A. Acronyms

ANM	Auxiliary nurse midwife
APHC	Additional primary health centre
BEMONC	Basic emergency obstetric and newborn care
BLA	Block level accounts manager
BPHC	Block primary health centre
BPL	Below poverty line
BPM	Block programme manager
CMO	Chief medical officer
CEMONC	Comprehensive emergency obstetric and newborn care
CS	Civil surgeon
CHC	Community health centre
CSO	Civil surgeon's office
DH	District hospital
EMRI	Emergency medical and research institute
EMOC	Emergency obstetric care
FRU	First referral unit
HBSAG	Hepatitis a surface antigen
HMIS	Health management information systems
JSY	Janani suraksha yojana
LSAS	Life saving anesthesia skills
MVA	Manual vacuum aspiration
NSSK	Navjaat shishu suraksha karyakram
HIV	Human immunodeficiency virus
HR	Human resources
MO	Medical officer
MTP	Medical termination of pregnancy
OBC	Other backward castes
PAC	Post abortion care
PPP	Public private partnership
RCH	Reproductive and child health
SC	Sub centre
ST	Scheduled tribes

Part-1

Internship Report

B.

➢ STATE OF PUBLIC HEALTH

Public health expenditure in India has declined from 1.3% of GDP in 1990 to 0.9% of GDP in 1999. The Union Budgetary allocation for health is 1.3% while the State's 4 budgetary allocation is 5.5%.

- Union Government contribution to public health expenditure is 15% while States contribution about 85%
- Vertical Health and Family Welfare Programmes have limit synergisation at operational levels.
- Lack of community ownership of public health programmes impacts levels of efficiency, accountability and effectiveness.
- Lack of integration of sanitation, hygiene, nutrition and drinking water issues.
- There are striking regional inequalities.
- Population Stabilization is still a challenge, especially in States with weak demographic indicators.
- Curative services favor the non-poor: for every Re.1 spent on the poorest 20% population, Rs.3 is spent on the richest quintile.
- Only 10% Indians have some form of health insurance, mostly inadequate Hospitalized Indians spend on an average 58% of their total annual expenditure
- Over 40% of hospitalized Indians borrow heavily or sell assets to cover expenses
- Over 25% of hospitalized Indians fall below poverty line because of hospital expenses

I. Organization profile:-

- The National Rural Health Mission (2005-12) seeks to provide effective healthcare to rural population throughout the country with special focus on 18 states, which have weak public health indicators and/or weak infrastructure.

- These 18 States are Arunachal Pradesh, Assam, Bihar, Chhattisgarh, Himachal Pradesh, Jharkhand, Jammu & Kashmir, Manipur, Mizoram, Meghalaya, Madhya Pradesh, Nagaland, Orissa, Rajasthan, Sikkim, Tripura, Uttaranchal and Uttar Pradesh.

• The Mission is an articulation of the commitment of the Government to raise public spending on Health from 0.9% of GDP to 2-3% of GDP.

• It aims to undertake architectural correction of the health system to enable it to effectively handle increased allocations as promised under the National Common Minimum Programme and promote policies that strengthen public health management and service delivery in the country.

• It has as its key components provision of a female health activist in each village; a village health plan prepared through a local team headed by the Health & Sanitation Committee of the Panchayat; strengthening of the rural hospital for effective curative care and made measurable and accountable to the community through Indian Public Health Standards (IPHS); and integration of vertical Health & Family Welfare Programmes and Funds for optimal utilization of funds and infrastructure and strengthening delivery of primary healthcare.

• It seeks to revitalize local health traditions and mainstream AYUSH into the public health system.

• It aims at effective integration of health concerns with determinants of health like sanitation & hygiene, nutrition, and safe drinking water through a District Plan for Health.

• It seeks decentralization of programmes for district management of health.

• It seeks to address the inter-State and inter-district disparities, especially among the 18 high focus States, including unmet needs for public health infrastructure.

• It shall define time-bound goals and report publicly on their progress.

• It seeks to improve access of rural people, especially poor women and children, to equitable, affordable, accountable and effective primary healthcare.

National health systems resource center (NHSRC)

India is witnessing a major effort at strengthening public health systems in the form of national rural health mission. The goal of this mission is to lead to the attainment of a much higher level of health for its people. It would achieve this by a significant in public health expenditures, by a better delivery of public health services, and by promotion of healthy life styles and convergent action on the social determinants of health. One of the major challenges the mission faces is capacity development. Capacity development is needed for enabling communities, service providers and health administrators, to make and implement locale specific, evidence based and outcome oriented health plans. One important aid is such a massive capacity building effort is creation of the national health observatory.

Building the Observatory:

The NHSRC hosts this observatory, as part of its function of being providing a single window for technical support. One of our key partners and inspiration for building the framework of this observatory is the Indian office of the world health organization (who). The observatory is not a standalone site of information. Where ever possible it provides

linkages to other sites which serve a similar purpose, and thus avoids duplication, while increasing ease of access. The observatory is interactive. All institutions and individuals are welcomed to correspond and to contribute information. The observatory needs to be built collectively and we welcome the participation and ownership of more and more institutions in this effort. Work on the observatory has just begun, there are many miles to go.

Vision:

Committed to facilitate the attainment of universal access to equitable, affordable, and quality health care, which is accountable and responsive to the needs of the people.

Mission:

Technical support & capacity building for strengthening public health systems.

Specific Objectives:

- Developing capacities in a network of institutions and individuals to improve the, efficiency, effectiveness and quality of health systems through interventions at the national, state, district and sub-district level
- Respond to technical assistance needs of the state and central health departments by mobilizing suitable agencies with necessary skills, by capacity development in technical assistance, institutions, by sharing of good practices and by training and orientation program.
- Facilitate the process of developing decentralized and accountable service delivery systems with community ownership and public participation in governance mechanisms.
- Assist states and national centres in establishing functional, effective, state-of-the-art health management information systems.
- Be a focal point in the identification, documentation and dissemination of knowledge and experiences in health systems and health program across the different states and across countries. Provide evidence-based insights on wider determinants of health outcomes and the choices in strategy available for health planning.

Policy:-

NHSRC is committed to lead as professionally managed technical support organization to strengthen public health system and facilitate creative and innovative solutions to address the challenges that this task faces.

In the above process, we shall build extensive partnerships and network with all those organizations and individuals to share the common values of health equity, decentralization and quality of care to achieve its goals.

NHSRC is set to provide the knowledge – centered technical support by continually improving its processes, people and management practices.

Department of NHSRC:-

a) Community Participation
b) Public Health Planning
c) Quality Improvement
d) Human Resource For Health
e) Public Health Administration
f) Legal Framework For Health
g) Health Management Information Systems (HMIS)
h) Health Care Financing & Public Private Partnership

Department of Community Participation:

NRHM has increased the space for community participation in public health systems. These include first and foremost the ASHA program me, one of the world's largest community health worker program. It also includes the creation of village health and sanitation committees, the involvement of local self government bodies, the participatory process of village and district health planning and public participation in hospital and health administration. Though there are a large number of NGO's with a wealth of experience of managing such programs in the NGO sector, NHSRC unique asset is the considerable technical support and guidance it can provide to government–led state level scaling up, a process intensive program me. This requires a mix of management skills, people skills, partnership building and capacity building skills.

The key objective of the Community Processes team in NHSRC is to provide technical support at state and national levels to the communitization component of the National Rural Health Mission, which includes the ASHA programme and the Village Health and Sanitation Committees, and the development of sustainable strategies for NGO involvement. Technical support encompasses a range of functions, including enabling states to create support structures for the community processes components at state, district and block levels, developing and consolidating training systems for ASHA training, developing training and communication material, conducting evaluations to inform and strengthen programme implementation, supporting process documentation, and providing policy inputs in the form of developing measurable outcome indicators, and operational guidelines for implementation. Within NHSRC the division also anchors the Secretariat for the National ASHA Mentoring Group which serves as the national policy and advisory body for the ASHA programme. At the national level, the team is headed by an Advisor, with two consultants, one fellow and a secretarial assistant. The team is also supported by state facilitators in Orissa, Rajasthan, Jharkhand, Uttar Pradesh, and Bihar.

NHSRC'S contribution in this regard is focused on:

a) Establishing ASHA resource centers at the state level and community processes support structures in each district and block. The resource centers provide leadership and an institutional framework for the massive task of training district and block coordinators and the local facilitators, who in turn train and support ASHAs, NHSRC through its network of state facilitators and organizational partnerships, responds to requests from states for assistance to build the institutional and human resource capacities needed for this task.

b) Secretariat of the ASHA mentoring group: the mentoring group is made up of a number of social workers and public health experts who have been active in organizing and carrying out advocacy for community health worker program. The numbers guide the center and the states on the design and conduct the program me. NHSRC acts as the secretariat for the mentoring group.

c) Documenting the disseminating best practices: there is much learning from the states in the way community processes are being encouraged and strengthened. Evaluating them, documenting them and sharing the learning's with all the states in one focus area of our work.

d) ASHA fellowship support: there are a number of NGO funding agencies and NGO's, which are potentially interested in contributing to public health systems strengthening in general and the ASHA programme in particular. NHSRC has encouraged each of these agencies to offer fellowships to 10-30 young graduates, who would be placed with the district NGO already engaged by the state in through NRHM programme. These fellows would help build the capacity of the NGO to deliver their NRHM assignment. The fellows would recruit by these NGO's, and provided induction and follow up training and support. They would be paid according to what each can command and what the funding agency / fellowship scheme is in a position to offer. This device of fellowships would also help transfer energy and experience from the many community health workers, experienced NGOs of Maharashtra and southern states, to the EAG states. NHSRC facilitates this but without incurring any costs on this.

   Ref: NHSRC (2009).

Thematic areas:-

a. Community participation
b. District Health action plan
c. Financing and PPP
d. Health sector overview
e. Human resource for health
f. Informatics (HMIS)
g. Legal frame work of health
h. Medicine and technology
i. Non communicable diseases
j. Nutrition
k. Public Health Administration
l. Public Health financing
m. Quality improvement
n. Reproductive and child Health

Contribution of Community Participation Department:-

a. ASHAs module
b. Communication kit for ASHA- Visual Aids-Flip Book
c. Communication kit for ASHA- Part 1- Visual Aids- posters
d. Communication kit for ASHA- part -2 – Visual Aids- Checklists
e. Communication kit for ASHA- Visual Aids- Flip Book
f. Menstrual Hygiene material
g. Others

II. Involvement:-

a. I was engaged with NRHM division of Ministry of Health & Family welfare through NHSRC for the Programme implementation plan (PIP), Record of proceeding (RoP), NPCC and supportive supervision.

b. I was engaged with routine or general managerial tasks which was related to the making of comments on states PIP, subgroup meeting, and preparation of RoP and finalized the budget of that states.

III. Managerial Tasks:-

a. I was the anchor of PIP (Programme implementation Plan) team of Government of India (GoI) for the 5 states. These states/UTs were Haryana, Punjab, Chandigarh, Himachal Pradesh and Jammu & Kashmir.

b. I was also involved in PIP appraisal of Punjab, Haryana, Chandigarh, Himachal Pradesh and Jammu & Kashmir.

c. I have represented to NRHM (National Rural Health Mission) Division in NPCC meeting of the Himachal Pradesh.

d. I also made to RoP (Record of Proceeding) of Himachal Pradesh and assisted in Finalize the RoP of Haryana, Punjab, Chandigarh and Jammu & Kashmir.

e. I was also involved in the supportive supervision of the four districts (Kanker, Bastar, Sarguja, and Jashpur) of Chhattisgarh.

f. I was also involved in the follow up of the any query related to PIP, RoP, Reappropriation of budget of Tamil Nadu and Pondicherry.

IV. Reflective learning:-

1. PIP preparation.
2. Comment on PIP of different states.
3. Concept of subgroup meeting.
4. Norms of NRHM for the approval of budget allocation.
5. RoP preparation.
6. NPCC meeting exposure.
7. Note sheet preparation.
8. Office memorandum preparation.
9. Comments on the Reappropriation of the Budget of the Tamil Nadu and Pondicherry state.

Part –II
Dissertation Report

1. Background:-

RCH:-

The International Conference of Population and Development (ICPD) 1994 was established an International consensus on a new approach to policies to achieve population stabilization. Fertility reduction should be addressed at the level of broad social policy, including reduction of gender discrimination in education, health care and income generation. Reproductive health programmes should focus the needs of actual and potential clients, not only for limiting births but also for healthy sexuality and child bearing. In India, the implications of the reproductive health approach would be to shift the focus from the use of family planning as a tool intended essentially for population stabilization, to use family planning as one among a constellation of interventions that would enable women and men to achieve their personal reproductive goals without being subjected to additional burdens of disease and death associated with their reproduction. World: (Reference:- RCH-II, Ministry of Health & Family Welfare, 2005-06, www.mohfw.nic.in/NRHM/RCH/Index.htm)

"Within the framework of WHO's definition of health as a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity; reproductive health addresses the reproductive processes, functions and systems at all stages of life. Reproductive health therefore implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide, if when, and how often to do so. This definition focus on right of men and women to be informed of and to have access to safe, effective, affordable, and acceptable methods of fertility regulation of their choice, and the right to access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant"

Essential Components of RCH Programme

1. Prevention and management of unwanted pregnancy.

2. Maternal care that includes antenatal, delivery and postpartum services.

3. Child survival services for newborns and infants.

4. Management of Reproductive Tract Infection (TRIs) and Sexually Transmitted Infections (STIs).

Major Elements of RCH Programme

- **Reproductive Health Elements**

a. Responsible and healthy sexual behavior

b. Interventions to Promote Safe Motherhood

c. Essential Obstetric Care for All

d. Prevention of Unwanted Pregnancies: Increase Access to Contraceptives

e. Emergency Contraceptives

f. Safe Abortion

g. Pregnancy and Delivery Services

h. First Referral Units (FRUs) for Emergency Obstetric Care

i. Management of RTIs/STDs

j. Infertility & Gynecological Disorders

k. Referral facilities by Government /Private Sector for Pregnant Woman at Risk

l. Reproductive Health Services for Adolescent Health

m. Global Reproductive Health Strategy

- **Child Survival Element**

a. Essential New Born Care

b. Prevention and Management of Vaccine Preventable Disease

c. Urban Measles Campaign

d. Elimination of Neonatal Tetanus

e. Cold Chain System

g. Polio Eradication: Pulse Polio Programs

h. Hepatitis B Vaccine

i. MMR Vaccine

j. Global Alliance for Vaccine and Immunization (GAVI)

k. Diarrhea Control Programme and ORS Programme

m. Prevention and Control of Vitamin A deficiency among children

2. Introduction:-

Adolescent Reproductive and Sexual Health (ARSH)

Adolescents (10-19 years) in India represent almost one-third of the total country's population. 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 implications. Adolescents are not a homogenous group. Their situation varies by age, sex, marital status, class, region and cultural context. This calls for interventions that are flexible and responsive to their disparate needs. Some of the public health challenges for adolescents include pregnancy, excess risk of maternal and infant mortality, sexually transmitted infections and reproductive tract infections in adolescence, and the rapidly rising incidence of HIV in this age group. Thus it is important to influence 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.

