



IMPLEMENTATION GUIDE ON RCH II ADOLESCENT REPRODUCTIVE SEXUAL HEALTH STRATEGY

FOR STATE AND DISTRICT PROGRAMME MANAGERS



स्वास्थ्य एवं परिवार
कल्याण मंत्रालय
भारत सरकार



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IMPLEMENTATION GUIDE ON RCH II ARSH STRATEGY

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Dated the 13th April, 2006

Adolescents (10-19 years) in India constitute 22% of country's population. Adolescents are not a homogenous group. Their situation varies by age, sex, marital status, class, region and the cultural context. A large number of them are out of school, get married early, work in vulnerable situations, are sexually active, and are exposed to peer pressure. These factors have serious social, economic and public health implication. This calls for health intervention that are flexible and responsive to their disparate needs. It is important to raise awareness regarding the health-seeking behaviour of adolescents as their situation will be central in determining India's health, mortality and morbidity; and the population growth scenario.

Keeping this in mind, we have identified Adolescent Reproductive and Sexual Health (ARSH) as a key strategy under the Reproductive and Child Health Phase-II (RCH-II) Programme and National Rural Health Mission. Our experience shows that the use of services by adolescents is extremely limited. Quite a number suffer from mal-nutrition and anaemia which adversely affects their physical well-being. It is our endeavour to influence the health seeking behaviour of adolescent youth through the existing Public Health System and Service. This intervention is likely to yield tangible results in empowering the adolescent group with regard to delaying the age at marriage, reducing incidence of maternal mortality and teen-age pregnancy, lowering incidence of STIs and preventing the rising incidence of HIV-AIDS.

The National Strategy on Adolescent Health focuses on the Public Health System to meet the health service needs of the adolescent youth. This strategy has been designed to facilitate adolescent services at key delivery points of the Public Health System in the country. The strategy incorporates a core package of services including preventive, promotive, curative and counseling services.

This Implementation Guide has been designed to help the key resource persons at the State and District levels in implementing the broad framework of the National Strategy. The Guide has been prepared keeping in mind the need, variations and capacities of State units in implementing national programmes. The Implementation Guide presents the framework of "what" to implement and "how" to implement step-wise the ARSH Strategy. The Implementation Guide has been supplemented by appropriate Training Manuals for Health providers which will enable them to be sensitized to the adolescent issues.

The Information, Education and Communication Division of this Ministry has prepared the Implementation Guide that will enable Medical Officers, Programme Managers and Health functionaries to mainstream adolescent services in our delivery mechanism. I congratulate the Division and the other organization, professional bodies and experts who have given their invaluable assistance for the development of these guidelines. I am sure that these guidelines, when implemented in word and spirit, will go a long way in positioning adolescent sensitive health services in our country.

(PRASANNA HOTA)
Secretary (Health & Family Welfare)



सम्पर्क से पहले सोचो, एच आईवी/एडस से बचो

HIV/AIDS: Prevention is better than cure

ACKNOWLEDGMENTS

Adolescent Health is one of the key technical programmes under the National Rural Health Mission and RCH-II. Under the RCH-II framework, a National Strategy to implement the Adolescent Health component in the existing Public Health System, has been designed for the first time. The strategy highlights the need to create awareness and a supportive environment for improving health seeking behaviour of adolescents. It focuses on an awareness generation communication programme and a service delivery mechanism for providing Adolescent Sexual Reproductive Health Services through the existing public health system. The National RCH-II Adolescent Sexual Reproductive Health Strategy has been adapted in almost all State RCH-II Programme Implementation Plans. In designing the interventions for effective implementation, the IEC Division undertook a consultative process with key stakeholders and has come out with the Implementation Guide which has been supplemented by appropriate Training Manuals for Health providers.

It would not have been possible to bring out these Guidelines and related Training Manuals without the vision and constant encouragement provided by Shri. P.K. Hota, Secretary, Health & Family Welfare. He has always provided us with insights that have enabled us to mainstream our interventions within the given realities of the existing health system. I am grateful to Smt. S. Jalaja, Additional Secretary, Ministry of Health and Family Welfare for providing us valuable guidance for weaving the NRHM-related themes in the National Strategy. I am indebted to Shri B.P. Sharma, Joint Secretary of the Programme Division for having guided us in balancing the communication component with programme requirements. His constant encouragement has enabled the IEC Division to come out with innovative communication tools for the programme.

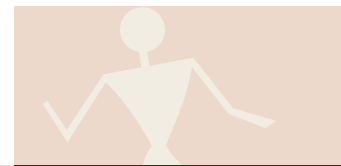
These Guidelines and Manuals have been designed with the technical assistance and other related support systems provided by UNFPA and WHO India. Without their pro-active participation, it would not have been possible to bring out these publications. I am particularly thankful to Dr. Dinesh Agarwal (Technical Adviser, Reproductive Health, UNFPA India Office) and Mr. Mandeep Juneja, National Programme Officer, Adolescent Health, UNFPA for their technical and strategic inputs in outlining the design of the interventions and their valuable time in preparing the guidelines and modules. I also wish to thank Dr. Arvind Mathur, Coordinator - Family & Community Health, WHO India, Dr. Neena Raina, Regional Advisor, Adolescent Health & Development, WHO, SEARO and Dr. V. Chandramouli, Coordinator-FCH/CAH, WHO, Geneva for not only providing the technical expertise for our programmatic interventions but also facilitating the program design by sharing their experiences and program designs in the field. I would also like to thank Dr. Rajesh Mehta, Senior Paediatrician, Safdarjung Hospital and Dr. Patanjali Nayyar of Hindu Rao Hospital for providing key inputs during the designing and testing of the Training Modules.

Last but not the least, I would like to express my sincere appreciation for the hard work and contribution put in by Shri R.N. Singh, DAC (PE) in the Department of Health & Family Welfare, in facilitating the programme design. My other colleagues in the Division Shri R.S. Meena 'Kalky' Editor (Hindi), Shri Rakesh Bhatia PO (AV), Shri R.K. Sarkar Editor (English), Shri Raman Prasad AVMO and Shri Syama Prasad, Chief Media provided invaluable communication inputs for designing the outreach component of the Strategy. At the same time, I am grateful to other colleagues in the Ministry and the IEC Division in providing assistance and timely advice as and when it was necessary. All this has enabled the IEC Division in providing assistance and timely advice as and when it was necessary. All this has enabled the IEC Division in outlining a comprehensive plan for mainstreaming the Adolescent Health intervention.



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1

BACKGROUND

PURPOSE OF THE IMPLEMENTATION GUIDE

In the National Rural Health Mission (NRHM), a national strategy for Adolescent Reproductive and Sexual Health (ARSH) has been approved as a part of the Reproductive and Child Health Phase II (RCH II). Various states as a part of their State and District RCH II Plans have adapted this national strategy. This strategy is now to be implemented in the districts in the primary health care setting. In this context, this document is intended to guide state and district RCH II programme managers in implementing the ARSH strategy.

This document is guided by the National Guidelines of the Ministry of Health and Family Welfare (MoHFW) developed for the technical strategies under RCH II. Special attention is to be given to gender and equity differentials at every stage of implementation. The RCH II ARSH strategy is to be implemented within the framework of inter-sectoral convergence emphasized by the National Rural Health Mission. Linkages are to be established between the RCH II ARSH strategy and the strategy for adolescents and young people, under the proposed third phase of the National AIDS Control Programme (NACP).

This guide presents what to implement and how to implement the ARSH strategy. Part two focuses on what is to be implemented, detailing the RCH II ARSH strategy at the national level. It also presents an overview of the strategy which has been adapted by the different states. In part two, the guide discusses the desired quality in implementation of the ARSH strategy. This dimension of quality is defined in terms of key principles or standard statements, which are to be fulfilled in order to achieve the expected results, viz., improving the health seeking behaviour of adolescents and contributing towards the long-term health goals/outcomes of reduced MMR, IMR, TFR and HIV infections in this age group.

Part three of the guide details how the strategy is to be implemented. It outlines the steps that are to be undertaken for creating a supportive environment, generating awareness among adolescents, organizing services, improving capacity of service providers, and monitoring service provision and utilization. Essential actions are specified to guide the programme managers to meet the desired standards. These actions are to be further adapted as per the context specific requirements of the states and districts, without compromising on quality

It is expected that the state and district programme managers will use this implementation guide, once they have undergone an orientation on ARSH issues. For this purpose a one-day orientation package for programme managers has been suggested.



A draft of this document was discussed and deliberated upon at the National Consultation on RCH II ARSH Strategy in September 2005, organized by the MoHFW, the UNFPA and the WHO. The inputs given by the experts who participated in this consultation from all over the country have been largely incorporated.

This guide is not intended as a prescriptive document. It is a suggestive framework for implementation for programme managers. It is to be treated as work in progress and it is hoped that the rich input and feedback from the states and districts will give further shape to this guide.

