In many countries, including 19 in the African Region, geographic coverage of IMCI has been expanded to cover more than 50% of all districts.

In 2006–2007 the Department continued work on the multi-country evaluation (MCE) to measure the impact, cost and effectiveness of IMCI. Information on key indicators such as child mortality, child nutritional status, and family behaviours was gathered in Brazil, Peru, Uganda and the United Republic of Tanzania, and activities are ongoing in Bangladesh. The results of the MCE so far indicate that:

- IMCI improves health worker performance and quality of care;
- IMCI can reduce under-five mortality and improve nutritional status, if implemented well;
- IMCI is worth the investment, as it costs up to six times less per child correctly managed than current care.

Implications of the findings are that:

- child survival programmes require more attention to activities that improve family and community behaviour;
- the implementation of child survival interventions needs to be complemented by activities that strengthen system support;
- a significant reduction in under five mortality will not be attained unless large scale intervention coverage is achieved.

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**Estimated coverage of IMCI training, as of December 2007**

Proportion of districts, by country, reported to have initiated IMCI training

<table>
<thead>
<tr>
<th>Country</th>
<th>Coverage (% of districts)</th>
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<tbody>
<tr>
<td>Bangladesh</td>
<td>75% – 100%</td>
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<tr>
<td>Bolivia</td>
<td>50% – 74%</td>
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<tr>
<td>Brazil</td>
<td>25% – 49%</td>
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<tr>
<td>China</td>
<td>10% – 24%</td>
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<tr>
<td>Egypt</td>
<td>Less than 10%</td>
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<td>Eritrea</td>
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<td>Guatemala</td>
<td>25% – 49%</td>
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<td>Haiti</td>
<td>25% – 49%</td>
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<td>Indonesia</td>
<td>25% – 49%</td>
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<td>Lao People's Democratic Republic</td>
<td>25% – 49%</td>
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<td>Mexico</td>
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<td>Central African Republic</td>
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<td>Chad</td>
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<td>the Congo</td>
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<td>Equatorial Guinea</td>
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<td>Lesotho</td>
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<td>South Africa</td>
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<td>Swaziland</td>
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<td>Zambia</td>
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<tr>
<td>Zimbabwe</td>
<td>25% – 49%</td>
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**Country Profiles**

To support the development of evidence-based policies and strategies for child health in countries, we have developed a number of “country profiles”. These profiles present key epidemiological information to help countries determine the best package of interventions and strategies for delivery, based on their specific needs and circumstances. Profiles for countries, including Bangladesh, India, Indonesia, Myanmar and Nepal were made available on our website in 2007, and many more will be published in 2008.

www.who.int/child_adolescent_health/data/country_profiles
New Treatment for Severe Malnutrition at Community Level

Malnutrition contributes to more than half of all childhood deaths globally. However, a recently developed home-based treatment for severe acute malnutrition is giving hundreds of thousands of malnourished children a new chance at a healthy life. Ready-to-use Therapeutic Food (RUTF) – based on peanut butter mixed with dried skimmed milk and vitamins and minerals – has revolutionized treatment of severe malnutrition. It is safe to use at home, can be consumed directly by the child and provides sufficient nutrient intake for complete recovery. Local production of RUTF paste is already under way in several countries including the Congo, Ethiopia, Malawi and Niger. In 2007 WHO, UNICEF, the World Food Programme and the UN System Standing Committee on Nutrition adopted a Joint Statement on the community-based management for severe malnutrition. WHO and UNICEF have since worked together to develop a field manual for the community-based management of severe malnutrition, and the IMCI guidelines have been revised to take account of the new home-based treatment.

New approaches to training health workers

To develop the capacity of more health workers to prevent and treat sick children, we have developed new approaches for delivering training on the Integrated Management of Childhood Illness (IMCI). In 2006–2007 we worked with the Novartis Foundation for Sustainable Development to develop a computerized tool for adapting the IMCI guidelines for distance learning or classroom training of health workers in both pre-service and in-service settings. We have also continued working with countries to introduce IMCI into the curriculum of medical and nursing schools.