The goals of the Government of India RCH-II programme are reduction in IMR, MMR and TFR. In order to achieve these goals, RCH-II has four technical strategies. One of these is Adolescent Health. Strategy for ARSH has been approved as part of the RCH-II National 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 sub-centre clinics and ensure service availability on fixed days and timings at the PHC and CHC levels. This is to be in tune with outreach activities. A core package of services includes preventive, promotive, curative and counselling services. Further, addressing adolescents will yield dividends in terms of delaying age at marriage, reducing incidence of teenage pregnancy, prevention and management of obstetric complications including access to early and safe abortion services and reduction of unsafe sexual behaviour. Since service provisions for adolescents are influenced by many factors, wherein for example, at the level of the health system, lack of adequate privacy and confidentiality and judgmental attitudes of service providers, who often lack counselling skills, There are 225 millions adolescent comprising nearly one fifth (22%) of India's total population (census 2001), of total adolescent population,12 percent belong to the 10-14 years age group and nearly 10 percent are in the 15-19 years age group. Females comprise almost 47 percent and males 53 percent of the total population. More then half of the currently married illiterate females and married below the legal age of marriage. Nearly 20 percent of the 1.5 million girls married under the age of 15 are already mothers. (census 2001).(Reference:- Implementation Guide on RCH-II ADOLESCENT REPRODUCTIVE SEXUAL HEALTH STRATGEY, Ministry of Health & Family Welfare, May 2006.)

Mortality in the female adolescent of 15-19 years is higher than adolescent of 10-14 years. More than 70 percent girls in the age group of 10-19 years suffer from sever moderate anemia (DLHS-RCH 2004). Age specific fertility rate in the age group of 15-19 years contribute to 19 percent of total fertility rate. Amongst currently married women, the unmet need of contraception (NFHS-2). Most sexually active adolescent are in their late adolescence. Over 35 percent of all reported HIV infection in India occur among young people in the age group of age 15-24 years, indicating that young people are highly vulnerable. The majority of them are infected through unprotected sex.

Given the above scenario, the government of India (GoI) has recognized the importance of influencing the health seeking behavior 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 dividend 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 (STI) 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.

In spite of the large and increasing size of this sector of the population, the health of adolescent people in developing countries has largely been ignored, particularly in comparison to the work on the health of children under 5 years and of adults. Traditionally, the main health indicator used by health planners, policy-makers, researchers and programme staff, has been mortality. Young people have lower mortality rates relative to younger and older age groups in both developing and industrialized countries. Consideration of mortality rates alone has therefore resulted in young people being seen as a healthy age group, and this has led to them being accorded allow priority for health-related interventions. (Reference:- Implementation Guide on RCH-II ADOLESCENT REPRODUCTIVE SEXUAL HEALTH STRATGEY, Ministry of Health & Family Welfare, May 2006.)

3.Objective:-

General objective:- To study the Adolescent Reproductive and Sexual Health strategy implementation in EAG states of India.

Specific Objective:-

a. To study the AFHC in the EAG states.
b. To study the Training status in the EAG states.

4. Methodology:-

a. Secondary data review from programme implementation plan of states.
b. Review of secondary data on ARSH from the RCH division.

5. Rationality of ARSH :-

ARSH scheme was launched in RCH-II, it was launched for the welfare of adolescent health.

Situation of adolescent people:-

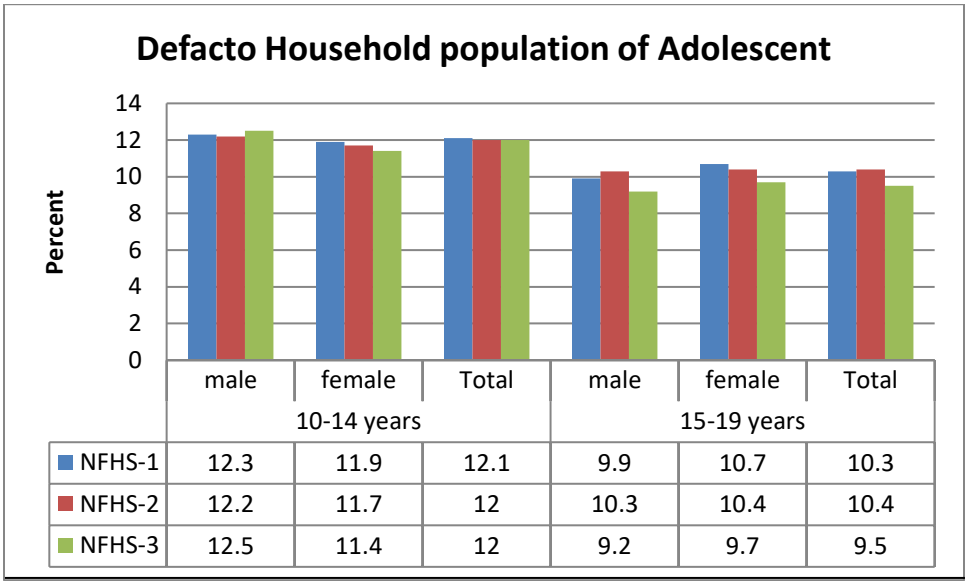
Demographically, India is a young country today as more than 70 percent of the population is under the age of 35. According to Census 2001, there are 225 million adolescents in the age group of 10-19 years, comprising nearly one-fifth of the total population (21.8 percent) of India. Of the total adolescent population, 12 percent belong to 10-14 years age group and nearly 10% are in the 15-19 years age group.

a. Socio-demographic profile:-

Household population by age and sex

According to the third National Family Health Survey the de facto household population shows that adolescents (10-19 years) constitute about 21.5% of the population while the youth (15-24 years) constitutes more than 18% of the population (Figure 1). The age distribution of the household population for NFHS-3 shows one-third (35%) of the population below 15 years of age, 9% is above 59 years and the remaining 56% in the 15-59 years age group

Figure-1



Key finding:- (Annexure 1-7)

- Mortality rates are much higher for adolescent women compared to adolescent men. The difference is especially glaring in the age groups of 15-19 and 20-24 years reflecting the consequences of lower nutritional intake, early marriage and childbirth, low level of knowledge and information about reproductive health and insufficient access to health care among women of these age groups.

- A number of adolescents are also suffering from diseases like asthma, tuberculosis, malaria, diabetes, goiter and other disorders. The prevalence of these diseases, for example, asthma and goiter are much higher among adolescent women compared to adolescent men.

- Overall educational attainment is low for both men and women.22% (15-19 years) have had no formal education (NFHS-3). NFHS-1 and 2, the data shows that a higher percentage of younger married women are illiterate compared to older ones, revealing that early marriage sharply reduces girls' access to education. More than 60% of ever married women aged 15-19 years during NFHS-1 and 2 had no education while less than 6% of them have completed at least 10 years of education. Though NFHS-3 shows

an increasing trend towards women receiving formal education, only about 18% of 15-19 years old women have completed at least 10-11 years of education.

- Gender disparities persist at all levels of education and widens further at secondary and higher level of schooling.

- The current employment status of women (NFHS-3) shows that almost 27% of 15-19 years are currently employed. Adolescent boys are more likely to be employed than adolescent girls Almost half of men aged 15-19 are employed.

- Information on women aged 15-24 years shows that the occupational distribution of young women varies greatly by urban-rural residence. In rural areas most employed women are either agricultural workers or skilled or unskilled production workers while urban women have more occupational diversity - professionals, sales or service worker.

- Trends show that more women are now being regularly exposed to some form of mass media. Still, more than 31% of women (15-19 years) are not exposed to any form of media (NFHS-3).

- Television is the main source of mass media for both women and men. While large gender differentials in literacy is revealed by media choice of radio by women an newspaper by men, limited mobility of young women is revealed by the low percentage of women (about 8%) visiting the cinema/theatre compared to men (27-33%) in both the age groups

- Almost half the women reported their current husband as the perpetrator of the violence and 8% said it was their former husband. Among women who first experienced sexual violence before age 15, 19% revealed that the violence was perpetrated by a relative, or by a friend or acquaintance (10%).

- Alcohol and tobacco use is more prevalent among young men (15-19 years) as compared to young women. Almost 29% of men in this age group use some kind of tobacco (smoking/chewing), more than 12% smoke cigarettes or bidis.

b. Age at marriage (Annexure 8, 9)

Early marriage marks a turning point in the life of a large proportion of adolescent girls in India having far reaching educational, health, social and economic consequences. Early marriage often results in curtailing adolescent girls' opportunities for education and skill formation. It also impedes proper physical and mental development before taking on the burden of reproduction resulting in greater reproductive health risks. Early marriage means early sexual activity and consequently early childbearing. As a result of incomplete growth, young married girls experience much higher levels of maternal mortality and morbidity. Many face the risk of STIs or HIV infection from older spouses.