ARSH IN RCH II

Why Adolescent Reproductive and Sexual Health?*

There are 225 million adolescents comprising nearly one-fifth (22 per cent) of India's total population (Census 2001). Of the total adolescent population, 12 per cent belong to the 10-14 years age group and nearly 10 per cent are in the 15-19 years age group. Females comprise almost 47 per cent and males 53 per cent of the total adolescent population. More than half of the currently married illiterate females are married below the legal age of marriage. Nearly 20 per cent of the 1.5 million girls married under the age of 15 are already mothers (Census 2001).

The pervasiveness of discrimination, lower nutritional status, early marriage, complications during pregnancy and childbirth among adolescents contribute to female mortality (CSO 2002, SRS 1999).

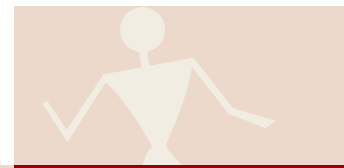
Mortality in female adolescents of 15-19 years is higher than adolescents of 10-14 years. More than 70 per cent girls in the age group of 10-19 years suffer from severe or moderate anaemia (DLHS-RCH 2004). Age-specific fertility rate in the age group of 15-19 years contributes to 19 per cent of the total fertility rate. Amongst currently married women, the unmet need of contraception is the highest in the age group of 15-19 years. Nearly 27 per cent of married female adolescents have reported unmet need for contraception (NFHS-2). Most sexually active adolescents are in

their late adolescence. Over 35 per cent of all reported HIV infections in India occur among young people in the age group of 15-24 years, indicating that young people are highly vulnerable. The majority of them are infected through unprotected sex.

Adolescent mothers are at a higher risk of miscarriages, maternal mortality and give birth to stillborn and underweight babies.

Given the above scenario, the Government of India (GoI) has recognized the importance of influencing the health seeking behaviour of adolescents. The health situation of this age group will be central in determining India's health, mortality, morbidity, and population growth scenario. Investment in adolescent reproductive and sexual health will yield dividends in terms of delaying age at marriage, reducing incidence of teenage pregnancy, meeting unmet contraceptive needs, reducing the number of maternal deaths, reducing the incidence of sexually transmitted infection (STIs) and reducing the proportion of HIV positive cases in 10-19 years age group. This will also help India in realizing its demographic bonus, as healthy adolescents are an important resource for the economy.

* Data in this section has been taken from the MOYAS – UNFPA Advocacy Kit "Healthy Adolescents, Empowered Adolescents", 2005



Existing Policy and Programme Scenario

It is useful for the programme managers to bear in mind the existing policy context and programme scenario with regard to adolescent health. The Tenth Five Year Plan recognizes adolescents as a distinct group for policy and programme attention. The National Population Policy 2000 identifies adolescents as an underserved group for which health, specifically reproductive and sexual health interventions are to be designed. The National Youth Policy 2003 recognizes 13-19 years as a distinct age group, which is to be covered in programmes of all sectors, including health, education, science and technology etc. In this regard, the Youth Ministry has devised special programmes for adolescent health and empowerment.

The National Curriculum Framework 2005 for School Education explicitly highlights the need for integrating age appropriate adolescent reproductive and sexual health, including HIV/AIDS messages into the school curriculum. This framework is translated into the National Adolescence Education Programme of the MHRD-NACO, which proposes 100 per cent coverage of all secondary and higher secondary schools with HIV/AIDS prevention and ARSH messages.

In keeping with the spirit of convergence under the MoHFW's NRHM, 2005, the RCH II ARSH strategy emphasizes the need for intersectoral linkages with other departments at the policy and programme levels. This is needed in order to create a supportive environment for adolescent interventions and to improve awareness levels among adolescents. The public health system at the primary health care level is to be reorganized to cater to the service needs of adolescents. Special focus is to be given on linking up with the VCTCs and establishing appropriate referrals for HIV/AIDS and RTI/STI infections. In this regard, operational linkages are being proposed between the RCH II and all other interventions, for young people in the National AIDS Control Programme III.

ARSH Strategy in National RCH II PIP

The goals of the GoI RCH II are reduction in IMR, MMR and TFR. In order to achieve these goals, the RCH II lists out four technical strategies. One of the technical strategies is for adolescent health.

A strategy for ARSH has been approved as part of the National RCH II Programme Implementation Plan (PIP). This strategy focuses on reorganizing the existing public health system in order to meet the service needs of adolescents. Steps are to be taken to ensure improved service delivery for adolescents during routine check ups at sub centre clinics and to ensure service availability on fixed days and timings at the PHC and CHC levels. This is to be in tune with the outreach activities. A core package of services would include preventive, promotive, curative and counselling services. The framework of services in the RCH II ARSH Strategy in the National PIP is presented below. This describes the intended beneficiaries of the adolescent friendly reproductive and sexual health services (target group), the health problems/issues to be addressed (service package) and the health facilities and service providers to be involved.

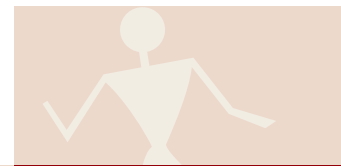
Such friendly services are to be made available for all adolescents, married and unmarried, girls and boys during the clinic sessions, but not denied services during routine hours. Focus is to be given to vulnerable and marginalized sub-groups. A plan of service provision as per level of care may be developed based on the RCH II service delivery plan.



| Level of Care | Service Provider | Target Group | Flow of service delivery activities | Services |
|---|---|--|--|--|
| Sub-Centre | • HW (F) | Unmarried F Married F Unmarried M Married M | During routine sub centre clinics | <ul style="list-style-type: none"> • Enrolment of newly married couples • Provision of spacing methods • Routine ANC care and institutional delivery • Referrals for early and safe abortion • RTI/STIs and HIV/AIDS prevention education • Nutrition counselling including anaemia prevention and menstrual hygiene • Immunization for pregnant adolescent mothers |
| Primary Health Centre/ Community Health Centre/ District Hospital | <ul style="list-style-type: none"> • Health Assistant (F)/LHV • Medical Officer | Unmarried Male and Female | Once a week: teen clinic will be organised at PHC for 2 hrs. | <ul style="list-style-type: none"> • Contraceptives, condom programming • Management of menstrual disorders, menstrual hygiene guidance • RTI/STI and HIV/AIDS preventive education and management • Counselling and services for pregnancy termination • Nutritional counselling • Counselling for sexual problems • Immunization for pregnant adolescent mothers |

ARSH Strategy in State RCH II PIPs

The National RCH II ARSH Strategy has been adapted in several State RCH II PIPs. By and large, most states have incorporated a strategy for adolescent health. The variation in them across the states can be explained in terms of the scope of demand generation activities and service provision. Some states have stressed more on knowledge/awareness generation and environment building activities through involvement of NGOs and other departments such as Women and Child Development, Youth



and Education. Other states have proposed adolescent clinics and counselling through NGOs. Most states articulate a service delivery strategy for adolescents through the public health system at the PHC and CHC levels. Some have proposed linkages with the adolescent-related work already initiated at the tertiary level through district hospitals. While some states have proposed selective coverage of PHCs and CHCs in a phased manner, others have proposed full coverage of all districts for ARSH interventions. In the RCH II, district programme managers are expected to identify PHCs and CHCs based on certain key criteria. The RCH II programme proposes additional inputs for strengthening RCH services in 50 per cent PHCs as 24-hour functional centres. These facilities will have additional nursing staff for organizing services. It is recommended to select only such facilities in the first phase of implementing the RCH II ARSH Strategy. The available physical infrastructure is to be kept in mind while selecting these facilities.

To conclude,

This section highlights the health situation of adolescents in the country. It also presents in brief, the policies and programmes that address adolescent health issues. An overview of the ARSH strategy at the national and state levels has been explained. Given this understanding of the scope of ARSH in RCH II, the focus of the next section is on the key principles or standards that are to be fulfilled for these services to be effectively delivered to adolescents.



2

WHAT TO IMPLEMENT?

STANDARDS FOR QUALITY AND FRIENDLY REPRODUCTIVE AND SEXUAL HEALTH SERVICES FOR ADOLESCENTS

This section focuses on standards or principles that can guide programme managers to effectively implement the ARSH strategy.

A standard is a statement of desired quality. In a number of countries around the world (eg Bangladesh, United Kingdom, and South Africa), standards have been developed for ascertaining the performance of health facilities for adolescents. Standards are valuable in strengthening programme implementation, monitoring and evaluation. This is because they set clear performance goals and make explicit the definition of quality required for a service. They provide a clear basis against which performance can be monitored, assessed and/or compared.

The key 'friendly' characteristics of services for adolescents are at the levels of the user, provider and health system. These in turn are the determinants of quality of the services. From the user's perspective, health services must be:

- (i) accessible – ready access to services is provided
- (ii) acceptable – that is, healthcare meets the expectations of adolescents who use the services.

From the provider's and manager's perspective, services must be

- (i) appropriate - required care is provided, and unnecessary and harmful care is avoided
- (ii) comprehensive – care provision covers aspects from prevention through to counselling and treatment
- (iii) effective – healthcare produces positive change in the health status of the adolescent. The health system must focus on efficiency in service delivery, that is high quality care is provided at the lowest possible cost.
- (iv) equitable – that is, services are provided to all adolescents who need them, the poor, vulnerable, marginalized and difficult-to-reach groups/areas.