BRINGING HEALTH TO COMMUNITIES

To bring essential child survival interventions into more homes and communities, we are developing state-of-the-art materials to provide community health workers with basic care-giving skills for the management of childhood illness, better care for newborns, and to promote key family practices to prevent illness and promote wellness. The package of training materials is designed to be delivered at a designated “health house” where parents and other caregivers can seek care for a sick child, and through home visits, targeting newborns in particular. The modules on the management of childhood illness have been developed as a first priority, to meet the urgent demands of countries and partners to expand access to care for child diarrhoea, malaria, and pneumonia.

PNEUMONIA

Pneumonia is the largest single cause of death in children under five. In 2006–2007 we led the initiative to develop a Global Action Plan for Pneumonia (GAPP). In March 2007 consensus was reached on a comprehensive approach to pneumonia which includes key strategies of nutrition, reduction of indoor air pollution, immunization, and better case management. In 2008 the GAPP will continue with work to facilitate the promotion and implementation of these interventions at country level, in the context of child survival strategies to achieve MDG4.

In addition, in 2006–2007 we supported two key studies – one in Pakistan, the other in Bangladesh, Egypt, Ghana and Viet Nam – to examine whether severe pneumonia can be safely treated at home. The Pakistan study demonstrated the safety and efficacy of treating children aged 3-59 months with severe pneumonia with oral antibiotics outside of a hospital setting. Findings indicate that treatment guidelines for severe pneumonia should be reviewed in 2008. However, it should be noted that this treatment strategy will not be appropriate in high HIV prevalence settings, nor in cases of very severe pneumonia.
CHILD AND ADOLESCENT RIGHTS

To facilitate the integration of a “rights-based perspective” into the planning and implementation of policies, interventions and programmes for child and adolescent health, we have developed a training course. The course strengthens understanding and knowledge of child rights and the United Nations Convention on the Rights of the Child (CRC). Participants from WHO and counterparts in countries learn about the relationship between needs, obligations and rights, and about how the CRC can be used for policy development, as well as planning, programming and managing programmes for child and adolescent health.

During 2006–2007, we conducted multi-country trainings in the African and Western Pacific Regions, as well as two countries in the Region of the Americas: Honduras and Nicaragua. As a result, in 2006 and 2007, the African, Americas and Western Pacific Regions all provided support to the CRC reporting process, including through the review of selected state party reports.

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Regional Story

Eastern Mediterranean Region

Staff from the Department of Child and Adolescent Health and Development in the Eastern Mediterranean Region visited Yemen in 2007 to assess access to primary health care facilities, and to look into the low utilization of health services. Geographic access was identified as a barrier to first-level health care for mothers and children, and an innovative response was proposed: the use of integrated mobile teams for child and maternal health. That proposal was approved by the Deputy Minister of Health in July 2007, and in August 2007 pilots were implemented in two districts with high population density and few health facilities. Two mobile teams were set up for each district, each consisting of a physician and a health worker trained in IMCI, as well as a midwife, expanded immunization programme staff member, and a health education officer. Results so far show that, in a five-day visit, a mobile team can see as many mothers and children as would usually be seen in a month at an ordinary health centre in a fixed location.

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ORs+Zinc

Diarrhoeal diseases are a leading cause of sickness and death among children in developing countries. We have built an evidence base that shows that treating children with diarrhoea with low-osmolarity Oral Rehydration Salts (ORS) and zinc supplements is safe, cost-effective and saves lives. Low-osmolarity ORS shortens the duration of diarrhoea and reduces the need for hospital-based intravenous fluids. Zinc supplements reduce the severity and duration of the episode. We have developed guidelines and tools to support implementation, monitoring and evaluation of the combined ORS+zinc treatment strategy. We are now looking at the feasibility of incorporating zinc into routine treatment through studies in India, Mali and Pakistan. We have developed guidance for manufacturers on the production of low-osmolarity ORS and, together with partners, transferred technology to Bangladesh, India and Pakistan for the production of zinc tablets.