Figure 1

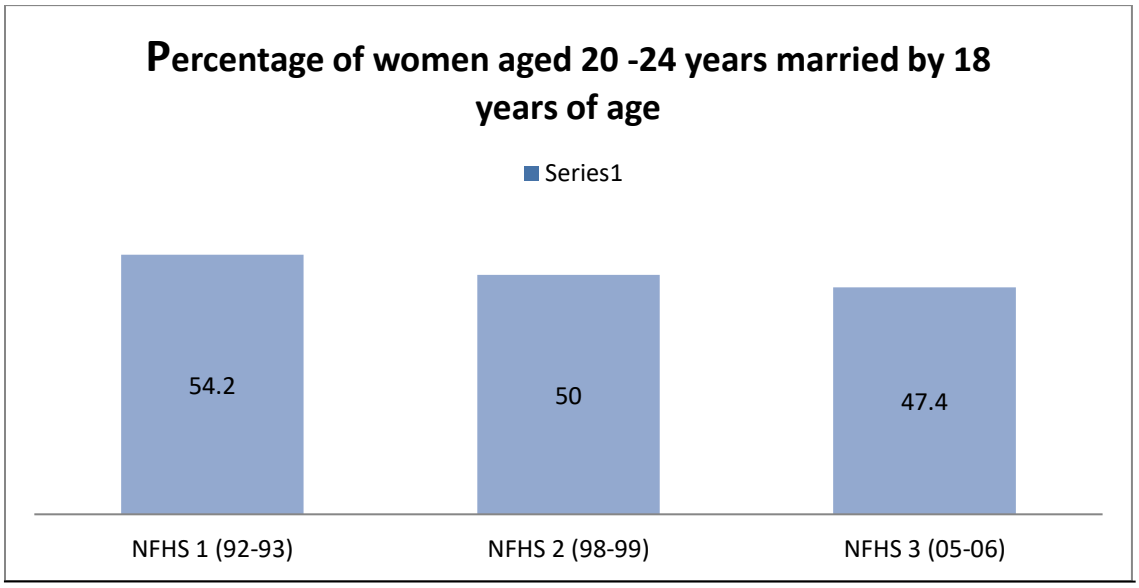


Figure-2

NFHS-3

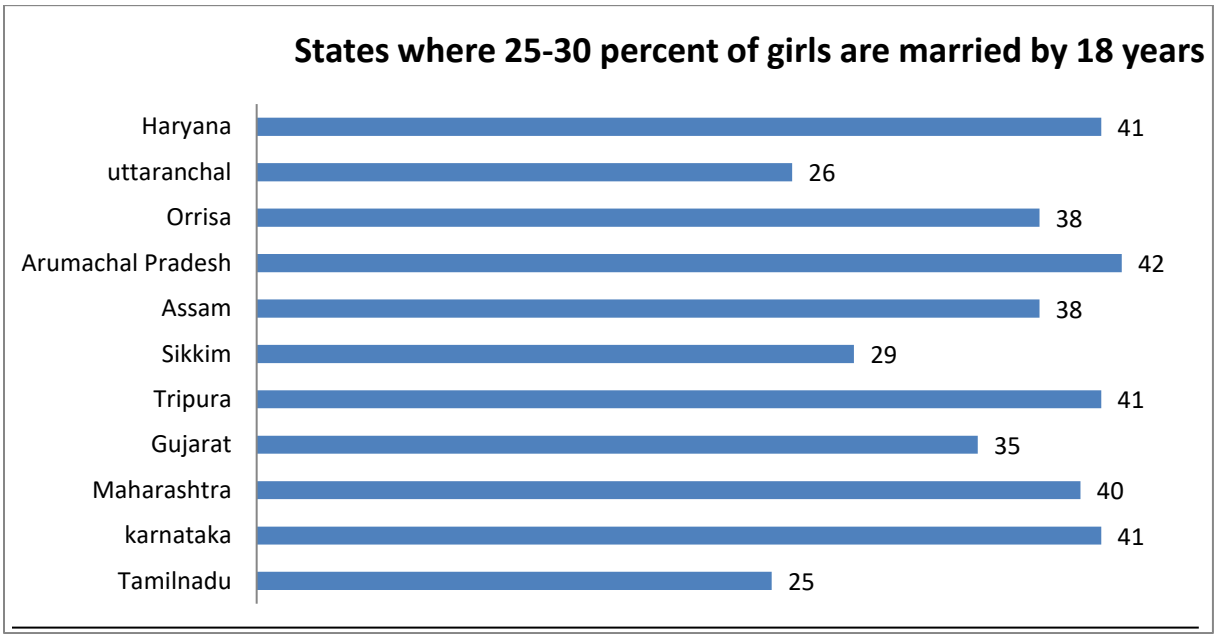


Figure-3

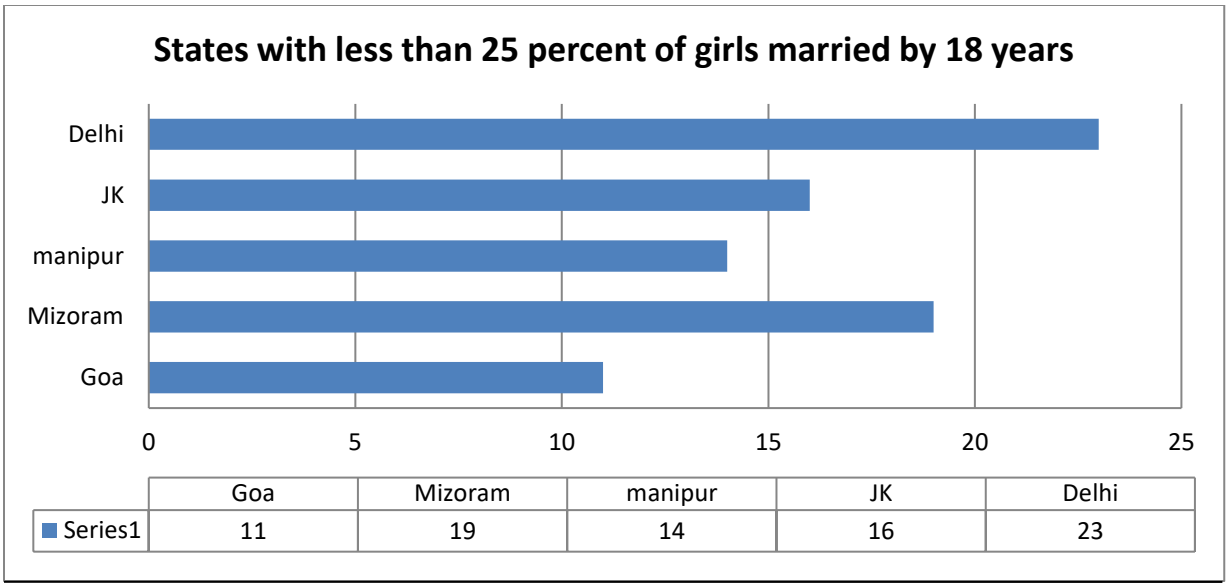
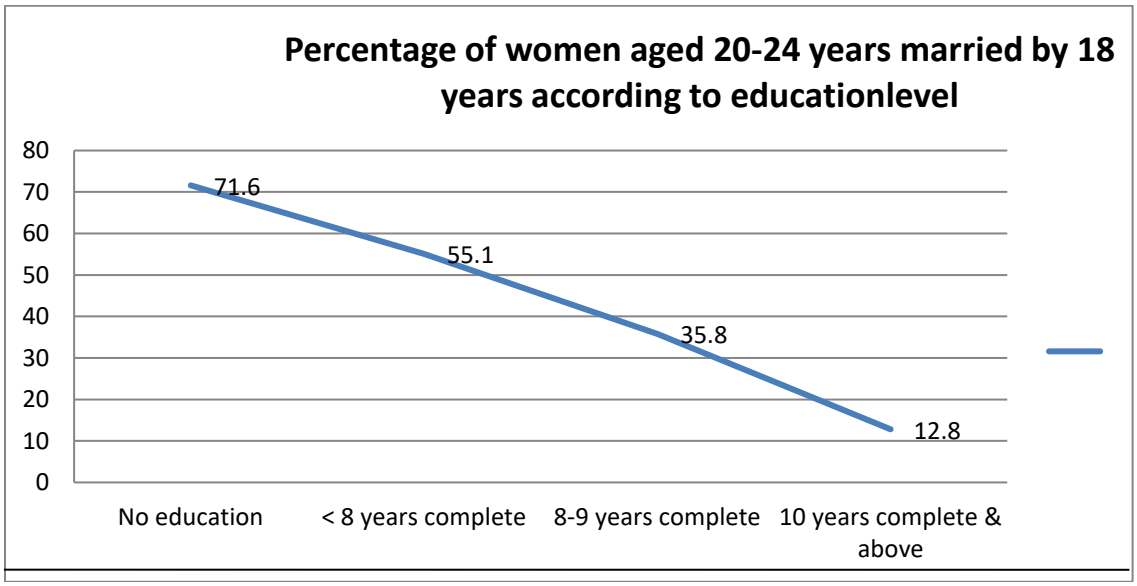


Figure 4



Key finding:-

- Marriage occurs in adolescence (10-19 years) for a large percentage (more than 47%) of girls in India.

- Age at marriage for both boys and girls has vast urban and rural differences. Women and men living in urban areas and those with higher levels of education marry later as compared to those living in rural areas and those who are less educated.

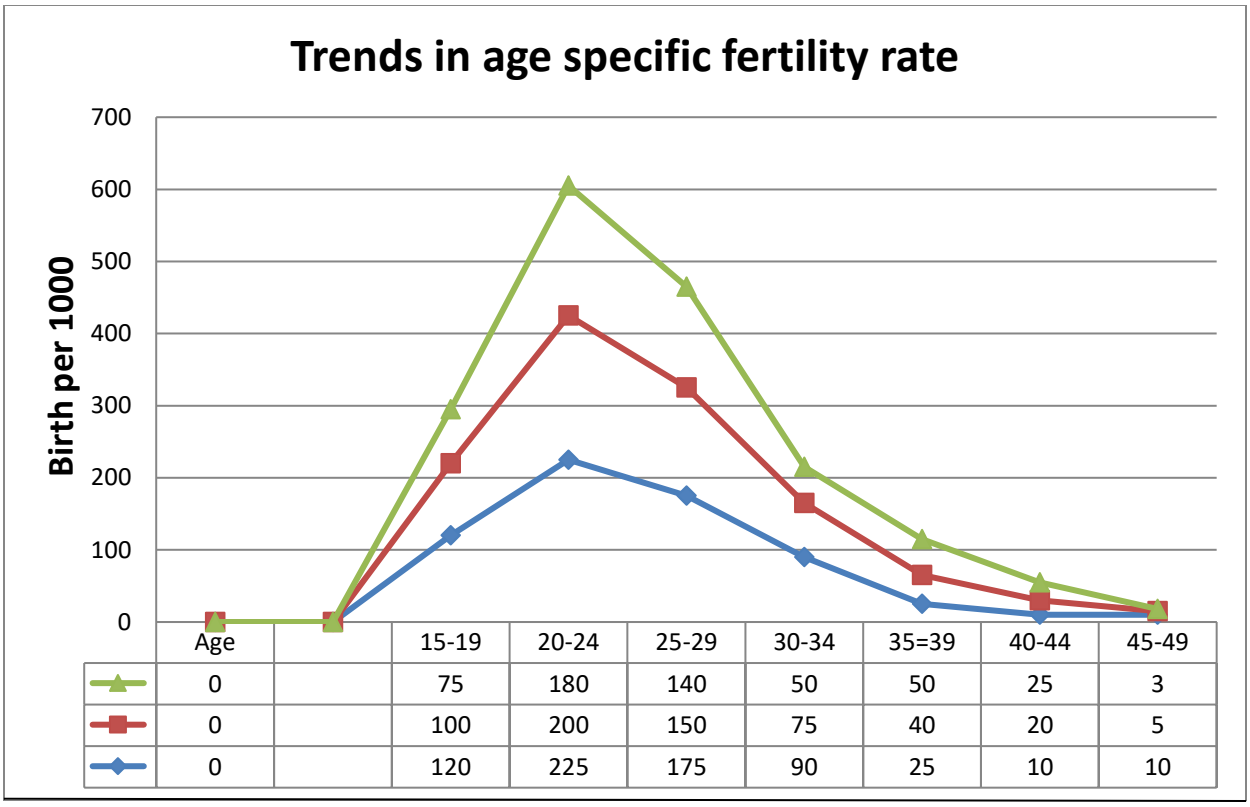
- Age at marriage for both boys and girls has wide regional variations as well. More than half of the women aged 18-29 years get married by the age of 18 years in the states of Bihar (64%), Jharkhand (60%), Rajasthan (58%), Andhra Pradesh (56%), West Bengal (53%), Madhya Pradesh (53%), Uttar Pradesh (52%) and Chhattisgarh (51%).

- The median age at first marriage among women (20-49 years) is 17.2 years and 18.3 years for women aged 20-24 years. Increase in the median age at first marriage is proceeding at a very slow pace. Trends of the median age at first marriage reveal that the increase at age at marriage of those aged 20-24 years has increased from 17.4 years (NFHS-1) to 18.3 years (NFHS-3).

c. **Fertility**

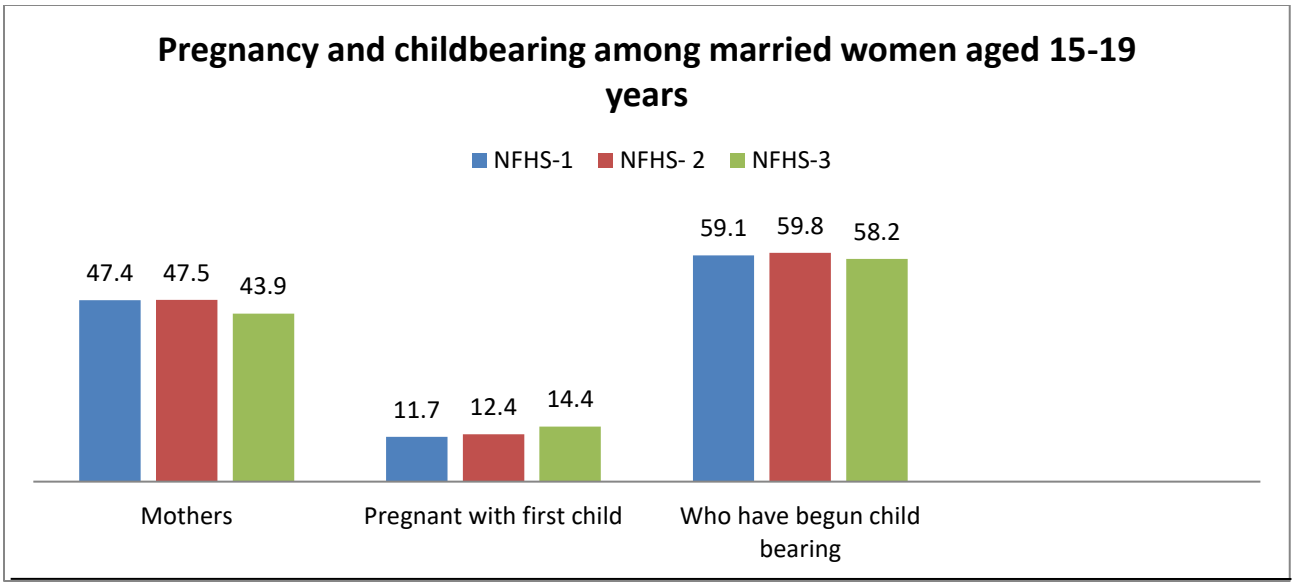
One of the major objectives of the national family health surveys is to provide information on fertility levels, state differentials and trends. According to NFHS-3, at current fertility levels, a woman in India will have an average of 2.7 children in her lifetime. Trends suggest a slowdown in fertility decline in the seven years between NFHS-2 and NFHS-3 compared to NFHS-1 and NFHS-2 (Figure 1). During the period between NFHS-1 and NFHS-2, fertility decreased mainly at ages 20 and above and very slightly at age 15-19 years. Between NFHS-2 and NFHS-3, the decline in age specific fertility was very small at all ages

Figure 1



	Age		15-19	20-24	25-29	30-34	35=39	40-44	45-49
▲	0		75	180	140	50	50	25	3
■	0		100	200	150	75	40	20	5
◆	0		120	225	175	90	25	10	10

Figure 2



KEY FINDINGS (Annexure 8, 9)

- Trends indicate a slow but steady decline in fertility in the seven years between NFHS-2 and NFHS-3 compared to NFHS-1 and NFHS-2. Between NFHS-1 and NFHS-2, fertility fell mainly at ages 20 and above and very little at age 15-19. Between NFHS-2 and NFHS-3, the decline in age specific fertility was very small at all ages.

- Nationally ASFR for 15-19 ages declined from 116 (NFHS-1) to 107 (NFHS-2) to 90 (NFHS3)

- There is a considerable contribution of adolescents to total fertility accounting for 14% of total fertility in urban areas and 18% in rural areas of those aged 15-19 years. Trends show a slight decrease in adolescent fertility from NFHS-2 to NFHS-3 and the decline is more in rural areas as compared to urban.

- Trends show that age specific fertility rates have declined for both urban and rural women aged 15-19 years and 20-24 years. Currently, the age specific fertility rates are higher for young rural women.

- There are wide state differentials in ASFR and in some states the fertility rate is much higher than the national average.

- Adolescent childbearing is common in India. Significant proportions of married adolescents give birth in adolescence, despite the fact that pregnancy in adolescence is associated with higher risks than older ages. NFHS-3 shows that 12% of all women (married and unmarried)

aged 15-19 years while 44% of currently married women in the same age group have begun childbearing.

- Trends indicate that there is a very slight decrease in adolescent childbearing (among married women) from NFHS-2 to NFHS-3.

- According to NFHS-3 the proportion of 15-19 years old women who have begun childbearing is higher in rural areas as compared to urban areas. Adolescent pregnancy and childbearing is also higher for women with no education and those in low income households.

- NFHS-3 data at state level shows that adolescent childbearing is highest in Jharkhand (28%), West Bengal (25%) and Bihar (25%), and is lowest (less than 5%) in the states of Himachal Pradesh, Goa and Jammu and Kashmir.

d. **Family planning:-**

Knowledge of contraceptive methods is fundamental to the ability of women and men to make informed choices about reproductive health decisions. Information collected by NFHS-3 shows that knowledge of contraceptives is almost universal among young women. Almost 99% of currently married women aged 15-24 years know of some method of contraception.