Given the above, following are standards that can guide implementation of RCH II ARSH interventions. The rationale for each standard is also explained in brief. These standards emanate from the policy documents that already exist in the country.

The Indian Public Health Standards for Community Health Centres: Draft guidelines (Directorate General of Health Services, Ministry of Health and Family Welfare, Government of India, Undated) and the ARSH Strategy in the RCH Phase II National Programme Implementation Plan (Ministry



of Health and Family Welfare, Government of India, Undated), provide the overall policy and programme framework for these standards. These documents clearly stress that health facilities at the different level of the health system will be required to provide a set of “assured services”, attain and maintain an acceptable level of quality care, ensuring the appropriate physical infrastructure, availability of providers with required knowledge and skills, making services more responsive and sensitive to the needs of community, undertake awareness and environmental building activities. There is an emphasis on internal and external review and monitoring to ensure the quality of services.

1. Health facilities provide the specified package of health services that adolescents need

This standard seeks to ensure that the specified package of health services is provided. In many places, health facilities do not provide adolescents with the health services they need. Often, general health complaints are used as an entry point to provide the required sexual and reproductive health services. This standard seeks to ensure that the specified package of health services is in fact provided.

2. Health facilities deliver effective health services to adolescents

In many places, health services are not provided effectively by service providers for a variety of reasons viz. service providers are not in place, they do not have the required competencies, the required supplies, equipment and basic amenities are not available etc. This standard therefore stresses that health facilities are well equipped to deliver services to adolescents as per their need/s.

3. Adolescents find the environment at health facilities conducive to seek services

Adolescents will not seek health services if the physical environment and procedures are not appealing to them. This standard focuses on ensuring that a reasonably conducive environment exists in health facilities for adolescents to access these services.

4. Service providers are sensitive to the needs of adolescents and are motivated to work with them

Due to a variety of reasons, e.g. judgmental attitudes of service providers, many adolescents do not seek health services. Service providers are to be technically competent and motivated to provide services to adolescents as per their need/s. This standard seeks to ensure that the service providers imbibe and demonstrate appropriate attitudes and behaviour to reassure the adolescents in addressing their needs. The standard therefore seeks to address issues relating to service providers attitudes and motivation.

5. An enabling environment exists in the community for adolescents to seek the health services they need

In many situations, community members (especially parents) are not aware of the value of providing sexual and reproductive health services to adolescents. They do not believe that adolescents should have access to these health services. This deters service providers from providing health services to adolescents, and deters adolescents from seeking the same. The standard seeks to address these environment-building factors.



6. Adolescents are well informed about the availability of good quality health services from the service delivery points

Adolescents are generally not aware of where they can get good quality health services. The standard seeks to address the gaps in knowledge and awareness among adolescents on health, sexual and reproductive health issues and emphasizes the importance of seeking quality services in time from the service delivery points.

7. Management systems are in place to improve/sustain the quality of health services

Data that is gathered at sub-centres, primary health centres and community health centres is generally sent to a higher authority for analysis. Often no feedback is received. Only rarely is the data used locally to address problems and take remedial measures leading to an improvement in quality. This standard focuses on the importance of monitoring systems to ensure that interventions are effectively implemented as planned and that appropriate feedback mechanisms are in place.

To conclude,

This section has outlined seven standard statements, which will guide the effective implementation of the ARSH strategy. Subsequent sections in part three of this guide detail the guidelines for operationalizing the ARSH strategy. Implementation of the strategy is to be guided by these standards. The RCH Phase II National Programme Implementation Plan and Indian Public Health Standards for CHCs constitute the integral components of the NRHM. Standards suggested in this guide largely conform to IPHS with special reference to human resources, supplies and equipment, services etc.



3

HOW TO IMPLEMENT?

Part three of this guide details out steps and actions to be carried out for making operational the ARSH strategy and achieving the desired standards. These operational guidelines on how to implement indicate the minimum and core actions that are to be undertaken if the strategy is to be effectively implemented. These guidelines can be further adapted to meet the state and district specific requirements, as appropriate. The operational guidelines below (in seven sections) are organized in terms of the seven standard statements discussed in part two of the guide. Based on the operational guidelines, section eight presents a sample step-wise implementation plan for the state and district programme managers to operationalize the strategy.

SECTION ONE: SERVICE DELIVERY PACKAGE

STANDARD: Health facilities provide specified package of services that adolescents need

Services are to be made available for all adolescents, married and unmarried, girls and boys. Focus is to be given to the vulnerable and marginalized sub-groups. The package of services is to include promotive, preventive, curative and referral services. A plan of service provision as per the level of care may be developed based on the RCH II service delivery plan presented in the previous section.

The package of services is to include promotive, preventive, curative and referral services. Selected facilities in the districts must be in a position to provide the following core package of services:

1. Promotive Services:

- 1.1 Focused care during the antenatal period
- 1.2 Counselling and provision for emergency contraceptive pills
- 1.3 Counselling and provision of reversible contraceptives
- 1.4 Information/advice on SRH issues

2. Preventive Services:

- 2.1 Services for Tetanus Immunization
- 2.2 Services for Prophylaxis against Nutritional Anaemia
- 2.3 Nutrition Counselling
- 2.4 Services for early and safe termination of pregnancy and management of post abortion complications



3. Curative Services:

- 3.1 Treatment for common RTIs/STIs
- 3.2 Treatment and counselling for menstrual disorders
- 3.3 Treatment and counselling for sexual concerns of male and female adolescents
- 3.4 Management of sexual abuse among girls

4. Referral Services:

- 4.1 Voluntary Counselling and Testing Centre
- 4.2 Prevention of Parent To Child Transmission

5. Outreach Services :

- 5.1 Periodic health check ups and community camps
- 5.2 Periodic health education activities
- 5.3 Co-curricular activities

1. Promotive Services:

1.1. Focused care during the antenatal period

Pregnant adolescents may more conveniently access adolescent-friendly clinics at dedicated timings. It is generally considered that antenatal care should start early, preferably in the first trimester. Evidence shows that adolescents either don't seek care or that care is often delayed and infrequent. ASHAs or other community-based functionaries may also accompany such pregnant girls from their respective villages to these clinics. Availability of female service providers, such as LHV or staff nurses or ANMs, will help in winning the trust of pregnant girls, since for many of them this may be the first contact with the public health system.

ANC protocol for pregnant adolescents is not different from the protocol for other pregnant women. Providers are to follow the guidelines for antenatal care as developed by the Maternal Health Division of GoI. However, the following issues need to be reiterated:

- Ensure Institutional Delivery: Primi paras are more at risk of developing obstetric complications.
- Nutritional counselling: Increased risk of nutritional deficiencies as adolescents enter pregnancy with nutritional deficiency
- Contraceptive counselling
- Couple counselling
- Referral to be made for complications during pregnancy and the precautions to be taken while the patient is carried in such cases.

1.2. Counselling and provision for emergency contraceptive pills

- Adolescent boys and girls may also access these clinics for ECPs (emergency contraceptives). As per revised guidelines, ECPs are now also available without prescription. Levonorgestrel pills have been made available at the PHCs under the programme. Advance provision of emergency contraceptive pills must be considered in situations where access is likely to be restricted. There is enough programmatic evidence to demonstrate effectiveness of advance provision of ECPs in preventing unwanted pregnancies.



- Opportunity must be used to emphasize safe sex practices and risk reduction counselling.
- Information and counselling on regular contraception must be provided.

1.3. Counselling and provision of reversible contraceptives

Adolescent-friendly clinics are to provide services for OCPs, condoms and IUD insertion as per the national guidelines. Service providers are to be encouraged to offer a package of contraceptives, so that adolescents can choose a particular method as per their need/s. Providers are to also inform the adolescents about resupply provisions and sources for further supply. Non-clinical reversible contraceptives are available with the community-based health functionaries such as ASHA and also through social marketing channels.

Dual protection is to be an integral part of contraceptive counselling. Adolescents must have information and access to methods that provide dual protection.

1.4. Information/advice on SRH issues

Providers must be able to address specific questions of male and female adolescents on common sexual and reproductive health concerns. Adequate resource materials are to be made available to providers in order for them to respond to questions posed by the adolescents. Resource materials are to cover topics related to growth and development, puberty, sexuality concerns, myths and misconceptions, pregnancy, safe sex, contraception, unsafe abortions, menstrual disorders, anaemia, sexual abuse, RTIs/STIs, etc.

2. Preventive Services

2.1. Services for Tetanus Immunisation

As per the national guidelines, adolescents must be given immunisation against tetanus. Adolescents receiving complete primary immunisation during childhood need to be administered with Tetanus Toxoid at 10 years and then at 16 years.

For adolescents not receiving complete DPT immunization, they are to be administered with two doses at six weeks interval and then after six months. This needs to be repeated every five years. Therefore, sufficient amount of Tetanus Toxoid must be available at these clinics.

