Internship Training

At

INDIA HEALTH ACTION TRUST

A Study To Assess Knowledge level of Front line workers on adolescent counselling at village health and nutrition day in Budaun District Of Uttar Pradesh

By

Dr. RACHNA SHARMA

PG/14/053

Under the guidance of

Dr. DHANANJAY SRIVASTAVA

Post Graduate Diploma in Hospital and Health Management

2014-16

International Institute of Health Management Research
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TO WHOMSOEVER IT MAY CONCERN

This is to certify that **Rachna Sharma** student of Post Graduate Diploma in Hospital and Health Management (PGDHM) from International Institute of Health Management Research, New Delhi has undergone internship training at **India Health Action Trust** from **February 2016** to **April 2016.**

The Candidate has successfully carried out the study designated to him during internship training and his approach to the study has been sincere, scientific and analytical.

The Internship is in fulfillment of the course requirements.

I wish him all success in all his future endeavors.

Dr. A.K. Agarwal
Dean, Academics and Student Affairs
IIHMR, New Delhi

Dr. Dhananjay srivastava
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INDIA HEALTH ACTION TRUST

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(Completion of Dissertation from INDIA HEALTH ACTION TRUST)

The certificate is awarded to
Dr. Rachna Sharma

In recognition of having successful completion of her
Internship in the department of

NUTRITION

Has successfully completed her Project on
A Study To Assess Knowledge level of Front line workers on adolescent counsellling at VHND in Budaun district of Uttar Pradesh

From February to April, 2016

She comes across as a committed, sincere & diligent person who has a strong drive & zeal for learning
We wish her all the best for future endeavors

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Training & Development

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Certificate of Approval

The following dissertation titled **"A Study To Assess Knowledge level of ASHA, AWW and ANM on adolescent counselling in Badaun district of Uttar Pradesh"** at **International Institute of Health Management Research, New Delhi** is here by approved as a certified study in management carried out and presented in a manner satisfactorily to warrant its acceptance as a prerequisite for the award of **Post Graduate Diploma in Health and Hospital Management** for which it has been submitted. It is understood that by this approval the undersigned do not necessarily endorse or approve any statement made, opinion expressed or conclusion drawn there in but approve the dissertation only for the purpose it is submitted.

Dissertation Examination Committee for evaluation of dissertation.

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Certificate from Dissertation Advisory Committee

This is to certify that **Dr. Rachna Sharma,** a graduate student of **Post graduate diploma in hospital and health management** has worked under our guidance and supervision. She is submitting this dissertation titled" A Study **To Assess Knowledge level of Front line workers on adolescent counselling at VHND in Budaun district of Uttar Pradesh** at IHAT in partial fulfilment of the requirements for the award of the **Post graduate diploma in hospital and health management.**

This dissertation has the requisite standard and to the best of our knowledge no part of it has been reproduced from any other dissertation, monograph, report or book.

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CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled **"A Study to Assess knowledge level of front line workers on adolescent counseling at VHND in Budaun district of Uttar Pradesh** submitted by **Rachna Sharma,** Enrollment No. **PG/14/053** under the supervision of **Dr. Dhananjay srivastava, Assistant Professor, IIHMR-New Delhi** for award of Post-Graduate Diploma in Hospital and Health Management of the Institute carried out during the period from **February 2016** to **March 2016** embodies my original work and has not formed the basis for the award of any degree, diploma associate ship, fellowship, titles in this way or any other Institute or other similar institution of higher learning.

Signature

India Health Action Trust

INDIA HEALTH ACTION TRUST

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FEEDBACK FORM

Name of the Student: Rachna Sharma

Dissertation Organisation: India Health Action Trust

Area of Dissertation: Nutrition

Attendance: Full

Objectives achieved:

- Training of CRP about nutrition
- Visits to Anganwadi centres for observation and assessment
- Participation in Districts, Block and Zonal Meetings held by an organization

Strengths:

- Hard working and sincere
- Always complete tasks with full dedication
- Good analytical and communication skills
- Good Team player

Suggestions for Improvement: Coordination skills can be an area for improvement.

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PREFACE

The PGDHM (hospital and health management) course is well structured and integrated course of business studies. The main objectives of practical training at MBA level is to develop skill in students by supplement to the theoretical study of business management in general. Professors give us theoretical knowledge of various subjects in the institute. But we are practically exposed of such subjects when we get the training in the organization. It is the training through which we come to know that what an organization is and how it works. During this whole training I got a lot of experience and came to know about management practices in real that how it differs from those of theoretical knowledge and the practically in the real life.

It's very beneficial to learn health care delivery system at various levels. I observed the implementation of various National Health Programmes at National/State/District levels, I understood various functions of health systems by interactions with key stakeholders, policy makers, programme managers, academicians and researchers.