Figure-1

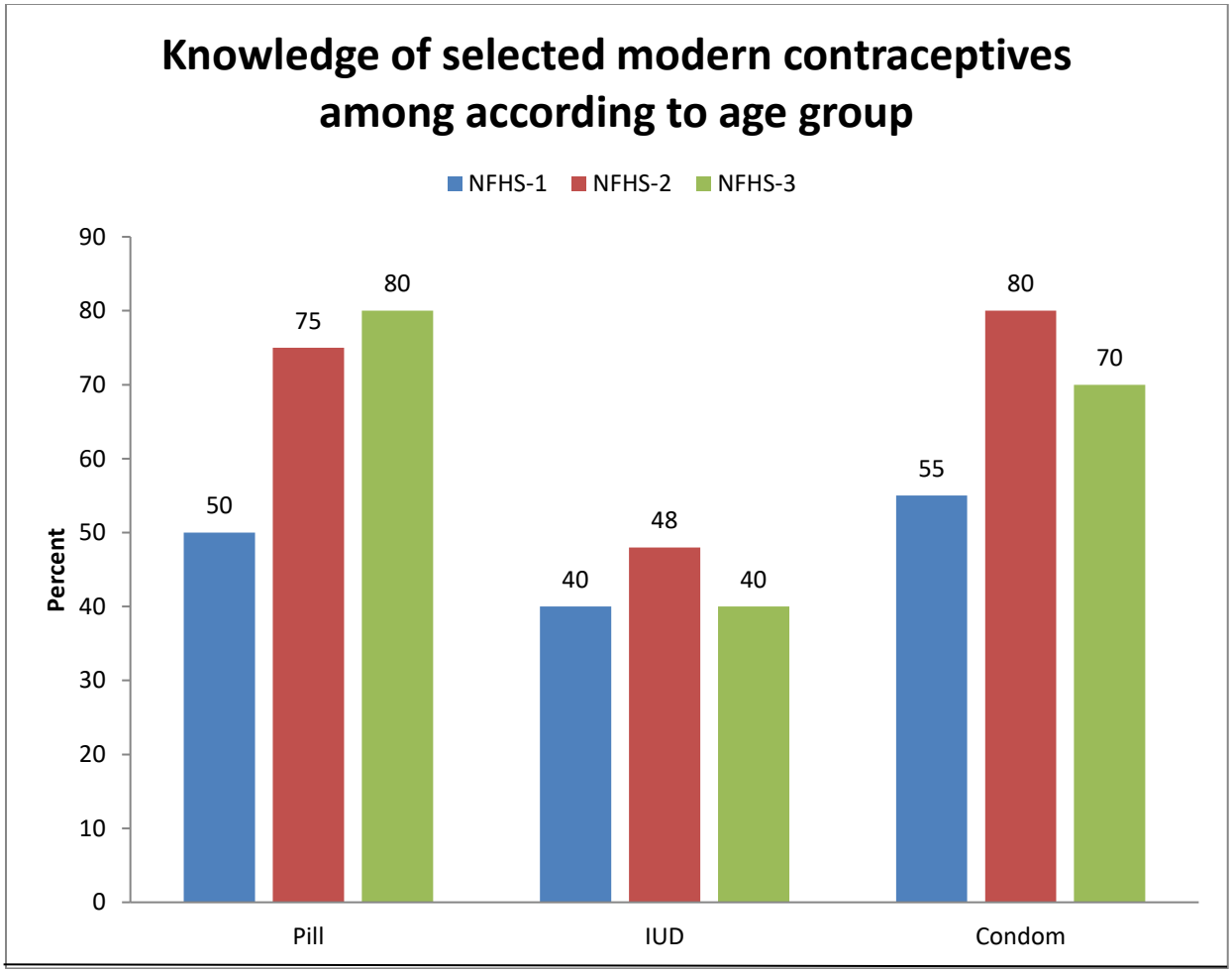


Figure-2

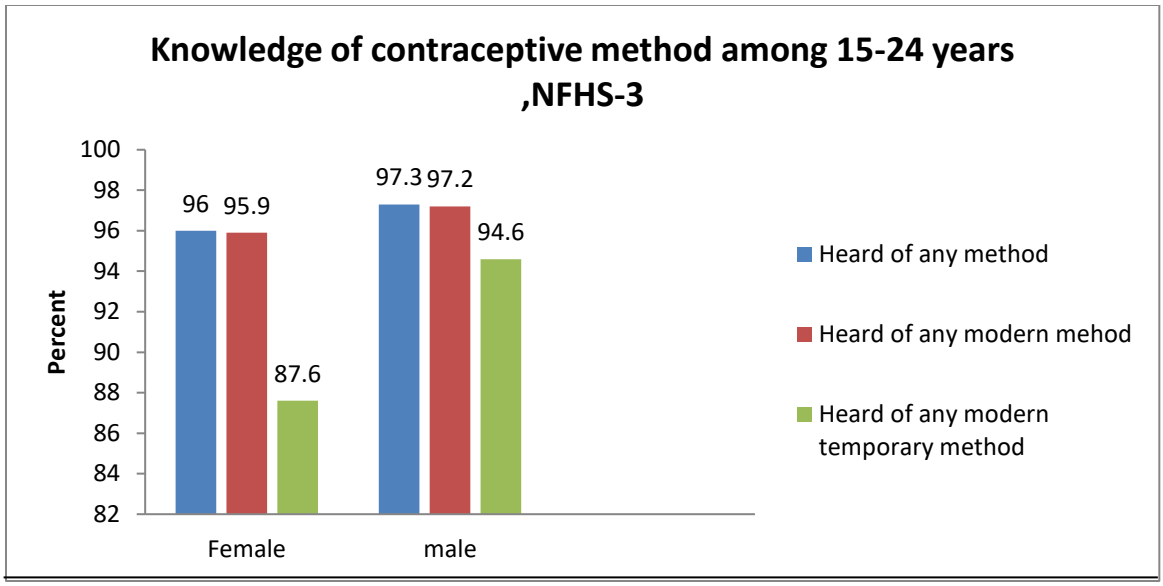
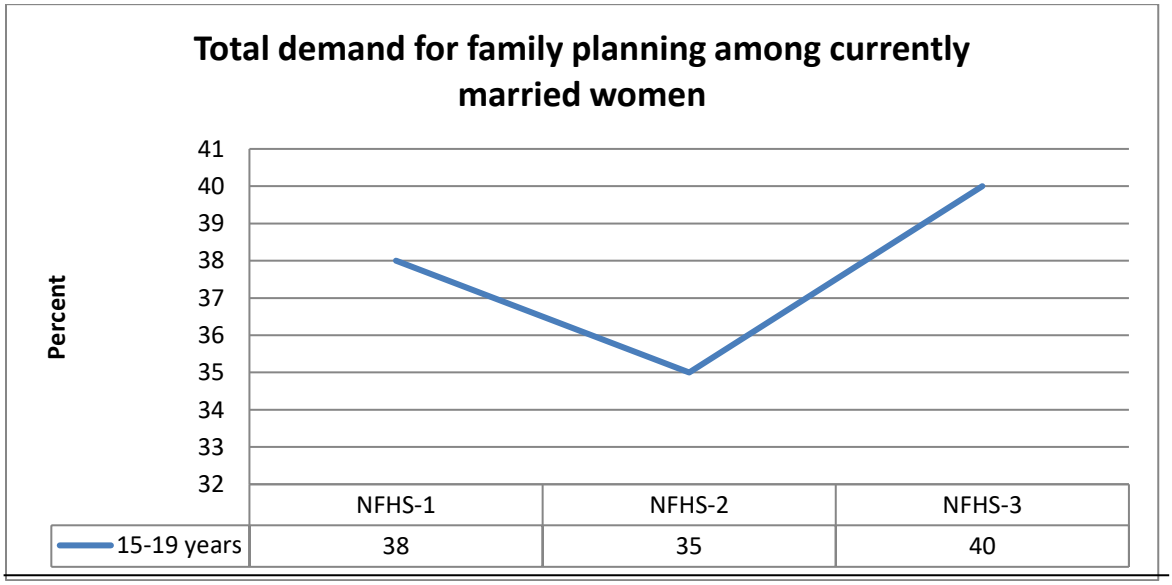


Figure 3



KEY FINDINGS

- Knowledge of contraceptives is almost universal among adolescent women. Almost 99% of currently married women aged 15-24 years know of some method of contraception (NFHS-3).

- Trends show that knowledge of contraception has increased over the years. The increase has been substantial between NFHS-1 and NFHS-2 as compared to NFHS-2 and NFHS-3.

- Among modern spacing methods adolescent women are most likely to know about pills and least likely to know about IUD.

- Almost 97% of 15-24 years old men know of some method of contraception

- Only twenty three per cent of 15-19 years old and 46% of 20-24 years old currently married women have ever used some method of contraception. Trends show that the use of contraception has been increasing over the years among adolescent women. The increase between NFHS-2 and 3 is significantly more than that between NFHS-1 and 2.

- Use of contraceptives was found to be very low among unmarried young women who have had sex.

- Though an increasing trend is seen in the use of contraception among married adolescent women since NFHS-2 for both in urban as well as rural areas, the use is still low.

- According to NFHS-3 the total unmet need of currently married adolescent women is about 27% (15-19 years old) to 21% (20-24 years old).

- Trends show that there has been a very slight decrease in the unmet needs of adolescent married women between NFHS-1 and NFHS-2 (from 30% to 27% for 15-19 years old and from 28 to 24% for 20-24 years old). Between NFHS-2 and 3 the decrease in unmet needs for young married women has been almost negligent.

- Among married young women the demand and unmet need for spacing is much higher among 15 19 years old as compared to 20-24 years old. Trends show that demand for family planning services has increased over the years while unmet needs for spacing and limiting has not reduced significantly for both 15-19 and 20- 24 years old women.

- Between NFHS-1 and NFHS-2 there was a significant increase in exposure from both radio and television for both the age groups (15-19 and 20-24 years). However, between NFHS-2 and NFHS-3 the medium of television has gained much more popularity with decreasing audiences for radio messages. According to

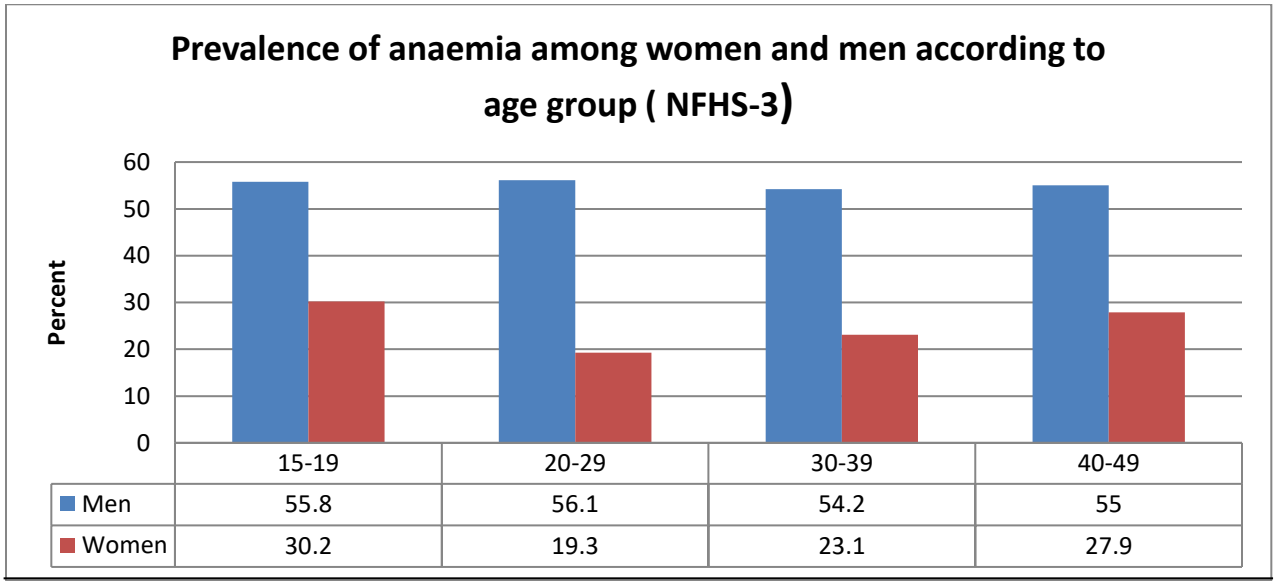
- NFHS-3 more than 50% of adolescents (15-24 years) have seen family planning messages on television.

- More young men are exposed to family planning messages as compared to women in the same age group.

e. **Nutrition status:-**

Adolescence is a period of rapid growth with adolescents gaining up to 50% of their adult weight, more than 20% of their adult height and 50% of their adult skeletal mass. The growth demands extra nutritional inputs thus making nutrition a significant determinant of adolescent health

Figure-1



KEY FINDINGS (Annexure 10)

- Food consumption pattern of adolescent women show that they consume more of vegetables and pulses compared to other nutritious foods like milk, fruits, meat chicken etc. Gender disparities also play an important role in the food consumption patterns negatively impacting the nutritional status of young women.

- The data on BMI reveals a high level of nutritional deficiency among adolescent men and women.

- The mean BMI for adolescent women (15-19 years) is 19, a little above the low normal range (18.5-24.9). For men in the same age group it is lower than normal at 18.3. Almost

half of adolescents (both women and men) come below the normal range varying from totally thin to severely thin.

- Almost 12% women (15-19 years) are under 145 cm in height heightening their risks in pregnancy and the health of their babies.

- Obesity among adolescents is also growing with more than 2% (15-19 years) women being obese.

- According to NFHS-3 more than half of women are anemic in every age group

- The prevalence of anemia is higher for those aged 15-19 years in both women and men.

- Trends show that there has been almost no change in the prevalence of anemia among women aged 15-19 and 20-24 years.

- According to NFHS-3, anemia is more widespread among both women and Children and has risen almost 5 percentage points since NFHS-2 in both the groups

f. **Maternal death:- (Annexure 11,12)**

- Trends show that utilization of ANC services (women aged 15-49 years) has increased over time from 66% in NFHS-2 to more than 76% in NFHS-3.

- Among mothers aged 15-24 years almost 69% (NFHS-1) and 70% (NFHS-2) received at least one antenatal check up. Less than half the mothers received 3 or more antenatal check up while only about 26% (NFHS-1) and 35 %(NFHS-2) received antenatal check-up during the first trimester of pregnancy.

- According to NFHS-3, more than 76% mothers (15-49 years) received at least one antenatal check-up while 52% received 3 or more. About 44% of women had an ANC visit in the first trimester of pregnancy.

- Among mothers aged less than 20 years more than 51% received antenatal care from doctors, 25% from health workers like ANM/nurse/midwife/LHV and less than 1% utilized the services of TBA/Dai. Almost 20% women did not go for any ANC visit.

- (NFHS-3).

- Trends reveal that the percentage of women (less than 20 years) receiving ANC from doctors and other health professionals has increased continuously from NFHS-1 to NFHS-3.

- A higher percentage of adolescent mothers living in urban areas receive ANC and are more likely to receive from a doctor or other health professionals compared to those living in rural areas.

- A higher percentage of women aged less than 20 years faced the problem of family not allowing them to go for antenatal checkups and lack of knowledge of ANC services compared to older women.

- Among mothers aged less than 20 years more than 62% of deliveries took place at home while only 38% took place in a health facility or institution (NFHS-3).

- Overall findings through age disaggregated data reveals that adolescent mothers (less than 15 years and 15-19 years) are more vulnerable to risks related to pregnancy and childbearing. They are also more disadvantaged in terms of antenatal and postnatal care, delivery and assistance during delivery. They suffer higher levels of postpartum complications and risk of having low birth babies along with higher levels of neonatal, postnatal, infant and child mortality.

- Trends show that delivery of births by health care professionals is also increasing.