2.2. Services for Prophylaxis against Nutritional Anaemia

Selected facilities are to provide the facility for screening of anaemia by offering routine Haemoglobin estimation. For pregnant adolescents, the national guidelines need to be adhered to. For non-pregnant adolescents, treatment is to be given in the form of iron therapy. In some states, project interventions have been undertaken in the past to provide prophylaxis in the form of weekly IFA tablets.

Service providers are to provide information on balanced diet and consumption of green leafy vegetables and other iron rich foods. Worm infections have to be treated accordingly.

2.3. Nutrition Counselling

Adolescents invariably suffer from a range of nutritional problems including vitamin and mineral deficiency. Some adolescents may approach providers with specific concerns regarding excess weight and obesity. Service providers are to offer appropriate advice to adolescents to address these concerns.



2.4. Services for early and safe termination of pregnancy and management of post-abortion complications

Facilities are to be fully equipped to provide early and safe abortion services to adolescents. The national guidelines refer to the provision of termination of pregnancy of up to eight weeks using MVA (manual vacuum aspiration) procedures at PHCs (primary health centres). Permission of the guardian is mandatory for conducting a MTP (medical termination of pregnancy) for girls below 18 years of age. Counselling for safe MTP services must be offered. Simultaneously, if required, terminations up to a period of eight weeks can be performed at these facilities during clinic timings.

Evidence suggests that younger adolescents are more likely to delay seeking a termination of pregnancy. In such a situation, referrals for MTP must be made to CHCs or district hospitals, as these facilities are fully equipped to handle second trimester abortions.

Adolescents may also access these facilities with complications attributable to unsafe abortions. Such clients are to be managed as per the Guidelines for Management of Common Obstetric Complications.

Post-abortion contraceptive counselling is to be an integral component of MTP services and is a must for those presenting post-abortion complications.

3. Curative Services

3.1. Treatment for common RTIs/STIs

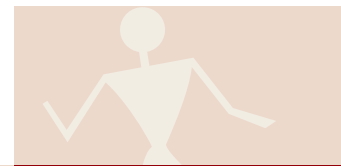
Adolescents are more vulnerable to genital infections on account of biological and social factors. Adolescent girls may find it difficult to negotiate condom use with their partners. National algorithms for the management of common RTIs/STIs are being developed and service providers will be trained in these protocols in RCH II. The following elements of quality of care deserve special attention:

- Privacy and Confidentiality - It is crucial that complete audio and visual privacy is maintained during the client-provider interaction. Similarly, access to service delivery register etc. is to be restricted to ensure confidentiality.
- Treatment compliance - It is important to emphasize compliance with the drug regimen prescribed for each adolescent. Non-compliance will lead to treatment failure. This also includes advice on personal hygiene and safe sex during treatment.
- Partner management - As per national algorithms, partner management should constitute an integral component of services. Adolescents should be explained the importance of the treatment of their partner in order to prevent reinfections.
- Follow-up visits and referrals for treatment failures – Adolescents are to be advised to adhere to the schedule of follow-up visit. In case they do not respond to therapy, they are to be referred to higher levels.

3.2. Treatment and counselling for menstrual disorders

Several community-based studies indicate that menstrual disorders are perceived to be very common amongst adolescent girls. Service providers must be able to manage these problems in the following manner:

- Symptomatic treatment for pre-menstrual tension, dysmenorrhoea etc.



- Counselling for menstrual problems and hygiene
- Referrals for any investigations and for puberty-related problems

3.3. Treatment and counselling for sexual concerns of male and female adolescents

Adolescents have several concerns regarding sex and sexuality. Clients may come to the clinic with crypto orchidism or any other disorders. The clinic must be in a position to cater to the specific concerns of boys and girls on these issues. Referrals may be needed in most of these situations.

3.4 Management of sexual abuse among girls

Adolescent facilities are to offer services for management of sexual abuse, especially for adolescent girls. A separate protocol needs to be developed for such clients, whereby they will have access to emergency contraception pills, prophylaxis against STIs and PEP for HIV along with counselling as per the National Guidelines.

Additional/Optional services

In addition to the above package of services, programme managers may also consider some services according to the local needs, for example:

- **Screening for Sickle cell:** Sickle cell anaemia is suspected based on an individual's ethnic racial background and the symptoms of anaemia. Sickle cell anaemia is a genetic disorder. A child who inherits sickle cell trait from both parents (25 per cent chances), will develop sickle cell anaemia. Sickle cells have developed a life span in comparison to normal red blood cells, as they survive only for 10-12 days. As a result, the infected individuals develop anaemia. At times, "painful crisis" also occurs as a primary symptom of sickle cell anaemia. Screening for sickle cell* and genetic counselling for those having sickle cell trait will help in preventing risk of transmission to offspring.
- **Blood Grouping for RH and ABO:** Adolescents usually come forward to attend these clinics for getting their blood group tested. This can also serve as an ideal entry point to introduce adolescents to the range of services being made available at the health facilities.
- **Immunization for Hepatitis B and Rubella** if MMR not given in childhood.

4. Referral services

Selected facilities must be in a position to make appropriate referrals for care and support, especially for HIV/AIDS.

4.1 Voluntary Counselling and Testing Centre (VCTC)

Voluntary counselling and testing services are the gateway to prevention and care for HIV/AIDS. Adolescents who are sexually active are to be imparted pre-test counselling for getting a voluntary test. In high prevalence states, such facilities are located at CHCs while in other districts these facilities

* A blood count reveals the anaemia, and a sickle cell test reveals the presence of the sickle cell trait. The sickle cell test involves mixing equal amounts of blood and a two per cent solution of sodium bisulfite. Under these circumstances, haemoglobin exists in its deoxygenated state. If haemoglobin S is present, the red blood cells are transformed into the characteristic sickle shape. This transformation is observed with a microscope, and quantified by expressing the number of sickle cells per 1,000 cells as a percentage. The sickle cell test confirms that an individual has the sickle cell trait, but it does not provide a definitive diagnosis for sickle cell anaemia



are located at the district hospitals. It is envisaged that in NACP III, such facilities are to be expanded to cover more peripheral facilities. A VCTC site is to facilitate access to ART if required.

4.2 Prevention of Parent To Child Transmission

Ideally, access for PPTCT is to be an integral component of focused ANC services. Adolescents are to be counselled about the risk of HIV infections during pregnancy and must be encouraged to undergo testing and subsequent Nivaparine therapy for prevention of transmission of infection. Adolescents are to be referred to appropriate facilities in the district for access to ART interventions.

For services that are not available on the spot, mechanisms are to be in place to ensure effective referral to other service delivery centres and/or counselling centres.

5. Outreach Services

In the past, the PHCs have been made responsible for provision of school health services. However, there is a need to make these services more regular and productive. It is envisaged that effective school health services will provide opportunities for getting timely referrals. The school outreach services could be also seen as a mechanism for demand generation and social marketing of the adolescent friendly service delivery point.

5.1 Periodic health check ups and community camps

In each academic year, the MO in-charge must list the number of schools to be covered, based on which an annual work plan is to be developed after taking into consideration the holidays and academic activities etc. Bi-annual health check-ups must be a part of the plan. Most states are using a school health card for this purpose. School teachers must also be involved for carrying out anthropometrical examinations and tests for measuring visual acuity. District programme officers may consider organizing orientation for one or two interested teachers from selected schools in consultation with the Education Department. Some activities (such as anthropometrical examination) can be conducted by such teachers, thus reducing the requirements of the medical officers' time.

Adolescent health camps may be organized periodically to increase awareness about adolescent issues and availability of adolescent services, provide health education and health check-ups. Counselling can also be provided at these camps to adolescents who need it.

5.2 Periodic health education activities

Health education activities are to be organized in schools for the adolescents. The MO in-charge or LHV can conduct sessions on health-related issues during the assembly. Some experience is available on the organization of question box activities in schools. A simple health resource such as ASHA reading books can be made available to the school teachers and they can organize discussions and other co-curricular activities in the schools.

5.3 Co-curricular activities

Providers may prefer to organize question box activities in schools. Students are encouraged to anonymously drop questions in a letterbox. These questions are then taken up for discussion in the health assembly. Depending on staff availability, the medical officer or any other trained nursing staff from a nearby PHC/CHC can attend these sessions and respond to specific questions.

**Key Points:**

Package of services should be such that it responds to the needs of adolescents

Services should be comprehensive, that is, there should be a judicious mix of preventive, promotive and curative services

Services at Adolescent Clinic/Health Facility:

Core Package:

ARSH: Information, counselling and services related to sexual concerns, pregnancy, contraception, abortion, menstrual problems, etc.