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Child Development

Each year over 200 million children fail to reach their full potential in cognitive development because of poverty, poor health and nutrition, and lack of early stimulation. In 2007 The Lancet published a series on “Child development in developing countries” which was co-authored by staff from the Department. The series shed light on new information demonstrating the urgent need to scale-up activities to improve health and development in the early years. Also in 2007, we contributed to the development of a report of the WHO Commission on the Social Determinants of Health entitled “Early childhood development: a powerful equalizer”. It proposes ways in which governments and civil society can work with families to provide equitable access to strong nurturant environments for all children globally.

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Supportive, evidence-informed policies

Sound policies are essential for developing programmes and delivering health services that meet the needs of adolescents. Those policies must be evidence-based if they are to be effective. Two highlights of our work in 2006-2007 are described below.

Steady, Ready, Go!

Forty per cent of all new HIV infections around the world in 2006 occurred among 15-24 year olds. Over a two year period, we conducted a systematic review of the evidence from developing countries on the effectiveness of interventions for preventing HIV/AIDS in young people which are delivered through schools, health services, mass media, communities, and to young people who are most vulnerable to HIV infection. In 2006 we published a report which classified these interventions into three categories:

■ Steady – don’t implement yet, needs more work and evaluation;
■ Ready – implement widely, but evaluate carefully;
■ Go – implement on a large scale while monitoring coverage and quality.

In 2007, we followed-up with a series of policy briefs which synthesized the recommendations for policy-makers, programme managers and researchers to guide their efforts to increase access to information, skills and services in order to reduce the rate of HIV infection among young people.

Meeting the needs of pregnant adolescents

Babies born to girls aged 15-19 account for more than 10% of all births worldwide, and in many countries the risk of dying from pregnancy-related causes is twice as high for adolescents as it is for older mothers. More needs to be done to provide care for pregnant adolescents and their newborns, alongside efforts to prevent unwanted adolescent pregnancies. In 2006, we conducted a review of the literature and programmes on adolescent pregnancy and published a document entitled Adolescent Pregnancy – Unmet Needs and Undone Deeds which highlighted the considerable risks faced by adolescents during pregnancy and childbirth. This review provided the basis for a report published jointly with UNFPA: Pregnant Adolescents: Delivering on Promises of Hope. It outlines the most critical needs for adolescent expectant mothers: social support, information about services and how to access them, better access to antenatal care, skilled attendance at birth, and access to emergency obstetric care. We also presented the report’s key findings at a major regional meeting on adolescent pregnancy in Montevideo, Uruguay in December 2006.
Case study
Scaling up adolescent health services in Mozambique

In 2006 we published a review of the effectiveness of initiatives in developing countries for improving the utilization of health services by adolescents (see section on “Steady, Ready, Go!”). This review provided an outline of the actions taken to ensure that adolescents were able and willing to obtain the health services they need. However, it did not describe or analyse the context in which the initiatives were implemented or what it took to make them happen. To address this, analytic case studies were prepared on outstanding initiatives in Estonia, Mozambique and South Africa that have succeeded in scaling up health services while improving and sustaining improvements in quality. Each of these case studies describes what was done, and what challenges were faced and overcome in making health services “adolescent friendly”. They are intended to convince programme managers that scaling up in the ways that we recommend is both doable and worth doing.

One of the case studies is of the Geração Biz programme in Mozambique. The strong commitment of the Ministry of Health to sexual and reproductive health provided a good basis for an initiative to address adolescents. The aim of the Geração Biz programme was to provide adolescents with the information and skills they need to protect themselves, to promote safe behaviours, and to provide them with sexual and reproductive health services. It was launched in Maputo in 1999. Step by step, the programme was expanded, and today it covers virtually the whole country. As a result, a large and growing segment of the adolescent population are reached; not just a handful here and a handful there. Two key lessons to be learned from this experience are that: strong links between the health, education and youth sectors enabled a comprehensive strategy to be put in place; and that strong coordination at national, provincial and local levels is vital.
In 2006–2007 we supported wide-ranging actions to develop capacity at regional and country-level for using the evidence generated and tools developed at headquarters. We conducted capacity building workshops in the African Region, the European Region, the Region of the Americas and the South-East Asia Region. Staff from four WHO Regional Offices and 32 Country Offices as well as adolescent health programme managers from 17 countries’ ministries of health participated in the workshops. These workshops resulted in tangible follow up actions, such as the development of a national plan to strengthen the health sector’s response to adolescent health.