- Among mothers' aged less than 20 years 34 % of births were assisted by a doctor (NFHS-3) compared to 20% in NFHS-1 and 29% in NFHS-2.

Figure-1

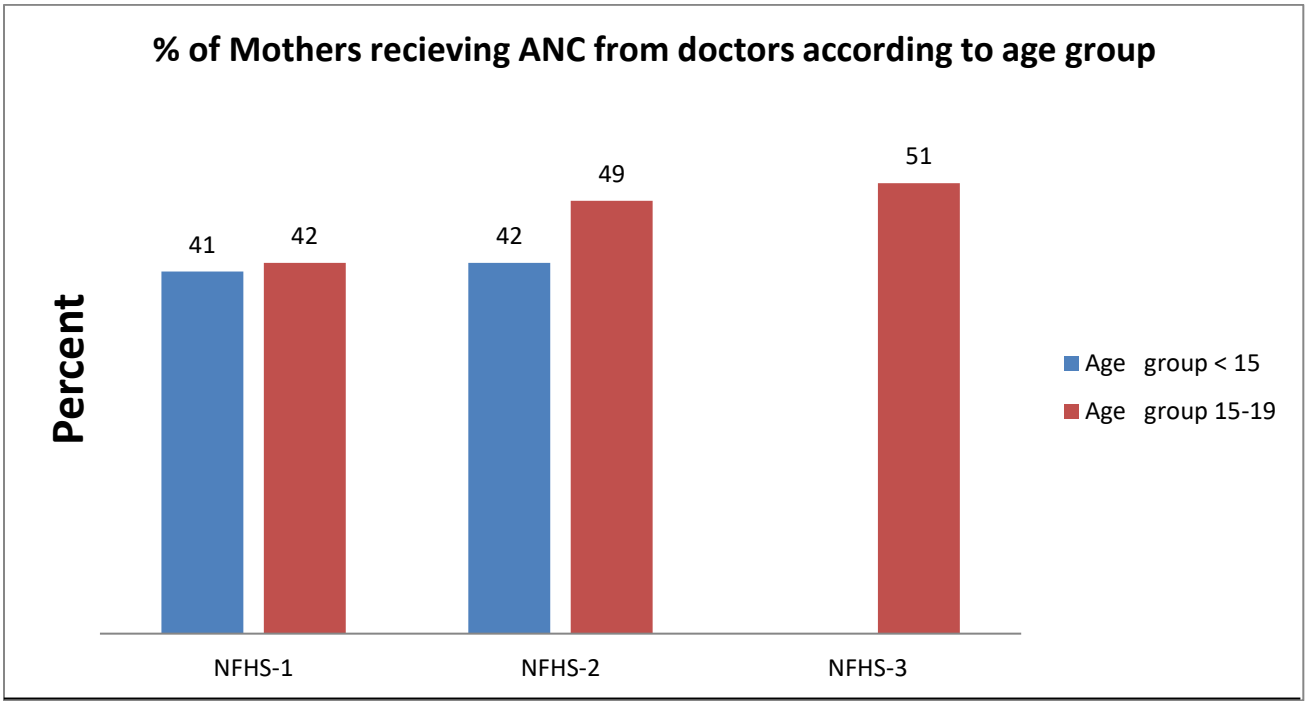


Figure-2

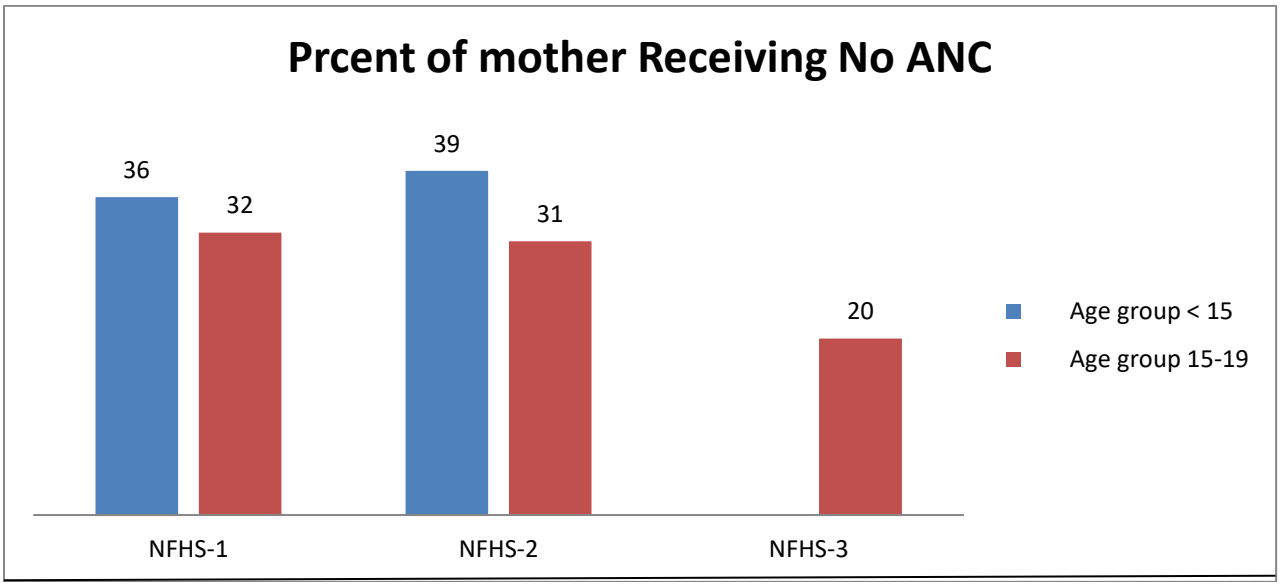


Figure 3

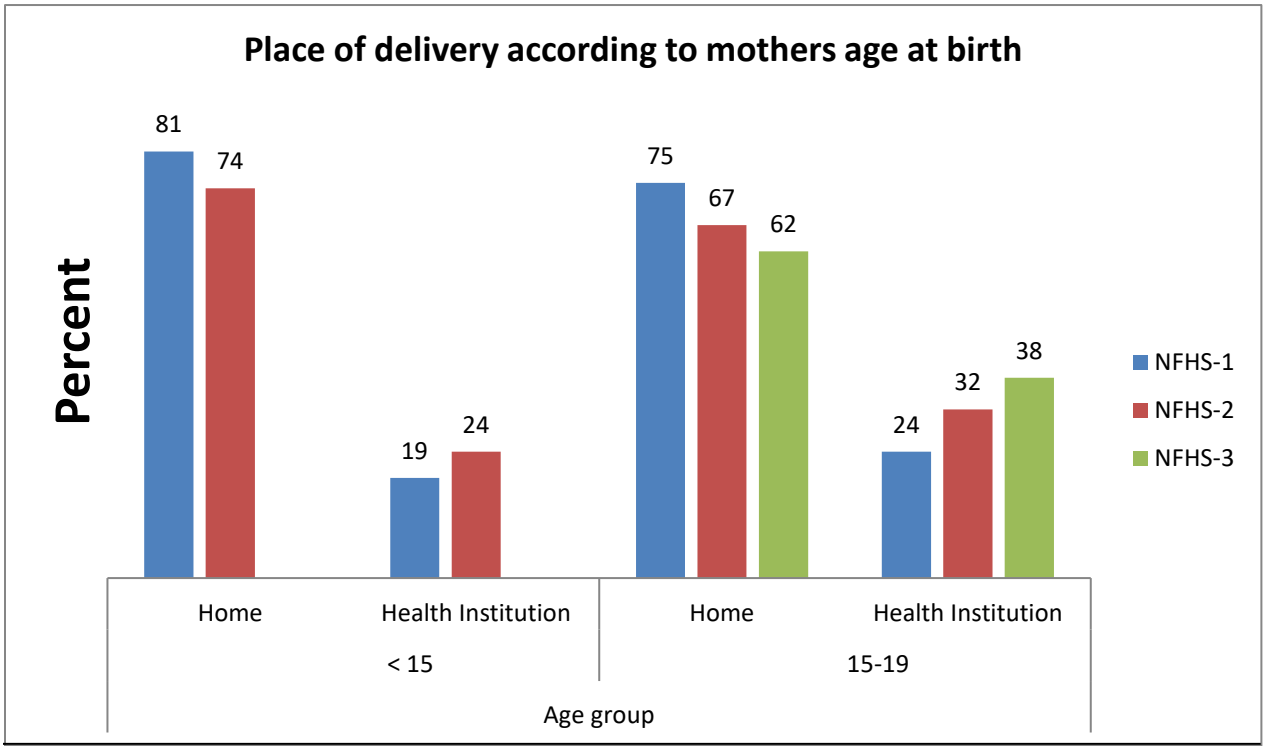
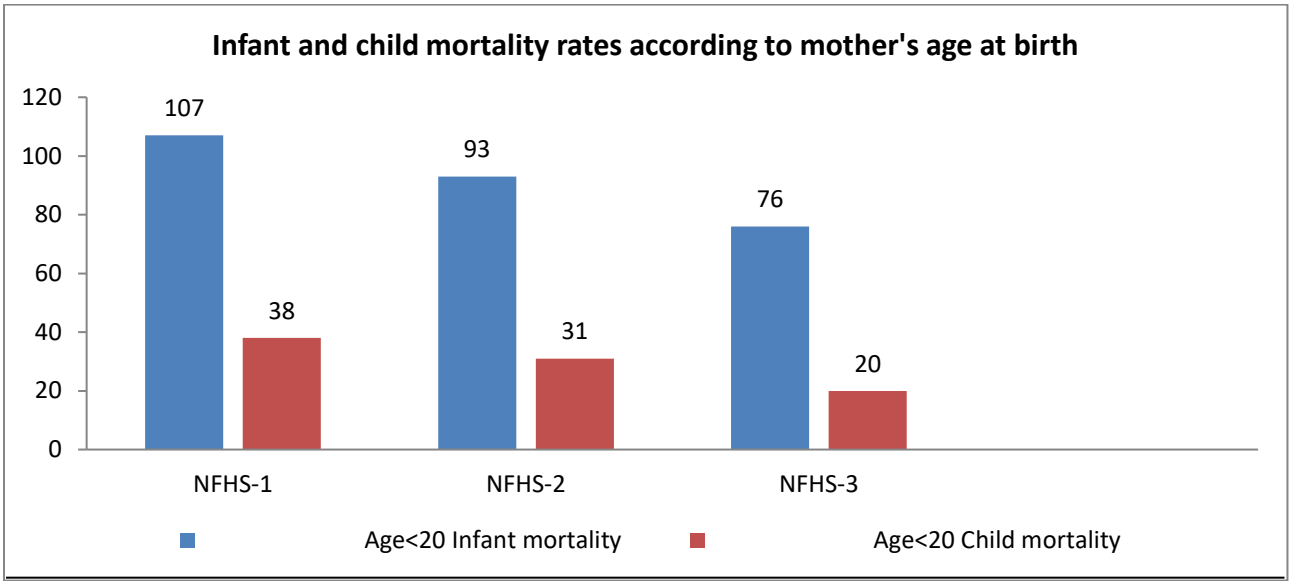


Figure-4



g. HIV/AIDS

NFHS-3 is the first national family health survey in India to include HIV testing. It was designed to provide a national estimate of HIV in the household population of women aged 15-49 years and men aged 15-54 years, and separate HIV estimates for each of six high prevalence states. Results indicate that 0.28% of adults aged 15-49 years are infected with HIV (April 2006). The HIV prevalence rate for women is 0.22% and 0.36% for men aged 15-49 years. HIV prevalence among young people (15-24 years) is lower than among persons in any other age group. The HIV prevalence among youth (15-24 years) is 0.1%. The prevalence among men aged 15-24 years is 0.9% and 0.11% among women.

The HIV prevalence among youth (15-24 years) is 0.1 percent. The prevalence among men aged 15-24 years is 0.9% and 0.11% among women (NFHS-3).

Figure-1

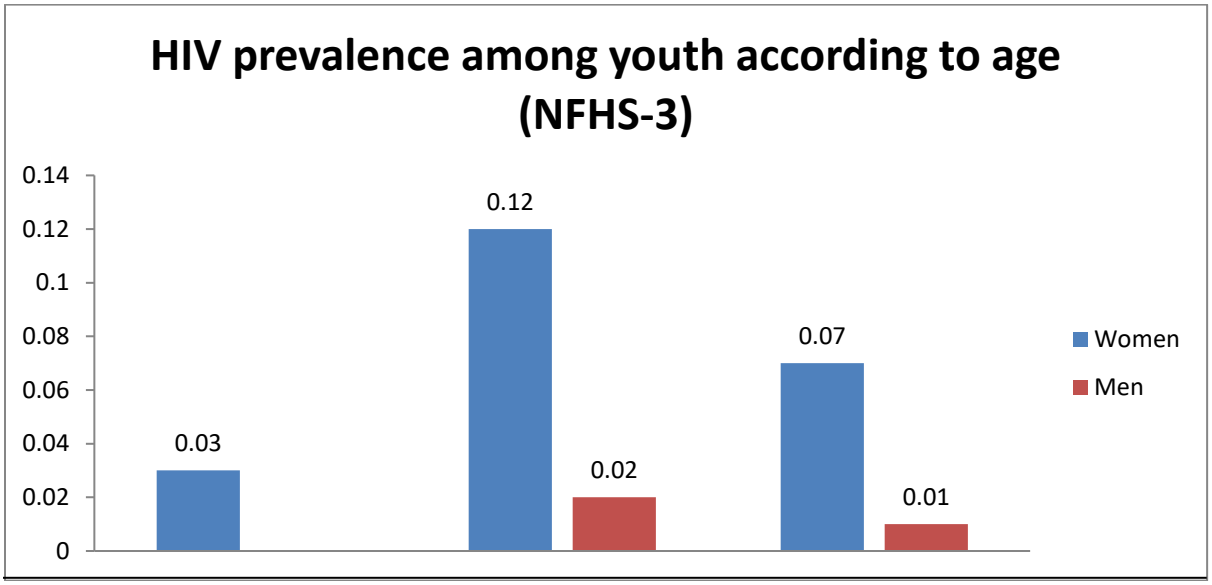
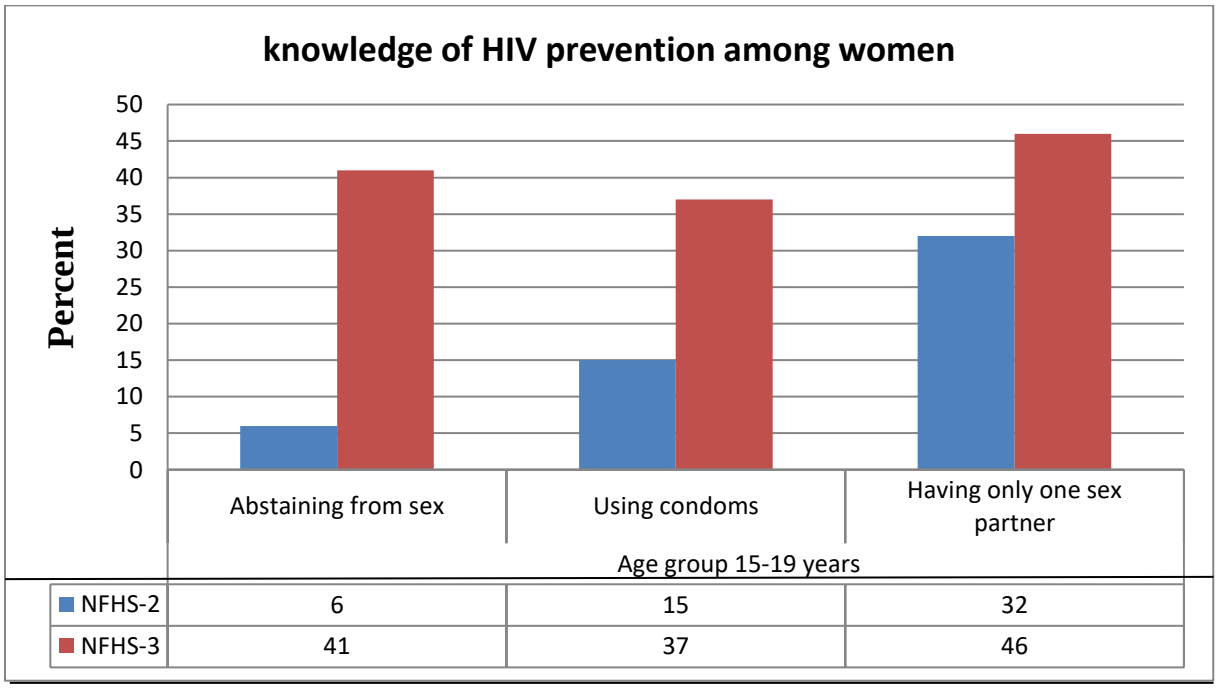