Nutrition counselling, prevention and management of anaemia

STI/RTI management

Referral services for VCTC and PPTCT

Optional/Additional Services: Depending on local needs

Outreach Services: School Health and Community camps:

Health check-ups, health education and awareness generation

SECTION TWO: ORGANIZING EFFECTIVE SERVICES

STANDARD: Health facilities deliver effective services to adolescents

Steps are to be taken to ensure that services are effectively delivered to adolescents who approach the health facilities. For ensuring effective services the following components are crucial:

Service Providers:

- Adequate and appropriate (identified) service providers are in place. At all health facilities, defining the staff profile is needed and it has to be ensured that the identified staff is present in all clinic sessions.
- Service providers are clearly aware of their roles and responsibilities in relation to the functioning of the health facility.
- Service providers have the competencies required to provide the specified health services effectively. The capacity building plan (described in a later section) addresses the issues of competencies relating to both clinical management as well as interpersonal communication. Additionally, the capacity-building plan should include elements of self-learning, follow-up after training, mentoring and continuous learning to address gaps that have been identified. For this, the necessary tools need to be developed.

Location, ambiance, and supplies:

- The medical officer in charge must be able to take a decision to locate/set up clinic in the existing infrastructure. The decision should be guided based on the availability of a separate room for the clinic, timing and frequency of organising the clinic, and the expected level of utilisation of services by adolescents. If the clinic is to be organised once a week, there has to be sufficient



dedicated space. Clash of timings with routine health care needs to be checked. If there is no clash of timings, the same room that is used for OPD in the morning may be used for the adolescent clinic in the afternoon.

- The waiting area is to be identified with appropriate seating arrangements, provision of drinking water and clean functional toilets. Also, reasonable cleanliness must be ensured.
- Adequate materials, supplies and basic amenities are available. The specified supplies, equipment and basic amenities are available in each type of health facility.

Guidelines and Procedures:

- Clinical management guidelines and standard operational procedures are in place for the provision of the specified health services. The existing guidelines in the RCH programme would be followed.

IEC and resource materials:

- Informational/educational materials directed at adolescents are available. It is suggested that an adequate number of information booklets are made available as take away material in these clinics. Such booklets can be developed at the state level. Partnerships with local NGOs may be explored specifically for this purpose. A resource directory containing contact details of VCTCs, ART centres could be made available for facilitating referrals.

It is essential that services for adolescents be reorganized at least at the levels of sub-centre and PHC. Establishing referral linkages and organizing clinics at CHC and district hospital levels is desirable.

Sub-centre level

At the level of the sub-centre, services are to be provided to any adolescent girl or boy approaching the sub-centre. The sub-centre must have essential supplies for adolescent care. These include: IFA tablets, drugs for dysmenorrhoea, TT vaccine and syringes, essential ANC equipment, haemoglobinometer, supplies for Hb estimation, emergency contraceptives, contraceptives and communication materials for adolescents. Most importantly, the staff should be physically present during the designated hours of the clinic.

In addition to routine services, the sub-centre could organize clinics for adolescents at least once a month depending on the availability of resources. During outreach sessions organized in the sub-centre villages, ANMs can also provide services to adolescents. ANMs can also talk with ASHAs and emphasize the importance of encouraging adolescents to seek services. The sub-centre ANM could develop linkages with AWW, ASHA, youth centres, NYK and PRIs on a continuous basis.

PHC level

At the level of the PHC, a dedicated clinic is to be organized once a week. This is in addition to the services being provided to adolescents who approach these facilities at any time (routine) for any services. Materials and supplies as listed above should be ensured in adequate quantities at the PHC level clinic.

CHC and District Hospital level

At the level of the CHC and district hospital, a clinic at a dedicated time may be organized at least twice a week. This would be in addition to service provision to all adolescents who attend the CHC/DH at any time for any service. At least one doctor and two support staff could provide services at this level. The VCTC counsellor may be tapped for counselling on SRH issues. Appropriate linkages are to be established with the sites where facilities for VCTC, PPTCT, ART may not be available.

**Key Points:**

For effective services:

Adequate and appropriate staff must be made available during clinic sessions

Staff must be competent and aware of their role and responsibilities

Adequate and appropriate materials/supplies, including information literature for the adolescents, to be made available

Key aspects of organizing services for adolescents at the sub-centre, PHC and CHC levels have been discussed. Additional features for organizing services may be identified locally. A prerequisite for effectively organizing and delivering services is the availability of competent and skilled providers.

SECTION THREE: CONDUCIVE ENVIRONMENT AT HEALTH FACILITIES

STANDARD: Adolescents find environment at health facilities conducive to seek services

In order to attract adolescents, appropriate conditions should be created at the facility to put them at ease and ensure that they can comfortably access the services. Both the location and ambiance of the clinic area should be inviting and comfortable, clean and have basic amenities as highlighted earlier.

Attention should be given to the following factors:

1. Staff

On all clinic days it must be ensured that the designated staff is present. Punctuality and regularity must be enforced. Staff attending to the adolescents must have the qualities that put the adolescents at ease for them to avail the services they need and are being offered. Follow-up action may be taken up by them to enhance their credibility with the adolescents.

2. Registration Procedures

Registration and retrieval of records of adolescent clients (at least at the special clinic) will be made simpler. If the client does not wish to reveal personal details, address, etc. the staff should not insist on it.

3. Privacy and Confidentiality

Arrangements of visual and audio privacy:

- Clinic rooms must have window curtains and a bed-screen surrounding the examination table.
- It is advisable to have give clear instructions to the staff about not allowing any one into the clinic when a client is already there, in order to ensure privacy.



- The confidentiality policy of the clinic may be displayed and clearly expressed to the client in the first session itself.
- Client records to be kept out of reach of unauthorized persons.

4. Clinic timings

The medical officer incharge of the facility must decide on the clinic timings and on the frequency of operation. It is advisable to have clinic timings that suit the needs of adolescents. Due attention is to be given to school timings and work timings of adolescents who are engaged in employment in the area. Availability of staff and rooms (after routine OPD hours) may be also checked.

5. Appropriate signboard

The clinic is to have an appropriate signage reflecting the location of clinic and its operational timings. Display board of the PHC may indicate the availability of services for adolescents. State and district programme managers can decide on the appropriate branding of these clinics to give them a distinct identity. Suggestions such as: 'Yuva', 'Saathi', 'Mitr' may be considered. The name may be identified in consultation with young people.

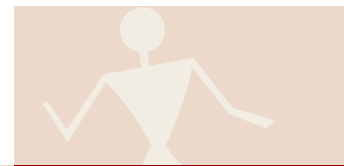
6. IEC

In case a dedicated space is available for running a clinic for adolescents, relevant posters and communication materials may be displayed. Reading material should be available on relevant issues, especially handouts that adolescents can take without having to request for them.

Key Points:

- Location and ambiance of the clinic area is inviting and comfortable. The clinic is clean and has basic amenities
- Clinic timings suit the needs of the adolescents
- Privacy and confidentiality are assured
- Staff are friendly
- Signboard is prominently displayed

Aspects of organizing services for adolescents at the sub-centre, PHC and CHC levels have been discussed. Additional features for organizing services may be identified locally. A prerequisite for effectively organizing and delivering services is availability of competent and skilled providers.



SECTION FOUR: CAPACITY BUILDING OF PROVIDERS

STANDARD: Service providers are sensitive to adolescent needs and are motivated to work with them

Utilization of services from nearby health facilities should be the logical choice for adolescents. Yet, available evidence indicates that when adolescents approach clinics and health centres for help, they are scolded, refused information or simply turned away. Hence it is critical to orient service providers towards delivery of quality services to adolescents, without being judgmental.

A district-specific capacity building plan may be developed for improving capacity and competency of service providers for ARSH service delivery. The capacity-building must address their competencies relating to clinical management, with an equal emphasis on developing their interpersonal communication skills, perspectives and attitudes on certain sensitive adolescent issues like sexuality, and remaining non-judgmental. Mechanisms would need to be developed in the system to sustain the motivation of providers to serve the adolescents sensitively. This plan could include elements of self-learning, formal training, follow-up after training from time to time and follow-up supervision. The section given below briefly discusses the training of service providers as a strategy for capacity building.

Selection of providers:

Selection of providers for adolescent-friendly clinics will vary as per the availability of staff. As mentioned earlier, 50 per cent PHCs are likely to have additional nursing staff for round the clock services. Therefore, such PHCs may be identified as sites for adolescent friendly clinics. Staff of such PHCs is to undergo the requisite training.

Sub-centres/PHCs:

- Medical Officer in-charge
- LHV/ANM/MPW-M (posted at headquarters)
- ANMs/MPW-M (posted at sub-centre attached to PHC)

CHCs and District Hospitals:

- Medical Officer (preferably a Lady Medical Officer). It is important to consider the routine emergency duties of staff

The major objectives of the orientation programmes are to sensitize service providers on relevant information, skills and services for adolescents and also to enhance their capacities to deliver the defined package of services according to the needs of adolescents. The Training Division of the Ministry of Health and of Family Welfare has developed training guidelines for states, to guide them in planning and organizing trainings under RCH II. These guidelines may be obtained from the MoHFW.

A comprehensive training strategy for RCH II has been developed by the MoHFW, which covers training of service providers in delivery of ARSH services.