In 2006 we helped to implement and evaluate a project in Argentina, Brazil, Chile, Mexico, Paraguay and Venezuela in which football coaches were trained to raise young men’s awareness about gender and masculinity, respect for self and others, sexuality and HIV, substance abuse, and violence. More than 125 professionals and over 2,000 adolescent boys have been involved in the project so far, and plans are under way for the development of a curriculum for football coaches, a training of trainers guide, and a set of evaluation tools.

A recent review of the effectiveness of gender-based interventions carried out by the WHO Department of Gender and Women’s Health described this initiative as one of the few promising programmes designed to address gender issues in young men in this age group.

Helping parents improve adolescents’ health

In 2006 we reviewed recent research and held a technical consultation on parenting of adolescents in developing countries, to examine the evidence and determine the best role for parents that programmes should aim to promote and improve. In 2007 we published the report which identified five key parental roles which have a positive influence on adolescent behaviour:

1. connection – love;
2. behaviour control – limits;
3. respect for individuality – respect;
4. modelling appropriate behaviour – modelling; and
5. provision and protection – provide.

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Reaching boys with health messages through football

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In 2006 we reviewed recent research and held a technical consultation on parenting of adolescents in developing countries, to examine the evidence and determine the best role for parents that programmes should aim to promote and improve. In 2007 we published the report which identified five key parental roles which have a positive influence on adolescent behaviour:

1. connection – love;
2. behaviour control – limits;
3. respect for individuality – respect;
4. modelling appropriate behaviour – modelling; and
5. provision and protection – provide.

In 2006–2007 we supported wide-ranging actions to develop capacity at regional and country-level for using the evidence generated and tools developed at headquarters. We conducted capacity building workshops in the African Region, the European Region, the Region of the Americas and the South-East Asia Region. Staff from four WHO Regional Offices and 32 Country Offices as well as adolescent health programme managers from 17 countries’ ministries of health participated in the workshops. These workshops resulted in tangible follow up actions, such as the development of a national plan to strengthen the health sector’s response to adolescent health.

Reaching boys with health messages through football

In 2006 we helped to implement and evaluate a project in Argentina, Brazil, Chile, Mexico, Paraguay and Venezuela in which football coaches were trained to raise young men’s awareness about gender and masculinity, respect for self and others, sexuality and HIV, substance abuse, and violence. More than 125 professionals and over 2,000 adolescent boys have been involved in the project so far, and plans are under way for the development of a curriculum for football coaches, a training of trainers guide, and a set of evaluation tools.

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What has been achieved in India in 2006–2007 is an example of the results of these focused efforts. A national Adolescent Reproductive and Sexual Health strategy was developed with the aims of preventing adolescent pregnancy, maternal mortality in pregnant adolescents, and HIV and sexually transmitted infections in adolescents.

We supported the Ministry of Health in developing national quality standards and guidelines for making health services “adolescent friendly”. Following their launch in May 2006, orientation workshops were conducted in 28 of India’s 35 states and union territories to introduce programme managers to the standards.

Additional work has been done to adapt generic WHO materials to train health workers in India. Posters, leaflets and booklets to reach adolescents and community members were developed. Collaborative links were strengthened with the Departments of Education, Youth, and Women and Child Development. Indicators to monitor progress were integrated into health management information systems and tools to assess the quality of health service provision were developed and tested.

To take this work to the next level, two rural districts were identified to pilot the approach: Ambala in Haryana state and Midnapur in West Bengal. Over a period of one year, every one of the two primary health centres and 16 sub-centres were designated as “adolescent friendly”, and the number of adolescents using the services more than trebled.

We have supported the Health Ministry through every step of the journey – from the conceptual to the operational, including the measurement. We are now supporting the efforts of the Health Ministry to document this story, to table it at a forthcoming meeting of state level programme managers and to use this to interest and challenge them to emulate this in their respective states.