Figure-2



Key Finding:- Annexure (13,14)

- HIV prevalence is higher among women aged 15-19 years (0.07% as compared to 0.01% among men) and is highest among women aged 20-22 years (0.21%). HIV Prevalence is highest for men aged 23-24 years (0.21%).

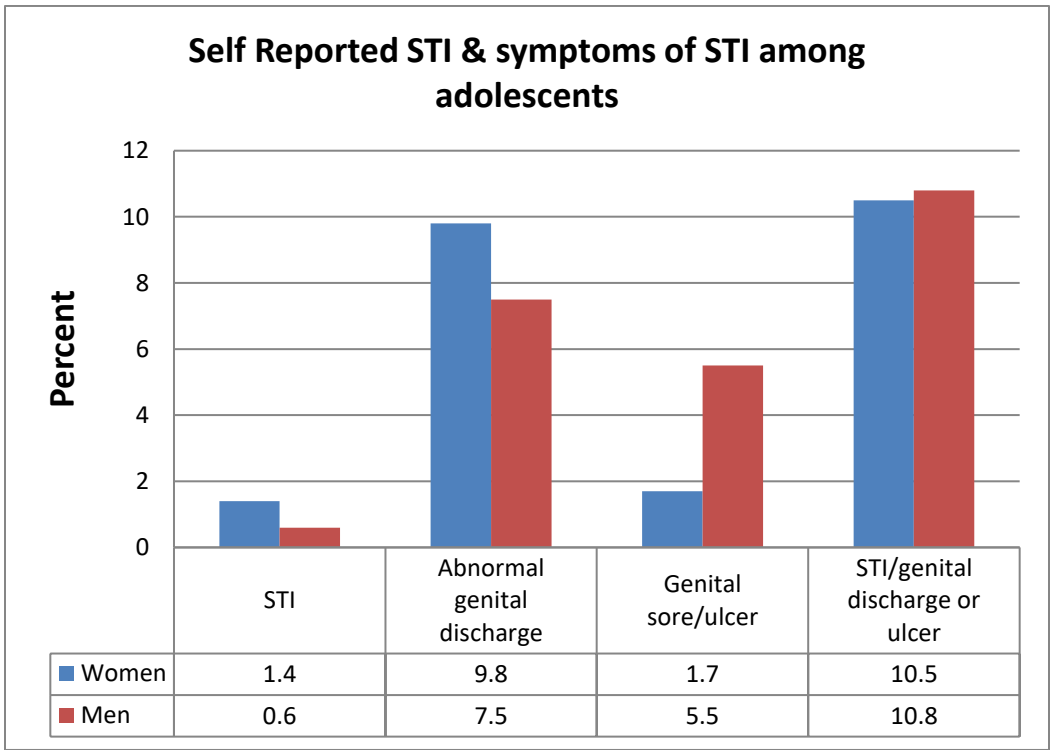
- HIV prevalence among youth was found to be higher in urban areas (0.14%) as compared to rural (.09%) and higher among women in both the areas.

- Early marriage, early sexual activity, lack of knowledge and exposure to HIV related information and limited access to health care services make young women more vulnerable to HIV risk.

- HIV prevalence is higher among youth who ever had sex, those who had sex with high risk partners and those with multiple sexual partners.

- Among young women HIV prevalence is higher for those whose first sexual partner was more than 10 years older.

Figure-3



- Comprehensive knowledge about HIV/AIDS is also found to be associated positively with educational level; wealth; exposure to media and residence in urban areas among both young men and women.

- Men are more likely than women to know where to obtain a condom from (85% and 46% respectively).

- Among sexually active youth aged 15-24 years less than one percent women and 26% men engaged in high risk sexual activity in the past 12 months preceding the survey.

- Adolescents and youth have more accepting attitudes towards those living with HIV/AIDS compared to older people.

h. **Health seeking behavior:-**

Key FINDINGS

- Age disaggregated data from NFHS-2 shows that more than 74% households with 15-19 and 20-24 years old women normally use the private medical sector when they get sick. Only about 26% use the public medical sector services.

- Utilization of private medical facilities is higher among urban areas than in rural areas.

- NFHS-3 shows that adolescents (26%) are least likely to visit public health facilities or camps as compared to women of older age groups.

- Among those who visited a health facility, high level of satisfaction was reported for the quality of care received. Ninety six percent women (15-19 years) reported that the health worker was responsive to their problems and needs.

- Age disaggregated data from NFHS-2 of women who reported that a health or family planning worker had visited her during the 12 months preceding the survey indicates that more than 90% were satisfied with the amount of time spent by the health worker with them.

- Only a small percentage also felt that the health workers did not talk nicely at all and this was more for younger women as compared to older ones.

- Almost 48% of adolescent women have at least one major problem in accessing medical care. (NFHS-3)

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- Distance to a health facility, transport, and concern over non-availability of health provider (especially female health provider) and drugs available at the health facility were reported as major concerns

➢ Sexual and reproductive health profile of young people in India

Indicator	India
Marriage (2005–6)	
% Females aged 20–24 married by age 18	44.5
% Males aged 25–29 married by age 21'	29.3
Pregnancy and childbirth (2005–6)	
% Girls aged 15–19 who were already mothers or pregnant	16.0
Median age at first birth for women aged 25–49	19.8
Total fertility rate	1.79
Contraceptive use (2002–4)	
% Married young women aged 15–24 currently practicing contraception by self or husband2	24.5
% Married young women aged 15–24 currently practicing modern contraception by self or husband2	19.2
% Married young women aged 15–24 expressing an unmet need for contraception	25.3
Maternal health seeking (2002–4)	
% Married young women aged 15–24 who received any antenatal check-up	77.5
% Married young women aged 15–24 who delivered at a health facility	42.0
Awareness of HIV/AIDS (2002–4)	
% Married young women aged 15–24 who have heard of HIV/AIDS	49.9
% Married young men aged 15–24 who have heard of HIV/AIDS	75.3
% Married young women aged 15–24 who know that consistent condom use can reduce the chance of getting HIV (among those who have heard of HIV)	23.3
% Married young men aged 15–24 who know that consistent condom use can reduce the chance of getting HIV(among those who have heard of HIV	40.3
HIV prevalence among women seeking antenatal care (2005)	0.8

Sources: IIPS 2007; [2]IIPS 2006; [3] NACO 2006. *refers to women in general and not just young people.

6. ARSH strategy in National RCH II PIP:-

The goal of the GoI RCH II is reduction in MMR, IMR 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 up at sub center clinics and to be tune with the outreach activities. A core package of services would include preventive, promotive, curative and counseling services. The framework of beneficiaries of the adolescent friendly reproductive and sexual health services (target group), the health problems/ issue to be addressed 9 service package) and the health and service provider to be involved. Such friendly services are to be made available for all adolescents, married and unmarried girls and boys during the clinic session, but not denied services during routine hours. Focus is to be given to vulnerable and marginalized subgroups. A plan of service provision as per level of care may be developed based on the RCH II service delivery plan.

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 the them across the states can be explained in terms of 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 department such as women and child development, Youth and education. Other states have proposed adolescent clinics and counseling through NGOs. Most states articulate a service delivery strategy for adolescent 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's 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 nursing staff for organizing services. It is recommended to select only such 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. A two pronged strategy will be supported. Strategy one falls within the over scale and coverage of the RCH phase II programme. The DoH&FW will incorporate adolescent issues in the all RCH training programs and RCH materials developed for communication and behavior change. This will entail that interventions for addressing unmet need for contraception and pregnancy care, prevention of STIs including HIV/AIDS will have specific activities to reach out to adolescent. Strategy two will be recognize services to deliver, staff availability and orientation.

Policy and institution framework

Both the National population policy 2000 and the tenth five year plan highlights the need for catering to the reproductive and sexual health needs of the underserved population group such as adolescent. The policy framework will guide the implementation of the operational plan for ARSH service delivery through the existing public health system. Policy level actions would need to be considered by the DoH&FW to facilitate implementation of the operational plan. These relate to, for example, administrative guidelines for providing contraceptive to unmarried adolescents, consistency and clarity with regard to contraceptive delivery and access to services, the identification of a core packages of services for adolescent at levels of health care. The DFW will need to steer policy dialogue and partnership with other departments for inter-sectoral activities.

At the district level, the district RCH society will be responsible for the overall implementation and regular monitoring. The district RCH officer will be the focal point. Medical and health care needs will be met through existing network of CHCs, PHCs and sub centers. Depending on the presence of the private sector especially in rural areas, private providers can be engaged in the provision of ARSH services. The possibility of engaging private providers for organizing teen clinics on dedicated days/time can be explored. Pediatricians and general practitioners could be engaged through their respective associations for providing free counseling services once a week for the adolescents. Partnership will also be attempted with members of FOGSI, local chapters of the Indian Academy of Pediatrics, NGOs and other departments and stakeholders groups. Synergy with other health initiatives, in particular, the National AIDS Control Organization, will need to be promoted, especially with school health programs.

Coverage:-

Any operational model to provide ARSH services of necessity will have to take in to cognizance the diversity of the program and maturity of health systems in the states. Hence, the specifics will need to be worked out, while developing state specific plans for RCH phase II. On a priority basis, it will be useful to pilot services delivery interventions in selected districts. One of the criteria for selection of districts could be the marriage age for girls and recent RHS data can be used to identity districts where more than 60% girls marry below the age of 18. It is presumed that in these districts the incidence of teenage pregnancy shall also be high.

Key interventions for operationalisation

ARSH:-

In order to facilitate provision for adolescent, the key interventions are explained below. These include the orientation of services provides, environment building activities and MIS.

a. Orientation of services providers

Equipping service providers with knowledge and skills so as to be enable them to cater to the reproductive and sexual health needs of adolescent need for services, and how to make existing services adolescent friendly. Based on the package of services chosen for implementation these orientation could be modified. A self learning module for peripheral service providers has been developed by DoH&FW and can be used in the orientation program for service providers.

These orientation would need to be integrated with other RCH phase II skill development training. At the district level the RCH officer would be the nodal person responsible for organizing quality reproductive and sexual health services.

b. Environment building activities:-

Prevailing social barriers restrain adolescent from using the services. There is need to conduct some environment building activities so as to reach out to a broader range of gatekeepers with appropriate message. The key audiences could include district officials, panchayat members, women's groups and civil society.

The communication activities would essentially focus on the vulnerabilities of adolescents, the need for ARSH and a suggested package of services. For each group of stake holders, communication material will have to be developed in the local language. It is proposed that the DHO/RCHO at the district level and the MO at the block level takes the lead in organizing such communication activities. In each district, the capacity of institution and NGOs for conducting such communication programs can be assessed.

An intensive national campaign to generate awareness on key adolescent issues could provide an ideal backdrop for launch of services in pilot districts**.**

c. MIS:-

Current health MIS does not analyze data in terms adolescents as a separate client group. The revised MIS suggested in RCH phase II will disaggregate information on key indicators to monitor the coverage of adolescents with preventive and promotive interventions. The main focus will be to monitor the teenage pregnancy rate, institutional delivery and prevalence of STIs etc.

d. **Evaluation and Operation Research**

Adolescent health in the new component of the RCH program. In order to convert this initiative in to a sustainable activity, it will be important to carefully monitor and evaluate its implementation. It is important that operational research studies are built in to the program to develop new strategies.

Purpose/ outcomes	Objectives/ outputs level		Activities/ input level	
	Objective/ outputs	**OVI/MOV**	**Activities/Input**	**OVIs/MOV**
Improved reproductive health status of adolescent girls and boys	To increase utilization of reproductive health/services by adolescent and young girls and boys	1.Teenage pregnancy rate 2.Prevalence of RTIs/STIs 3. Use of condoms during the last sex 4. Incidence of anemia in girls age 15-19 years 5. Mean age at marriage 6. Incidence of anemia in girls age 15-19 years. 7. Incidence of anemia among pregnant teenage mothers. 8. No. of maternal deaths among teenage mothers 9. proportion of HIV positives among 10-19 years age group. **MOVs for above** MIS/ Rapid HH survey, rapid survey MIS/PRI reports, sentinel surveillance report	**Increase supportive attitude towards ARSH through:** 1. Orientation of state and district program manager. 2BCC, communication activities and mass media campaigns. **Increase capacity and skills for providing information and service through** **1.**orientation of service 2. Providers**.** Improving MIS for data collection on ARSH**.**	1.% knowing benefits of providing adolescent friendly health services. 2.% of sub center having communication material for adolescents 3.% of planned group meeting held 4.% of public providers trained in providing adolescent friendly services. 5.No. of newly married

			Increase provision of ARSH services (including maternal health, RTI/STI management, Contraceptive, MTP and counseling services) through **.** Sub center . PHC	couples registered during the month 6.Proportion of teenage pregnant women attending ANCs 7. Proportion of teenage girls availing MTP services. 8. Proportion of adolescent seeking RTI services.