The following training programmes are proposed for service providers in RCH II on ARSH

- Orientation of Programme Managers – 1 day
- Orientation of Medical Officers to provide ARSH services – 3 days
- Orientation of ANMs/LHVs to provide ARSH services – 5 days

The key contents of training are as follows:

- Adolescent growth and development
- Communicating with adolescents
- Adolescent Friendly Reproductive and Health Services
- Sexual and reproductive health concerns of boys and girls
- Nutrition and Anaemia in adolescents
- Pregnancy and unsafe abortions in adolescents
- Contraception for adolescents
- RTIs/STIs and HIV/AIDS in adolescents

An orientation of the programme managers is to be organized at the state level by a designated training institute. This could be the nodal RCH II training institute and/or an external resource agency or a pool of state-level experts, as appropriate. A comprehensive training plan, which is to be developed by each state training institute (nodal agency for RCH II trainings), will reflect the details of the ARSH training calendar.

The state-level training institute/pool of resource persons is to further conduct a TOT of the district-level training institutions/training teams. Training programmes for MOs and ANMs/LHVs are to be organized at the district level by identified district level training institutions/training teams. State programme managers/training institution may selectively observe the training programmes at the district levels.

The training material for the above mentioned programmes include guidelines for facilitators and also reading material that has been developed by the MoHFW and which is to be made available to the state and district training institutions. The training package may be further adapted at the state and district levels if required. The district programme managers are to ensure that all identified staff at the adolescent-friendly reproductive and sexual health clinics in the district undergo the required training before the launch of specific adolescent-friendly services.

The need for capacity building to move beyond training has been recognized, since training alone does not ensure provision of effective services. States may complement training with other forms of capacity building, such as, supportive supervision, exposure visits, etc. A mechanism for supportive supervision may be developed. Peer learning, as an approach, may be promoted. A mechanism may be identified for recognizing and rewarding good performance of service providers. Panchayati Raj Institutions could be involved in this; for example, the Panchayat Health Committee may take cognizance of the popularity of a particular health functionary and recognize her/his contribution in a public meeting. Such public recognitions act as effective motivating factors even when there are no financial gains.

**Key Points:**

- Capacity building includes competency enhancement – both in clinical skills and interpersonal skills as well as motivation
- All identified providers will be oriented to 'How to do' skills in training workshops. Their 'clinical skills' will be updated during the standard skills development trainings in RCH- II
- Mechanisms will be developed for follow-up supported by supervision
- Mechanisms will be developed for rewarding good performers

MoHFW has steered a process of developing a comprehensive training package for MOs and ANMs/LHVs, on ARSH services. This package may be further adapted at the state and district levels. Training guidelines developed by MoHFW are expected to guide states in planning and organizing trainings under RCH II, including ARSH trainings. Reorientation programmes may be organized at appropriate intervals.

SECTION FIVE: ENVIRONMENT BUILDING

STANDARD: An enabling environment exists in the community for adolescents to seek services

The preceding sections have discussed service delivery-related interventions. However, it is crucial that appropriate interventions are concurrently undertaken to ensure that an enabling environment exists for adolescents to seek services. This section primarily focuses on environment-building activities to be undertaken by the Health Department.

District programme managers are to ensure that steps are taken to help key stakeholders in the community to understand and respond to adolescent needs. Key audiences are to be identified whose support would be needed for creating an enabling environment within the community. Key stakeholders can include policy makers, administrators, community leaders, service providers, parents, teachers, community-based organizations, NGOs and the media.

The community can be engaged in a variety of ways, like seeking their views, providing information, and involving them in prioritizing areas for quality improvement. They can help to publicise and generate demand for high quality services and increase adolescents' use of them. Linkages may be established with community-based organizations, NGOs, private practitioners, social marketing and franchising outlets. Media can be effectively engaged in generating awareness about adolescent issues and their importance as well as spreading information about Adolescent Friendly Reproductive and Sexual Health Services. Mass media as well as folk media can be used judiciously.

In their day-to-day interactions with adult women and men clients, the MOs, LHVs and ANMs can inform them about the value of providing adolescents with the health services they need. For each group of stakeholders, communication material maybe developed in the local language. In each district, institutions and NGOs working with adolescents could be involved for this purpose. The DHO/ RCHO at the district level and the MOs at the block level can take a lead in organizing environment-building activities as follows:



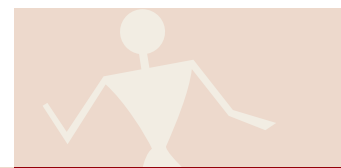
- (i) At the district level, a one-day ARSH orientation is to be organized by the DHO / RCHO for district level officers of different departments, including civil society representatives. The purpose of this orientation would be to
 - (a) increase awareness on ARSH issues
 - (b) facilitate inter-sectoral coordination, especially with WCD, school and youth sectors
 - (c) inform about ARSH service delivery.

Orientation content would cover vulnerabilities of adolescents, magnitude of ARSH problems, need for ARSH and outline of proposed services. Appropriate information material is to be made available to the participants.

- (ii) At the district level, a one-day orientation is to be organized by the DHO/RCHO for district- level zila panchayat members. The main purpose of this activity is to organize support of key district level PRI members for addressing ARSH issues as relevant for the district.
- (iii) At the block level, a one-day meeting of PRIs and WCD/Education/Youth Departments is to be organized by the Medical Officers. The main purpose of this activity would be to build a supportive environment for adolescents to seek information and services. Scope of discussions could cover vulnerabilities of adolescents, magnitude of ARSH problems and the need for ARSH services. Special focus is to be on role of PRIs in monitoring teenage pregnancy and early marriages.
- (iv) At the PHC level, a half-day meeting is to be organized by the LHV/ANM for self help groups' office bearers and VHC members. The main purpose of this activity is to generate support of women for participation of unmarried adolescents in the village group communication activities. The meeting is to cover issues of adolescent vulnerabilities, ARSH problems and need for services, role of self help groups and proposed package of services.
- (v) At the village level, the ANMs, while participating in the meetings of women's groups or self help groups or VHCs, must generate support for adolescents' need for information and services. They can take help of ASHA/AWW and other community-based functionaries in organizing such group activities.
- (vi) Folk media and mass media, as applicable for the setting, must be engaged for the purpose of environment building in the community.

MOs, LHVs and ANMs are to ensure that adolescent health issues are discussed on a continuous basis in community meetings.

The RCH II BCC strategy at the national and state levels is expected to cover adolescent health issues. In addition, relevant advocacy and communication materials for fostering a supportive environment for ARSH may be developed at the national and state levels. This may be further adapted in the local context. In doing so, linkages with other departments such as Education, Youth and Women and Child Development may be established. In order to facilitate the same, national and state specific coordination mechanisms are to be established and existing mechanisms are to be tapped. For example, the NRHM Steering Committee at national, state and district levels, the National Steering Committee for the Youth Policy, the NACP III Taskforce, the HIV/AIDS Inter-ministerial Group at the national and state level, as relevant. Appropriate channels of publicity may be identified, such as, mass media, folk media, posters, pamphlets etc.



Key Points:

This section illustrates the key actions that the Health Department can undertake to create an enabling environment for ARSH services. This is a continuous process in which partnerships are to be established with other departments and peripheral functionaries, as appropriate.

- Efforts must be made to increase awareness of the community regarding the adolescent needs and how to respond to them.
- Adolescents must be encouraged by the community to access the services.
- Health functionaries organize meetings with other departments and the community at various levels of administration to emphasize the need and role of adolescent-friendly services
- Adolescent health issues to be discussed continuously in routine contacts with the community members.

SECTION SIX: COMMUNICATION WITH ADOLESCENTS

STANDARD: Adolescents are well informed about the health services

Actions are to be taken to ensure that adolescents are well informed about the availability of health services. Adolescents are to be knowledgeable about their health problems including sexual and reproductive health problems. The Health Department is to take specific action to conduct communication activities with adolescents as follows:

- (i) **Outreach:** Communication activities are to be conducted at the level of village outreach, aanganwadi centre and/or youth group. The target group would include unmarried and married females and males. Such group communication activities are to be conducted once a month by the ANM, ASHA, AWW, Youth Coordinator and/or link workers. Communication aids in local language are to be used. Activities are to cover topics related to
 - (a) behaviour change communication on delaying marriage and first pregnancy, importance of spacing, fertility awareness, menstrual hygiene, care during pregnancy
 - (b) risk reduction counselling on RTIs/STIs and HIV/AIDS prevention
 - (c) nutrition education on balanced diet, sign and symptoms of common nutritional deficiencies like anaemia
 - (d) immunization and importance of TT
 - (e) prevention and management of unwanted pregnancy
 - (f) gender relations and role of men
 - (g) adverse sex ratio and related legislations on sexual abuse and violence.

ANMs are to ensure counselling on and provision of condoms, OCPs and emergency contraception. Adolescents participating in the outreach sessions are to be referred to PHC clinics as appropriate.