During my training period I had an overview of various programmes undertaken by Uttar Pradesh Technical Support Unit including the current status of the programmes. I also carried out a small study on-

"A Study To Assess Knowledge level of Front line workers on adolescent counselling at village health and nutrition day in Badaun District Of Uttar Pradesh"

I have tried to put my best effort to complete this task on the basis of skill that I have achieved during my studies in the institute.

ACKNOWLEDGEMENT

At the onset of the report I would like to express my special gratitude and appreciation for my college authorities for allowing me to pursue my Dissertation from India Health Action Trust, also own as Uttar Pradesh (Technical Support Unit).

I would like to extend my special gratitude for my mentor, Dr. Dhananjay srivastava, for helping me in my dissertation and guiding me throughout the process.

I would also like to acknowledge with much appreciation the crucial role of Mrs Mansi Shekhar, State Team Leader (Nutrition Project), UP (TSU) and Mr Umesh Singh, Zonal Community Specialist, UP (TSU) who despite of other pre occupations and busy schedule were there to guide me and whose stimulating suggestions and encouragement helped me complete my training.

So I would like to thank all the consultants in various departments and other staff members at IHAT for being so helpful all the time and making this Dissertation project an unforgettable experience.

A special thanks to Mr Vikas Gothalwal, Exexutive Director, UP (TSU) and Mr Sanjeev, Team leader (Nutrition Project) UP TSU.

Finally, and most importantly, I would like to thank God for allowing me to complete my project, my beloved parents for their blessings and my friends for their help and wishes for the successful completion of this training.

Table of Contents

ABBREVIATIONS

ABBREVIATION	FULL FORM OF ABBREVIATION
ASHA	ANGANWADI CENTRE
ANM	AUXILLIARY NURSE MIDWIFE
AWW	ANGANWADI WORKER
AWC	ANGANWADI CENTRE
ARSH	ADOLESCENT REPRODUCTIVE AND SEXUAL HEALTH
CHW	COMMUNITY HEALTH WORKERS
FLW	FRONT LINE HEALTH WORKERS
GoUP	GOVERNMENT OF UTTAR PRADESH
ICDS	INTEGRATED CHILD DEVELOPMENT SERVICES
IHAT	INDIA HEALTH ACTION TRUST
MIYCN	MOTHER INFANT YOUNG CHILD AND NEONATAL
NRC	NUTRITIONAL REHABILITATION CENTRE
NRHM	NATIONAL RURAL HEALTH MISSION
PMW	PARA MEDICAL WORKERS
RKS	ROGI KALYAN SAMITI

RMNCH+A	REPRODUCTIVE MATERNAL NEONATAL CHILD HEALTH AND ADOLESCENT
UM	UNIVERSITY OF MANITOBA
VHSNC	VILLAGE HEALTH SANITATION AND NUTRITION COMMITTEE
WIFS	WEEKLY IRON FOLIC SUPPLEMENT
UPTSU	UTTAR PRADESH TECHNICAL SUPPORT UNIT
VHND	VILLAGE HEALTH AND NUTRITION DAY

ABSTRACT

There are 225 adolescents comprising nearly one- fifth (22 %) of India's total population (census 2001). Of the total adolescent population, 12 per cent belong to the 10- 14 years age group nearly 10 per cent are in the 15- 19 age group. Female adolescents comprises almost 47 % of total adolescent population. Prevalence of Neonatal mortality is higher among adolescent mothers. 6 % of all mothers are adolescents and their pregnancy is high risk pregnancy and chances of dying are twice than women over the age of 20[3]. Over 55 per cent of adolescent girls are anaemic. VHND is a plateform for intersectoral convergance where health services to adolescent girls provided under all these schemes can be implemented at a single plateform and provided at a site very close to habitation of adolescents so that these services can be easily accessible for them and they can fully utilize these services. Front line workers play a significant role in making implementation of these services a success as these are the people who mobilize community to gather at the site and prepare plan to organize the session. Health systems are most effective when health workers are skilled, motivated, and trained to provide high-quality services. Front line health workers knowledge is one of the crucial aspects of health system to improve the coverage of community based health care programmes and for better service delivery.

Objective:

- To assess knowledge level of ASHA, AWW and ANM on different topics of adolescent counselling.
- To develop a scoring scale for knowledge assessment

Materials & methods: A descriptive cross sectional study was conducted in Badaun district of Uttar Pradesh. It is proposed to conduct the study in the assigned districts to the researcher.

164 ASHA, AWW and ANM were selected through convenient sampling in 2 blocks of Badaun district and self-administered interview schedule has developed for data collection.