What to implement

Standard for quality and friendly Reproductive and Sexual Health services for Adolescents

The Indian Public Health standard for community Health centers draft guidelines (Directorate General of Health services, Ministry of Health and family Welfare , GoI of India, undated) and the ARSH strategy in the RCH phase –II National Programme

Implementation Plan (Ministry of Health and Family Welfare, GoI undated), provide the overall policy and programme framework for these standard.

1. Health facilities provide the specified package of health services that adolescent needs.
2. Health facilities deliver effective health services to adolescents.
3. Adolescents find environment at health facilities conductive to seek services.
4. Services providers are sensitive to the needs of adolescents and motivated to work them.
5. An enabling environment exists in the community for adolescents to seek the health services they need.
6. Adolescents are well informed about the availability of good quality health services from the service delivery points.
7. Management systems are in place to improve/sustain the quality services.

How to Implement:-

Section One: Service Delivery Package

STANDRD: Health facilities provide specified package of service that adolescent need

The package of services is to include promotive, preventive, curative and referral services, selected facilities in the district must be in a position to provide the following package of services.

1. Promotive services
   - 1.1 focused care during the antenatal period
   - 1.2 counseling and provision for emergency contraceptive pills
   - 1.3 counseling and provision of reversible contraceptives
   - 1.4 Information advice of SRH issues.
2. Preventive services
   - 2.1 Services for tetanus immunization
   - 2.2 Services for prophylaxis against nutritional anemia
   - 2.3 Nutrition counseling
   - 2.4 Services for early and safe termination of pregnancy and management of post abortion complication.

3. Curative services:
   3.1 Treatment for common RTIs/STIs
   3.2 Treatment and counseling for menstrual disorder.
   3.3 Treatment and counseling for sexual concerns of male and female adolescents.
   3.4 Management of sexual abuse among girls.

4. Referral services
   4.1 Voluntary counseling and testing centers
   4.2 Preventive of parents 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.

SECTION TWO: ORGANIZING EFFECTIVE SERVICES

STANDARD: Health Facilities Deliver Effective Services to Adolescents

a. Service Providers:

Adequate and appropriate service providers are in place

b. Location and supplies:

The medical officer in charge must be able to take a decision to locate/set up clinic in the existing infrastructure

c. IEC and resource materials:

Section Three: conductive environment at health facilities

Standard: Adolescents find environment at health facilities conducive to seek services.

It is related to the staff, registration procedures, privacy and confidentiality, clinic timings, appropriate signboard and IEC activities.

Section Four: CAPACITY BUILDING OF PROVIDERS

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

Section Five: Environment Building

Standard: An enabling environment exists in the community for adolescent to seek services

Section SIX: communication with adolescents

Standard: Adolescents are well informed about the health services

1. Outreach
2. Sub center level
3. PHC level
4. DH level

Section Seven: Monitoring and supervision

Standard: Management systems are in place to improve/sustain the quality of health services

1. Service Register and monthly format
2. Supervisory checklist

Section Eight: Sample Implementation Plan

In the preceding sections, the guidelines for making operational the RCH II ARSH strategy have been detailed. Based of these guidelines, the state district programme managers can develop a detailed stepwise implementation plan.

	Core steps	Requirements	Timelines	Cost times
1	**Site selection** State level a. Selection of districts for ARSH strategy b. Draw up a phased plan of coverage of districts District level a. Selection PHCs for adolescent clinics b. Develop a referral plan. Identify CHCs/DH as appropriate c. Provision of equipments, supplies infrastructure as appropriate	-Lists of districts -Criteria for district selection to include poor indicators of adolescent health eg. Low age at marriage, teenage pregnancy, HIV prevention. - lists of PHCs and sub centers - selection from among the 50 percent PHCs which are to have additional staff and are to function as 24 hrs centers in RCH-II	Pre launch phase	Base lines survey, if commissioned, for obtaining data on adolescent-specific indicators -Equipments supplies infrastructure curtains -signboards

	d. Demarcate sites running adolescent clinics (sign board)			
2	**DEFINING SERVICE PACKAGE** Map an essential package of services to be provided at each level of care (SC,PHC,CHC)	Guidelines on essential package of preventive, promotive ,curative referral services Package to be defined based on any existing baseline data on service sought by adolescents	Prelaunch phase	
3	**CAPACITY BUILDING** **State level** Identify state level training institute resource agency resource pool and develop a training calendar Organize and orient state and districts programme managers Constitute district level master trainers teams and conduct TOT Adapt training package	MOHFW training guidelines Orientation package for programme manager Training package for service providers	Start of implementation and during implementation phase	Translation of training package 1 orientation programme for programme managers 1-2 TOTs for master trainers Districts specific training of MOs District specific training of LHVs/ANMs

	for services providers **District level** Programme managers to identify trainees MOs & LHV/ANMs District teams/training institution to train service providers. Develop a competency building plan Institute system for recognizing good performing PHCs/service providers			Costs of external resource agency(if required) for capacity building
4	**Environment Building** **State level** Develop step BCC and advocacy plan and resource materials on ARSH. **District level** Adapt BCC and advocacy materials on ARSH Substantiate with district specific data, as	Engage state level expert agency, if required to review and collate existing materials on ARSH Identify inter sect oral coordination mechanism with youth education and WCD departments for advocacy on ARSH and material development. Engage local level resource materials	Start of implementation phase continuous intervention.	State level agency for material collation and development. Local level agency for material adaption Half day/one day community sensitization programmes

	appropriate Prepare block level plans for orientation programmes by DHO,MOs, LHV and ANMs	Environment building guidelines of implementation guide		
5	**COMMUNICATION WITH ADOLESCENTS** **State level** Develop state level plan for linkage 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 intervention. **District level** Plan outreach session activities. Develop visits plan of MOs ANM to	Refer section on linkages with other department in implementation guide use local level learning materials for adolescents	During implementation phase Continuous intervention	Collation of learning materials for adolescents Develop take away materials adolescents

	school and adolescent group activities.			
6	**MONITORING** **State level** Consolidation of data from districts on monthly basis Review, analysis and feedback on quarterly basis Engage expert agency for periodic assessments **District level**: Service registers in place in PHCs Collation of data on monthly basis Action on feedback Field visits	-Monthly format -Refer section on monitoring in implementation guide	During implementation phase. Continuous intervention	Printing of monitoring formats External agency for rapid assessment evaluation (provide that this is included in the work plan) Setting up MIS

7.Progress in implementation of ARSH strategy in EAG states. (2010-11)

When ARSH scheme was launched at that time four main components were incorporated in this. Those were ARSH training, ARSH clinic, Help line and IEC/BCC. All these components helpful in the progress of ARSH scheme. All states included all these components in PIP so that they can measure over and year progress of ARSH scheme. Analysis of progress of ARSH scheme in different states based on components.

(a) ARSH training:-

In this scheme training is provided to different service providers which include medical officers, staff nurse.LHV/ANM, MPW etc.

Jharkhand:-

S.No.	Training/Capacity Building Adolescent Friendly Reproductive and Sexual Health Services	2010-11			Target for 2011-12
		Total	Target	Trained	
1	Medical Officers	400	125	73	**100**
2	Staff Nurse	3288	900	504	600
3	LHV/ANM/PHN				
4	MPW (M)				
5	Orientation Sessions for Program Manager	24	24	24	24
6	Counselors				

Madhya Pradesh:-

	Training/Capacity Building Adolescent Friendly Reproductive and Sexual Health Services	**2010-11**			**Target for 2011-12**
		Total	**Target**	**Trained**	
1	Medical Officers		400	97	**200**
2	Staff Nurse		400	263	200
3	LHV/ANM/PHN				
4	MPW (M)	0			
5	Orientation Sessions for Program Manager		26 Districts	18 Districts	24 Districts
6	Counselor		44 (Family Planning Counselor)	44 (Family Planning Counselor)	

Bihar:-

	Training/Capacity Building Adolescent Friendly Reproductive and Sexual Health Services	**2010-11**			**Target for 2011-12**
		Total	**Target**	**Trained**	
1	Medical Officers		400	97	**200**
2	Staff Nurse		400	263	200
3	LHV/ANM/PHN				
4	MPW (M)	0			
5	Orientation Sessions for Program Manager		26 Districts	18 Districts	24 Districts
6	Counselor		44 (Family Planning Counselor)	44 (Family Planning Counselor)	

Orissa:-

	Training/Capacity Building Adolescent Friendly Reproductive and Sexual Health Services	2010-11			Target for 2011-12
		Total	Target	Trained	
1	Medical Officers		220	50	**182**
2	Staff Nurse				
3	LHV/ANM/PHN/Staff Nurse/ICTC Counselor		1140	500	6733
4	MPW (M)/AWW		1200	1200	40381
5	Orientation Sessions for Program Manager		140	30	256
6	Counselors				

Uttarakhand:-

	Training/ Capacity Building Adolescent Friendly Reproductive and Sexual Health Services	2010-11			
		Total	Target	Trained	Target for 2011-12
1	Medical Officers	**16**	**16**	17	**165**
2	Staff Nurse	Nil	Nil	Nil	Nil
3	LHV/ANM/PHN		160	157	825
4	MPW (M)	Nil	Nil	Nil	Nil
5	Orientation Sessions for Program Manager	24	24	24	36
6	Counselors				

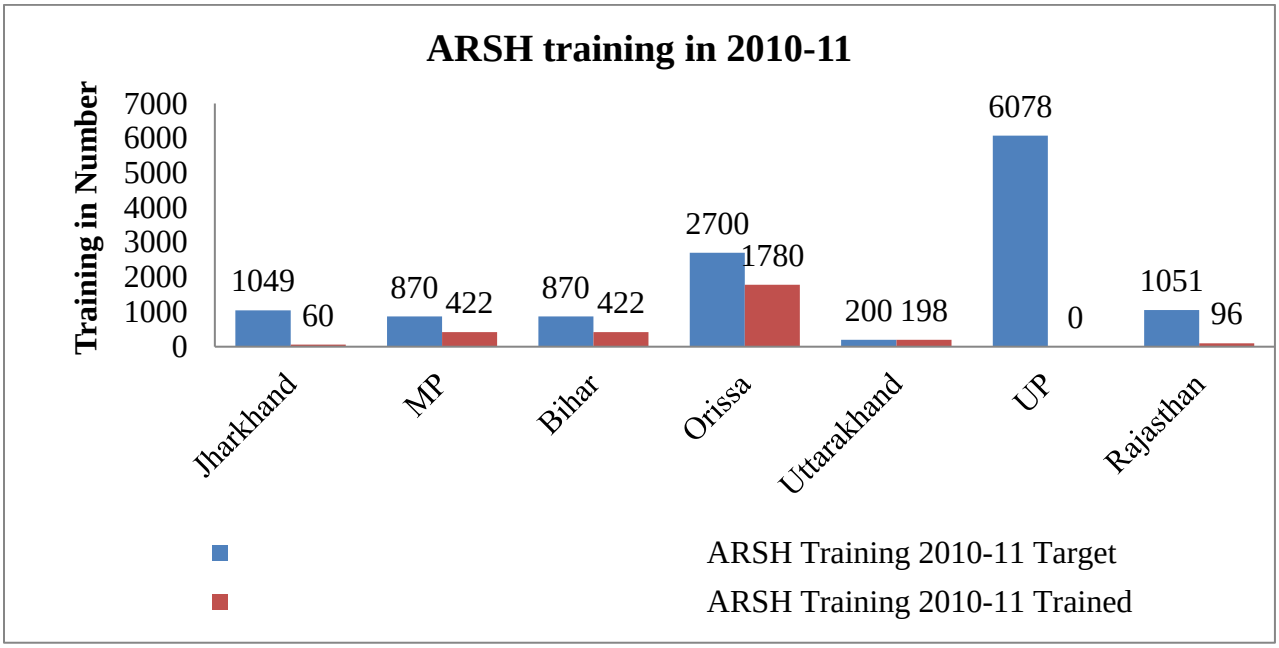
Uttar Pradesh:--

	Training/Capacity Building Adolescent Friendly Reproductive and Sexual Health Services	2010-11			Target for 2011-12
		Total	Target	Trained	
1	Medical Officers		1816	Nil	**7200**
2	Staff Nurse	Nil	4262		4800
3	LHV/ANM/PHN/Staff Nurse/ICTC Counselors				

Rajasthan:-

	Training/Capacity Building Adolescent Friendly Reproductive and Sexual Health Services	2010-11			Target for 2011-12
		Total	Target	Trained	
1	Medical Officers	811	240	96	**144**
2	Staff Nurse				
3	LHV/ANM/PHN	811	811	Nil Due to modules	405
4	MPW (M)				
5	Orientation Sessions for Program Manager				
6	Counselors				50

Analysis:-



According to this graph UP has not trained to any provider in the year 2010-11 but at another side uttarakhand has trained 198 providers out of 200.