- (ii) **Sub-centre level:** ANMs and male health workers are to be responsible for conducting once a month group communication activities in schools and youth groups. This is to be



linked to school health activities as reflected in earlier sections. In case a male health worker is not available, possibility of identifying an AWW or local teacher may be explored. Scope of communication activities is to include the topics mentioned above.

- (iii) Medical Officers from PHCs are to conduct health checkups once in six months under the school health programme. MOs and ANMs may periodically visit schools to inform adolescents about the availability of services.
- (iv) DHO is to ensure that all sub-centres and PHCs are equipped with locally relevant communication and counselling materials handy for service providers and adolescents visiting the health centres. IEC and BCC materials developed under RCH 2 are to incorporate adolescent issues.

The Health Department is to specifically establish linkages with other departments. These can be as follows:

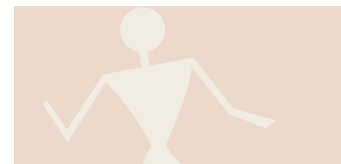
- (i) The District Health Officer is to develop a plan with DWCD, District Youth and Rural Development officials to incorporate adolescent health/ARSH issues in their ongoing programmes with adolescents through peer educators and outreach workers. Occasional participation of MO/ANM/LHVs in district/block level adolescent activities could be worked out.
- (ii) Adolescent education interventions are being implemented in secondary schools. RCHO can draw up a plan with the district education officer (DEO) on health education activities in schools, link up schools with PHCs and gain support of parents through PTAs, DIETS, NGOs. MOs and ANMs are to occasionally visit health education sessions to provide input as appropriate. Health check-ups are to be periodically conducted under the school health programme.
- (iii) MO to draw up a plan for linking AWW centres, Adolescent Development Centres, NYKS in blocks with adolescent clinics at PHC. Information about availability of health services for adolescents maybe posted in schools, pharmacies, shops, community centre etc. Folk media may also be engaged in publicizing these services.

Key Points:

This section has discussed communication activities that the Health Department is required to undertake with adolescents. In order to improve knowledge of adolescents on ARSH, some communication activities can be proactively undertaken by the Health Department. For other activities, linkages with ongoing programmes of various departments can be established at the state and district levels.

Key actions:

- Health facility will have a signboard welcoming adolescents and informing them about the availability of good quality health services.
- Health staff will periodically visit educational institutions to inform adolescents about the availability of quality health services. For facilitating this collaboration, appropriate authorities will write letter to schools.



- Community-based organizations (e.g. NGOs working with children/adolescents on the street) will have informed the adolescents they come into contact with about the availability of quality health services. For this necessary links will have to be established with such organizations.
- Local performing groups will provide information about the availability of quality health services for adolescents through folk media.
- Information about the availability of quality health services will be provided through the media.

SECTION SEVEN: MONITORING AND SUPERVISION

STANDARD: Management Systems are in place to improve/sustain the quality of health services.

Mechanisms are to be in place to monitor the performance of the health facility and to identify the needs for corrective/ameliorative actions.

Monitoring as a function comprises of supervision, analyzing data and reporting on progress. Effective supervision is necessary to ensure that activities and sub-activities are carried out in the desired manner. It is needless to say that supervision is not to be perceived as a control function. It is a tool to observe activities, detect problems, explore solutions and implement the appropriate solution to ensure that the same problems do not occur in future.

With the above understanding, monitoring of ARSH at the district level is to be undertaken as follows:

1. Actions are to be taken to ensure that mechanisms are in place to monitor the performance of clinics and to identify needs for corrective actions.
2. Service providers are to participate in problem identification and solving activities.
3. Steps are to be taken to ensure that the data is collected, analysed and used to make health services adolescent friendly.

The focus is to be on tracking the progress made on the take off and utilization of ARSH services.

Service Register and Monthly Format

For this purpose, each PHC/CHC facility is to maintain an ARSH Service Register, which will generate data on a monthly basis. The MO is to prepare a monthly report that will reflect on

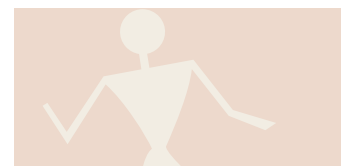
- (i) data from service register
- (ii) progress on training and communication activities



Monthly Report format is as follows:

| | | |
|--|-------------------------|-------------------|
| 1. Reporting month and year : | | |
| 2. Name of State and District : | | |
| 3. Name of Block, PHC : | | |
| 4. Input related data | | |
| Indicator | During the month | Cumulative |
| (i) % of Sub centres having communication material for adolescents | | N. A. |
| (ii) PHC having adequate supplies of ECPs | Yes/No | N. A. |
| 5. Process related data | | |
| Indicator | During the month | Cumulative |
| (i) Total number of clients who attended the facility a. Boys b. Girls | | |
| (ii) Number of group meetings held against planned | No. held/planned | N. A. |
| (iii) No. of service providers trained in providing Adolescent Friendly Reproductive and Sexual Health Services. | | |
| (iv) No. of new pregnancies below 20 years registered during the month (married/unmarried; 10-14 yr/15-19 yr) | | |
| (v) Total number of teenage pregnant women attending ANCs | | |
| (vi) No. of teenage PW delivering in the institutions | | |
| (vii) No. of teenage girls that availed MTP services (married/unmarried; 10-14yr/15-19yr) | | |
| (viii) No. of adolescent girls and boys that accessed contraceptives services by method (condoms, OCP, ECP, IUD) | | |
| (ix) No. of adolescent girls and boys that availed RTI/STI treatment | | |
| (x) No. of adolescents referred to CHC, DH, tertiary facilities | | |
| 6. Specific comments on communication activities | | |
| 7. Any comment on profile of adolescents accessing services | | |
| 8. Specific comments on networking, referrals and follow-up | | |
| 9. Any comment on profile of adolescents accessing services | | |

The district programme manager is to compile the monthly reports being received from all clinics. The feedback is to be given to the MO in-charge of PHCs on the basis of trends in utilization of services.



Supervisory Checklist:

Data on training and communication activities could be further obtained from supervisory checklists. National or state level facilitator could do this observation during training workshops. A format is suggested below:

| | | |
|--|----------------------------------|------------------------------------|
| Name of the training/communication activity attended: _____ Venue: _____ Date: _____ | | |
| 1. Participation | | |
| • Level of participation: | <input type="checkbox"/> Invited | <input type="checkbox"/> Attending |
| • If turnout is poor, specify reasons: | | |
| 2. Training/communication sessions observed | | |
| • Sessions: | <input type="checkbox"/> Planned | <input type="checkbox"/> Held |
| (Start till day of visit) | | |
| • Clarity of presentations: | | |
| • Interactivity of participants: | | |
| • Audio visual aids used: | | |
| • If any session not held, specify reasons: | | |
| 3. Training/communication materials and methodology | | |
| • Were materials available in adequate numbers? | | |
| • Was a schedule present? | | |
| • What core contents were covered in training/communication? | | |
| • Were sessions planned and held as per schedule and methodologies? | | |
| 4. Training inputs | | |
| • Are planned clinical/skill-based sessions held: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If not, provide reasons. | | |
| 5. Supervisor's feedback on strengthening future training/communication activities | | |

Further, programme managers could periodically use checklists during their supervisory visits in order to assess adherence to desired standards. The district manager could do this monitoring once in three months. A sample checklist is given below.

Supervisory checklist for facility

| Date _____ | Name of supervisor _____ | Name of facility _____ |
|---|--------------------------|------------------------|
| Interview with MO | | Remarks |
| 1. Availability of competent providers | | |
| - MO trained in AFRSH | Yes/No | |
| - S H/ANM trained in AFRSH | Yes/No | |
| - Vacant position of AFRSH staff | Yes (No.)/ No | |
| 2. Problems in referral if any (Assuming that the District official is aware of the existing Referral Linkages) | | |
| 3. Clarity on confidentiality and privacy | | |
| Remarks/suggestions if any | | |
| Interview with ANM/LHV | | |
| 4. Clarity about their roles and responsibilities | Yes/No | |
| 5. Clarity on importance of confidentiality and privacy | Yes/No | |



| | | |
|---|----------|--|
| 6. Clarity of package of services | Yes/No | |
| 7. Areas where they feel need for further training | | |
| 8. Feedback mechanism to staff/Discussed about ARSH Services in the monthly review meetings. | | |
| 9. Details of meetings held in school (with adolescents, teachers), with parents, with village leaders. | | |
| 10. Suggestions if any | | |
| Observation | | |
| 11. Signboard indicating location/timing of clinic | Yes/No | |
| 12. Basic amenities in place - water/toilets/space for consultation | Yes/No | |
| 13. Confidentiality policy displayed | Yes/No | |
| 14. Visual privacy | Yes/No | |
| 15. Centre has required equipments in working order | Yes/No | |
| 16. Any shortfall in supplies in the last month (Assuming there is a specific list of supplies) | Yes/ No | |
| 17. Adequate client information | Yes / No | |
| 18. Material available: - Posters on ARSH issues displayed - Take away material in local language targeted to gatekeepers - Take away material in local language targeted to adolescents | Yes / No | |
| Record Review | | |
| 19. Records properly maintained | Yes / No | |
| 20. Timely Submission of monthly reports | Yes / No | |

Assessments:

Rapid household surveys and assessment studies are to be conducted in the district at annual intervals, in order to reflect data on the following output/outcome indicators. States may also prefer to plan special surveys to get information on these indicators in selected districts.