Conclusion: It was found that the overall knowledge was satisfactory although the data reveals a noticeable gap between the recently trained in 2016 and trained before 2015 it shows that retention of knowledge level was comparatively low. It was also found in study that knowledge level on topic of sexual infectious diseases is comparatively low as compare to other topics the reason might be social stigma Main lack of knowledge was found in areas where there was unavailability of stocks as blue Fe tablets for adolescents, Unavailability of sanitary pads and there is no ARSH clinic infrastructure.

RECOMMENDATION:

- Unavailability of stocks should not be a ceiteria of training but training should be provided on each and every topic as per the guidelines of VHND.
- Advocacy for establishment of ARSH clinic is needed.
- IEC and BCC can be a medium to create awareness about HIV/ STDs like infectious diseases so it can be accepted by the community and it can be a part of VHND counselling then discussion of this knowledge at VHND may help in retention of this topic knowledge.

ORGANIZATION PROFILE

UTTAR PRADESH TECHNICAL SUPPORT UNIT

INDIA HEALTH ACTION TRUST, UTTAR RADESH

BACKGROUND

A Technical Support Unit (TSU) is established for the Government of Uttar Pradesh (GoUP), with the goal of providing techno-managerial support to the GoUP to improve the efficiency, effectiveness and equity of delivery of key RMNCHA interventions. This will be accomplished by supporting the state in the implementation of the nationally launched NRHM RMNCH+A strategy, and in the scale-up of agriculture and financial inclusion services.

The TSU's activities will be focused on the twenty-five most underserved districts in the state, where the aim is to improve RMNCHN service delivery and outcomes within 100 priority blocks. These districts have been selected and agreed upon jointly by GOI, GoUP and the foundation.

The India Health Action Trust (IHAT) will have overall responsibility for executing the TSU project in Uttar Pradesh. The University of Manitoba (UM) will provide key technical and managerial support to all RMNCHN areas, and financial inclusion/agriculture. John Snow International Research & Training Institute Inc. (JSI) will provide technical inputs in the areas of strategic planning and donor/stakeholder coordination, supply/cold chain management, new born care, and immunization. The JSI will also facilitate linkages and alignment of project activities to the Government of India (GoI) policies by providing support at national level.

ORIGIN AND HISTORY

Uttar Pradesh is India's most populous state, with approximately 200 million people, and with weak health infrastructure and poor health outcomes. There is a tremendous opportunity to improve the state execution capacity to enhance the efficiency, effectiveness and equity in health and development. This is the basis upon which the Bill & Melinda Gates Foundation (the foundation) has collaborated to provide techno-managerial assistance to the Government of Uttar Pradesh (GoUP) and this proposed to set up a Technical Support Unit (TSU) to execute against the Memorandum of Cooperation (MoC) signed by the foundation and GoUP in December 2012. The Government of India (GoI) has launched a renewed campaign to improve RMNCH+A performance across India, and the GoUP has followed up the national launch with its own show of commitment through the state RMNCH+A effort.

VISION

To reduce the adverse health and development outcomes to families, mothers, new-borns and children by achieving high reach, coverage and quality of effective interventions and services for health (reproductive, maternal, neonatal and child health and nutrition in communities and at health facilities), agriculture and financial inclusion

MISSION

The mission of the TSU is to support the government, not to implement on its own. Building the capacity of the health system to execute according to its own mandate, with strong political, bureaucratic and administrative ownership

OBJECTIVES:

The key **objectives** of the project are to:

- Support the GoUP to improve the quality and quantity of FLW interactions at the community level and within households to drive the eight priority RMNCHN behaviors
- Support GoUP in improving its RMNCHN related primary care services at facilities.
- Support GoUP to improve strategies and systems required to deliver improved FLW capabilities and service delivery at primary care facilities
- Support the GoUP in improving its capacity to fund, contract, and regulate/ mandate private providers
- Support the GoUP in improving the scale and quality of community accountability mechanisms

CORE VALUES:

The four core values to address the major barriers like poor accountability, poor focus on outcomes, lack of skilful planning and poor policies are as follows:

1. Efforts to improve leadership and outcome-focus by ensuring bureaucratic ownership of innovations, strong political will under the foundation-GoUP MOU.
2. Strengthening of internal and external accountability mechanisms through developing strong coaching, mentoring and supervisory systems within NRHM and the Directorate of Health/Family Welfare in the GoUP and by creating concurrent monitoring systems using data, dashboards and feedback loops to effect mid-course corrections.
3. Improving the skills and capabilities for FLW and primary care performance by ensuring trainings are conducted with high quality by GoUP and the skills and practices are enhanced through appropriate supportive supervision mechanisms and use of

Information Communication Technology (ICT) based solutions to improve FLW and facility performance.