(b) Establishment of Adolescent Friendly Health Clinics (AFHCs)/ Adolescent Clinics, ARSH Clinic-

1. Jharkhand:-

	Establishment of Adolescent Friendly Health Clinics (AFHCs)/ Adolescent Clinics, ARSH Clinics	2010-11			Target for 2011-12
		Total	Target	No. of AFHCs functional	
1	Total AFHCs in the state	194	154	91 (Established 102)	40
2	District Hospital:	24	24	13 (Established 16)	0
3	CHC:	170	130	78 (Established 86)	40
4	PHC:	0	0	0	0

Madhya Pradesh:-

	Establishment of Adolescent Friendly Health Clinics (AFHCs)/ Adolescent Clinics, ARSH Clinics	2010-11			Target for 2011-12
		Total	Target	No. of AFHCs functional	
1	Total AFHCs in the state				
	District Hospital:	50	32	27	18
	CHC:	333	54	40	
	PHC:	1156			
2	No. of AFHCs in high focus districts				
	District Hospital:	34	23	20	
	CHC:		30	21	
	PHC:				
3	No. of AFHCs in other districts				
	District Hospital:	16	9	7	
	CHC:		24	19	
	PHC:				

Bihar:-

	Establishment of Adolescent Friendly Health Clinics (AFHCs)/ Adolescent Clinics, ARSH Clinics	2010-11			Target for 2011-12
		Total	Target	No. of AFHCs functional	
1	Total AFHCs in the state				
	District Hospital:	1	1	Nil	3
	CHC:				
	PHC:	23	23	Nil	67
2	No. of AFHCs in high focus districts				
	District Hospital:	Nil	Nil	Nil	
	CHC:				
	PHC:	Nil	Nil	Nil	
3	No. of AFHCs in other districts				
	District Hospital:	Nil	Nil	Nil	
	CHC:				
	PHC:	Nil	Nil	Nil	

Rajasthan:-

	Establishment of Adolescent Friendly Health Clinics (AFHCs)/ Adolescent Clinics, ARSH Clinics	2010-11			Target for 2011-12
		Total	Target	No. of AFHCs functional	
1	Total AFHCs in the state	85	438	445	366
	District Hospital:	13	13	13	0
	CHC:	75	425	432	366
	PHC:				
2	No. of AFHCs in high focus districts				
	District Hospital:	----	----	-----	-----
	CHC:				366
	PHC:				
3	No. of AFHCs in other districts				
	District Hospital:				
	CHC:				
	PHC:				

Orissa:-

	Establishment of Adolescent Friendly Health Clinics (AFHCs)/ Adolescent Clinics, ARSH Clinics	**2010-11**			**Target for 2011-12**
		Total	**Target**	**No. of AFHCs functional**	
1	Total AFHCs in the state				
	District Hospital:		10	3	9
	CHC:		29	14	57
	PHC:				
2	No. of AFHCs in high focus districts				
	District Hospital:		5	2	3
	CHC:		6	2	25
	PHC:				
3	No. of AFHCs in other districts				
	District Hospital:		5		6
	CHC:		23		32
	PHC:				

Uttarakhand:-

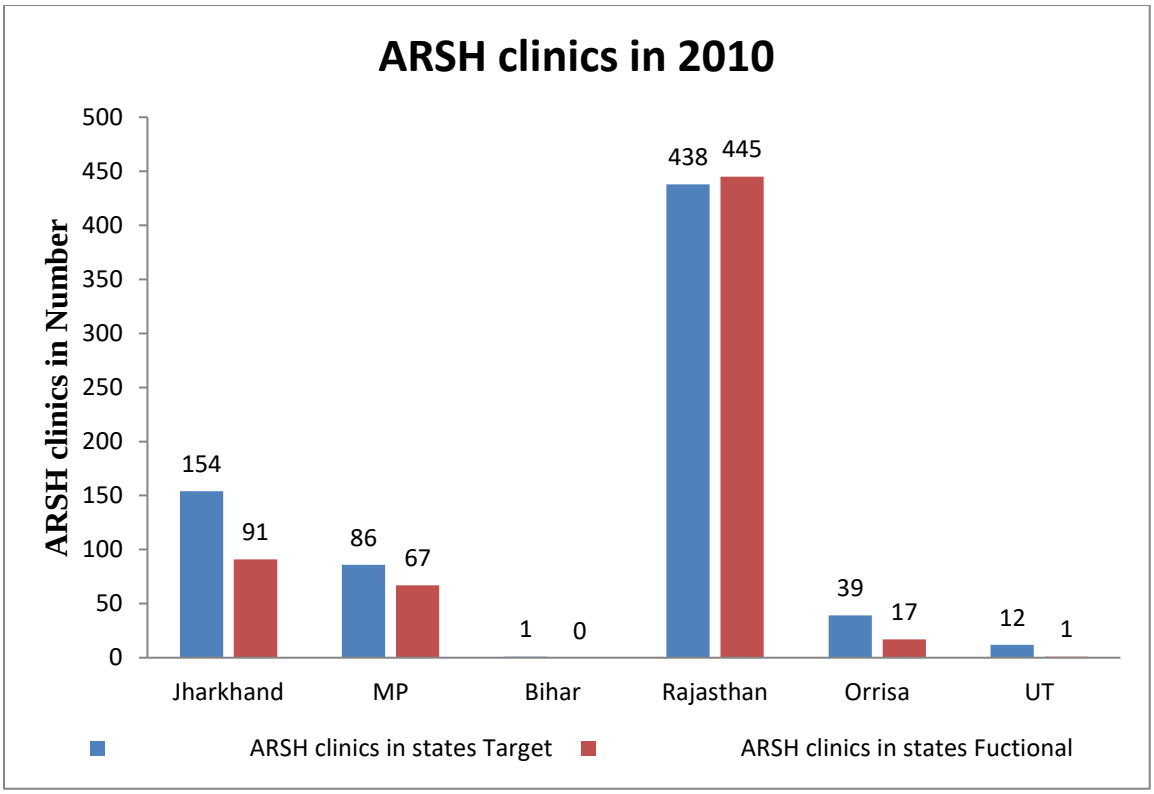
	Establishment of Adolescent Friendly Health Clinics (AFHCs)/Adolescent Clinics, ARSH Clinics	Total	Target	No. of AFHS functional	Target for 2011-12
	Total AFHS in the State				
	District Hospital	1	4	1	12
	CHC	8	8		45
	PHC				
	No. of AFHS in high focus Districts				
	Uttarkashi, Chamoli, Bageshwar, Pithoragarh District Hospital				4
	CHC		8		8
	PHC				
	No. of AFHS in other Districts				
	District Hospital	1	8	0	8
	CHC	8	37		37

Chhattisgarh:

There is no AFHCs clinic.

Uttar Pradesh:-

UP has not any ARSH clinic.



According to this graph Rajasthan has highest functional ARSH clinics against the targets in year 2010. While Bihar and uttarakhand are performing low.

(C) Service Delivery Package for Adolescents

Services at Adolescent Friendly Health Clinics	Jharkhand	MP	Bihar	Rajasthan	Orissa	Uttarakhand
ANC	Yes	Yes	State has not any AFHC clinics.	Yes	Yes	The data of AFHC is not yet available because they are recently being functional
Counseling and provision of contraceptives	Yes	Yes		Yes	Yes	
Anemia prevention and treatment	Yes	Yes		Yes	Yes	
Counseling on nutrition	Yes	Yes		Yes	Yes	
TT Immunization	Yes	Yes		Yes	Yes	
MTP services	Yes	Yes		Yes	Yes	
Treatment of RTIs/STIs	Yes	Yes		Yes	Yes	
Management of menstrual disorders	Yes	Yes		Yes	Yes	
Management of sexual abuse	No	Yes		Yes	Yes	
Any other service					Referral Service	

(D) ARSH Budget (2010-11)

States	Allocated Budget for ARSH (in Lakhs)	Expenditure till Dec. 20109 In Lakhs)	% Utilization
Jharkhand	34.5	5.00	14.00
MP	149.4	45.78	30.64
Bihar	42.89	0.28	0.65
Rajasthan	12.00	11.24	93.66
Orissa	30.08	0.4	1.32
Uttarakhand	195.89	118.88	96.42
Chhattisgarh	10.00	10.00	100
UP	311.00	114.33	36.76

8. Results:-

On the basis of these indicators these states have started more work on the ARSH area after the 2005-06, but the improvement is not up to mark. Although Rajasthan is performing well in comparison of other EAG states.

9. Conclusion/ Recommendation:-

- The mapping of essential actions does not rule out 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 NGOs may be roped in BCC and environment building activities. 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 clinics, signboard designing, fixing timing and name of the clinic and developing resource materials. There can be several other option that states and districts have to explore.

- It is possible to have local, participatory adolescent planning.

- Planning is a means, not an end; a means to encourage ATTITUDE change and to establish commitments to undertake activities.

- Adolescent are willing to assume commitments: there is need to continue working much more on HOW and WITH WHAT at the implementation of actions and monitoring and evaluation.

10. Challenges:-

- It is a process….. Continuous
- Multi sectoral coordination…….
- Coordination local with National…….
- Monitoring and follow up……..

11.References:-

1. Implementation Guide on RCH-II ADOLESCENT REPRODUCTIVE SEXUAL HEALTH STRATGEY, Ministry of Health & Family Welfare, May 2006.

2. National program implementation plan RCH-II, Ministry of Health & Family Welfare, 2005.

3. Reproductive and Sexual Health of Young People in India, Ministry of Health & family Welfare, Government of India, July 2009.

4. Narayan K.A.etal Puberty Rituals, Reproductive Knowledge and Health of Adolescent Schoolgirls in South India Journal of Asia- Pacific Population, June 2001.

5. Collumbien.etal: Male Sexual Debut in Orissa, India: Context, partners and differentials: systemic review Journal of Asia – pacific Population Journal, June 2001.

6. Bott sarah etal Towards adulthood: exploring the sexual and reproductive health of adolescents in South Asia, World Health Organization 2001.

7. Magnusson Josefine etal. : Parents' views on confidentiality and health advice for adolescents in general practice; Primary Health Care Research & Development 2007; 8: 121-127

8. Milne AC and Chesson R. Health services can be cool: partnership with adolescents in primary care: Family practices 2000; 17: 305-308.

9. Erhart Michael etal. An International scoring system for self-reported health complaints in adolescents: European journal of Public Health vol.18, No. 3, 294-299

10. Goodburn Elizabeth and Ross A David: Young peoples health in developing countries: a neglected problem and opportunity: HEALTH POLICY AND PLANNING; 15(2): 137-144.

12.Annexure:-

Table-1
Respondent's level of education

Survey	NFHS-1	NFHS-2	NFHS-3	
Sex	Female	Female	Female	male
No Education	67.1	59	21.7	7.4
< 5 years complete	5,6	6.1	7.7	6.9
5-7 years complete	13	16.8	19.4	18.3
8-9 years complete	8.6	11.1	23.6	32
10-11 years complete	5.6	5.2	18.1	24.7
12 or more years	0.2	1.8	9.4	10.6

Table-2
Employment status
Percent distribution of women by employment status

Women	Currently working	Not working	employed in the 12 months preceding the survey
NFHS-1(15-24 yrs)	25.1	74.9	
NFHS 2 (15-24 yrs)	29	69.1	-
NFHS-3(15-19 yrs)	26.6	6.8	66.6
NFHS-3(20-24 yrs) 2	28	6.7	65.2
NFHS-3(15-19 yrs) (M)	47.	4 3	49.5
NFHS-3(20-24 yrs) (M)	81.6	3.2	15.1

Table-3
Exposure to mass media

	NFHS-1	NFHS-2	NFHS-3	
	F	F	F	M
Watches TV at least once	22.6	38	59.4	71.2
Listen to the radio at least once a week	41	33.3	34.3	48.8
Visits a cinema theatre at least once a month	18.2	14.3	7.6	26.9
Not regularly exposed to any media	50.5	45	28.5	11.8
Reads a newspaper/ magazines at least once a week	-	14.6	28.6	55.7

Table 4

Women autonomy

Percentage of currently married women aged 15-19 years involved in household decision making, freedom of movement and with access to money by selected indicators (NFHS-2)

Year	% not involved in decision making	% involved in on own health care	% who do not need permission visit friends/relatives	% who do not need permission to go to the market	% with access to money
NFHS-2	24.3	38.6	10.2	13.8	45.5
NFHS-3	-	40.4	33.5	-	-

Table-5
Domestic violence
Reasons given for justifying a husband beating his wife (NFHS-2)

Age group	15-19 (NFHS-2)
% who agree with at least one reason 61.6	61.6
Husband suspects wife is unfaithful	37.1
Natal family does not give money or other items	8.5
Wife shows disrespect for in-laws	38.7
Wife goes out without telling husband	41.7
Wife neglects house or children	43.1
Wife does not cook food properly	28.8

Table-6
Experience of physical violence

Age	NFHS-2	NFHS-3
15-19	15.4	20.7

Table-7
Experience of sexual violence and age at first experience of sexual violence (NFHS-3)

Age	% who have ever experience sexual violence	Number of children	Age at first experience of sexual violence					
			Less than age 10	10-14	15-19	20-49	Not determined/do not know	Number of women
15-19	4.5	16617	2.1	9.8	32.2	NA	55.3	751

Table-8
Percent distribution of married women by number of children ever born according to Age.-

Mother age	15-19 years			
Children born	0	1	2	3
NFHS-1	52.3	35.3	10.5	1.9
NFHS-2	52.2	34.8	11.1	1.9
NFHS-3	56.1	33.4	9.1	1.4

Table-9
Outcome of pregnancy according to age group (All India)

Age group	15-19 Years			
Pregnancy Outcome	Spontaneous abortion	Induced abortion	Still birth	Live birth
NFHS-1	7.3	1.7	2.4	88.7
NFHS-2	4.5	0.6	1.4	93.4
NFHS-3	NA	NA		

Table-10
BMI of women and men (NFHS-3)

	Adolescent	
	women	Men
Mean BMI	19	18.3
18.5-24.9 (Normal)	50.8	40.2
< 18.5 (Totally thin)	46.8	58.1
17-18.4 (Mildly thin)	25.9	28.8
< 17 (Severely thin)	20.9	29.3
> 25 (Overweight or obese)	2.4	1.7
25-29.9 (overweight)	2.1	1.4
> 30 (obese)	0.2	0.2

Table 11
Stage of pregnancy at the time of the first antenatal check-up

	NFHS-1	NFHS-2
	<20	
No Antenatal checkup	32.4	31.7
First trimester	24	31.3
Second trimester	30.3	28.1
Third trimester	12.7	8.6

Table-12
Reasons for not receiving antenatal check-up among mothers who did not receive an ANC according to mother's age.

	NFHS-1	NFHS-2
Age group	<20	
Not necessary	55.5	59.2
Not customary	5.2	4.4
Costs too much	5.9	12.9
Too far/no transport	2.7	3.5
Poor quality service	1.3	0.7
No time to go	4	1.2
Family did not allow	7.1	10.5
No health worker visited	-	1.4
Lack of knowledge	16.3	4.6
Others	1.9	1.5

Table-13
Knowledge of HIV prevention methods among youth (NFHS-3)

	15-19 years	
	Male	Female
Prevention method	71.4	36.5
Using condoms	73.1	46.3
Limiting sexual intercourse to one un infected partner	65.5	32.4
Abstaining from sexual intercourse	68.1	41.2

Table-14

Sexual intercourse and condom use among never married youth (NFHS-3)

Age group	Total (15-19)		15-17		18-19	
	M	F	M	F	M	F
% Who never had sexual intercourse	91.4	99.4	93.7	99.5	87.5	99.2
% who had sexual intercourse in the 12 month	5.1	0.4	3.7	0.3	7.5	0.6
% Who used condom at last sexual intercourse	31.3	18.1	28.7	20.7	33.3	14.4