- Teenage pregnancy rate
- Unmet need for reversible contraceptives in 15-19 years age group
- Use of reversible contraceptive methods (%)
- Use of condoms during last sex among 15 – 19 years age group
- Prevalence of anaemia in girls of 15 – 19 years age group
- Knowledge on STIs and HIV/AIDS transmission
- Prevalence of RTI/STIs and treatment seeking behaviour
- Proportion of HIV positives among 10 – 19 years age group
- Mean age at marriage
- Mean age at first child



Flow of data:

The monthly reports submitted by the MOs are to be compiled by the DHO on a monthly basis and submitted to the State RCH Society/SPMU.

At the state level, the State RCH Society/State Programme Management Unit is expected to review RCH II programme implementation on a periodic basis. During these periodic reviews, the ARSH monthly reports from the districts are to be discussed.

Appropriate review and feedback mechanisms at the national, state and districts levels are to be in place to ensure that timely corrective actions are initiated.

Quality of outreach activities may be further assessed during supervisory visits. Depending on the maturity of the health system, mechanisms for quality assurance and improvement may be instituted. Further, community-monitoring mechanisms may also provide inputs on client satisfaction with special reference to adolescents.

To conclude,

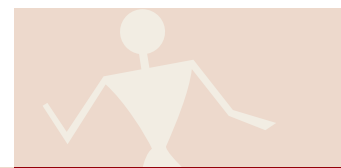
In this section, a system for monitoring RCH II ARSH interventions at the district level has been mapped. Focus is on monitoring off-take and utilization of ARSH services. Main source of data would be the service register. This is to be complemented by data from supervisory and field visits. Periodic assessments are to be undertaken for ascertaining progress on output/outcome indicators. Review and feedback mechanisms at state and national levels are to be further worked out.



SECTION EIGHT: SAMPLE IMPLEMENTATION PLAN

In the preceding sections, the guidelines for making operational the RCH II ARSH strategy have been detailed. Based on these guidelines, the state and district programme managers can develop a detailed step-wise implementation plan. A sample tool for facilitating this process is presented below.

| | Core Steps | Requirements | Timeline | Cost Items |
|----|--|--|---|---|
| 1. | SITE SELECTION State level: <ul style="list-style-type: none"> • Selection of districts for ARSH strategy • Draw up a phased plan of coverage of districts District level: <ul style="list-style-type: none"> • Select PHCs for adolescent clinics. • Develop a referral plan. Identify CHCs/ DH as appropriate • Provision of equipments, supplies, infrastructure as appropriate • Demarcate sites running adolescent clinics (sign board) | <ul style="list-style-type: none"> • List of districts • Criteria for district selection to include poor indicators of adolescent health eg. low age at marriage, teenage pregnancy, HIV infection • List of PHCs and sub-centres • Select from among the 50 per cent PHCs which are to have additional staff and are to function as 24 hour centres in RCH II • Minimum criteria for PHC/CHC selection: staff availability | Pre-launch phase | <ul style="list-style-type: none"> • Baseline survey, if commissioned, for obtaining data on adolescent-specific indicators • Equipments, supplies, infrastructure, curtains • Signboard/s |
| 2. | DEFINING SERVICE PACKAGE <ul style="list-style-type: none"> • Map an essential package of services to be provided at each level of care (SC, PHC, CHC) | <ul style="list-style-type: none"> • Guidelines on essential package of preventive, promotive, curative referral services (ref: implementation guide) • Package to be defined based on any existing needs assessment, baseline data on services sought by adolescents | Pre-launch phase | |
| 3. | CAPACITY BUILDING State level: <ul style="list-style-type: none"> • Identify state-level training institute, resource agency, resource pool and develop a training calendar | <ul style="list-style-type: none"> • MoHFW Training guidelines • Orientation package for programme managers • Training package for service providers | Start of implementation and during implementation phase | <ul style="list-style-type: none"> • Translation of training package. • 1 orientation programme for programme managers. • 1-2 TOTs for master trainers |



| | Core Steps | Requirements | Timeline | Cost Items |
|-----------|--|--|--|--|
| | <ul style="list-style-type: none"> Organize and orient state and district programme managers Constitute district-level master trainers teams and conduct TOT. Adapt training package for service providers District level: <ul style="list-style-type: none"> Programme managers to identify trainees – MOs & LHV/ANMs District teams/ training institutions to train service providers Develop a competency building plan Institute system for recognizing good performing PHCs/ service providers | | | <ul style="list-style-type: none"> District specific training of MOs District specific training of LHVs/ ANMs Costs of external resource agency (if required) for capacity building. |
| 4. | ENVIRONMENT BUILDING State level: <ul style="list-style-type: none"> Develop state BCC and advocacy plan and resource materials on ARSH District level: <ul style="list-style-type: none"> Adapt BCC and Advocacy materials on ARSH. Substantiate with district specific data, as appropriate Prepare block level plans for orientation programmes by DHO, MOs, LHVs and ANMs | <ul style="list-style-type: none"> Engage state-level expert agency, if required, to review and collate existing materials on ARSH Identify inter sectoral coordination mechanism with Youth, Education and WCD departments for advocacy on ARSH and material development. Engage local level NGO as appropriate Local level resource materials Environment building guidelines of implementation guide | Start of implementation phase. Continuous intervention. | <ul style="list-style-type: none"> State level agency for material collation and development Local level agency for material adaptation Half day/One day community sensitization programmes |
| 5. | COMMUNICATION WITH ADOLESCENTS State level: <ul style="list-style-type: none"> Develop state-level plan for linkage | Refer section on linkages with other departments in implementation guide | During implementation phase. | <ul style="list-style-type: none"> Collation of learning materials for adolescents |



| | Core Steps | Requirements | Timeline | Cost Items |
|-----------|---|---|--|--|
| | <p>with Education Department covering school going adolescents through Adolescent Education Programme. Plan to further highlight linkage with WCD/ Youth Departments covering out-of-school adolescents with health education and life skills interventions.</p> <p>District level:</p> <ul style="list-style-type: none"> Plan outreach session activities. Develop visits plan of MOs, ANMs to schools and adolescent group activities | Use local level learning materials for adolescents | Continuous intervention | <ul style="list-style-type: none"> Develop take away materials for adolescents |
| 6. | <p>MONITORING</p> <p>State level:</p> <ul style="list-style-type: none"> Consolidation of data from districts on monthly basis Review, analysis and feedback on quarterly basis Supervisory visits Engage expert agency for periodic assessments <p>District level:</p> <ul style="list-style-type: none"> Service registers in place in PHCs Collation of data on monthly basis Action on feedback Field visits | <ul style="list-style-type: none"> Monthly format Refer section on monitoring in implementation guide | During implementation Phase. Continuous interventions. | <ul style="list-style-type: none"> Printing of monitoring formats External agency for rapid assessment, evaluation (provided that this is included in the work plan) Setting up MIS |



4 MOVING AHEAD

CONCLUSION

This guide has detailed a framework for the state and district programme managers to implement the RCH II ARSH strategy. The scope of the strategy has been explained in part one of the guide. Standards have been defined in part two for guiding the implementation of the strategy in an effective manner and achieve the desired results. In part three of the guide, an attempt has been made to detail out certain non-negotiable or essential actions that would need to be undertaken by the health system and service providers. To the extent possible, focus has been limited to actions that are practical and doable by the Health Department. For example, for environment building and communication activities, the guide suggests appropriate linkages with other departments. For service delivery interventions, linkages with and involvement of the private sector are also to be explored.

The mapping of essential actions does not rule out scope for flexibility and further adaptation by the states and districts. There is enough space for innovations and fresh thinking. For example, the ASHA and block extension educators may be involved in conducting learning sessions on health with adolescents. The Mother NGO Scheme may be leveraged and field NGOs may be roped in for BCC and environment building activities. A question box may be placed at the PHC or CHC, which runs the adolescent clinic. States and districts are encouraged to take inputs from adolescents and young people in implementing the strategy. For example, inputs from young people may be taken for defining a service package, identifying space for the clinic, signboard designing, fixing timing and name of the clinic and developing resource materials. There can be several other options that states and districts may wish to explore.

The capacity and maturity of the health system is to be given due attention as the states and districts proceed to adapt this guide. Implementation of the ARSH strategy is not to be seen in a 'project' mode. It is a part of the larger programme framework of NRHM and RCH II. Care is to be taken to ensure that the training and monitoring load is duly rationalized. A modest attempt has been made to provide a sample implementation plan, which can serve as a planning tool for the programme managers. Costing details are to be further worked out based on inputs from the implementation partners. It is hoped that this guide would be subsequently updated.