4. Improving policy, planning and coordination by improving private sector stewardship, funding and contracting processes (such as providers for family planning services, developing new incentive schemes and contracting more management capacity out to the private sector for issues like accreditation), supply chain and G2P (Government to person) payment improvements, select human resource and infrastructure improvements at the field level, better annual planning and fund flow mechanisms.

STRATEGIES

Six structural components which define the *modus operandi* of the TSU have been identified as follows:

1. Strengthen FLW skills/capabilities: Strengthen FLW skills/capabilities through supportive supervision and job-aids to improve quality and quantity of interactions in households, at VHNDs and facilities, to increase service access and improve the eight key behaviors around MNCH, nutrition, and FP.
2. Build skills/capabilities of providers at facilities: Improve availability of services and quality of care at first level facilities (e.g., block PHCs) and referral facilities by offering improved training and on-site skills building (e.g., nurse mentors and skills labs) combined with improved case sheets, checklists and workflow management tools.
3. Improve health system management capabilities to support efficient and effective execution to support the above two areas.
    - Ensure robust project planning and funds flow (e.g., PIP processes)
    - Establish appropriate roles and responsibilities for supportive supervision at the block, district and state levels

- Leverage ICT to improve data, dis-intermediation, demand and to drive performance efficiencies, especially among FLWs and facilities
- Create robust systems for data collection, analysis, and planning to improve management of the program (e.g., MCTS, HMIS)
- Create robust concurrent monitoring systems to validate data collection by the system and feedback information for immediate and mid-course correction
- Assist the government to execute existing incentive schemes at scale by improving data management, planning and streamlining payment systems

4. Support critical infrastructure improvements at the health system level in collaboration with other DPs: support select cross-cutting areas of the health system that act as critical bottlenecks to the first two areas listed above

- Improve supply chain and cold chain management to minimize stock out of essential drugs
- In our role as the state lead partner, ensure alignment with donor/partner efforts in the state; coordinate with other 'units' to catalyze the overall response especially around creating critical infrastructure (e.g. PHCs, FRUs) and HR (staff nurses, supervisors, etc.)

5. Improve the government's ability to be better stewards of the private sector, through better management and contracting approaches:

- Assist the government with devising and executing schemes and contracts to outsource select provision to the private sector (e.g., ORS/Zinc scheme to improve distribution, institutional deliveries, clinical services for FP, 'outsourced' management of FRU staff through 'mother NGOs')
- Assist with improving accreditation and payment systems to enable private providers to be paid by the government to increase coverage – e.g., contracting of agencies (such

as Public Private Interface Agencies) to oversee accreditation processes and to streamline their function.

- Explore potential options for a primary care pilot involving government and private providers under a capitation-based model
- Work with the World Bank, UNICEF and other partners to ensure harmonization of efforts with other public private partnership (PPP) efforts in the state

6. Enable accountability measures to provide feedback on quality of services, improve external accountability and hence drive program change.

- The NRHM construct includes an external accountability framework that includes social audits and involvement of democratic grass root institutions (Panchayati Raj Institutions) and grievance redressal mechanisms. While progress has been slow, senior politicians and bureaucrats are committed to this vision.
- We would support government to strengthen the functioning of existing government-mandated accountability structures such as Village Health and Sanitation Committees (VHSCs), RKS (Rogi Kalyan Samiti) and grievance redressal mechanisms, where beneficiaries can directly register/log their complaints. Our grants would provide state level technical assistance for the state government to contract NGOs to build VHSC capabilities as has been done in other states.

UTTAR PRADESH'S TECHNICAL SUPPORT UNIT –NUTRITION PROJECT

The overarching goal of this grant is to provide high quality, well-coordinated nutrition techno-managerial support to the government's ICDS and NHM programs in UP in order to reduce < 5 morbidity and mortality due to childhood malnutrition in Uttar Pradesh

GOALS OF THE PROJECT

GOAL 1: Increased ICDS capacity to service delivery quality MIYCN interventions – implementation related activities

- Support AWWs in tracking and listing their target population in their catchment areas.
- Develop and roll out job-aids and tools on MIYCN counseling for the FLWs (ASHAs, AWWs and ANMs).
- Strengthen the delivery of MIYCN related services in Village Health and Nutrition Days.
- Support strengthening of convergence among ASHAs, ANMs and AWWs by leveraging existing common Health and ICDS platforms such as VHNDs, AAA meetings and Cluster meetings.
- Support activation of existing ICDS schemes such as Sneha Shivir, Godh Bharai and Annaprashan in 25 HPD in UP according to GoI's operational guidelines and build their capacity to deliver MIYCN related counseling.
- Support the district and Block ICDS teams to provide supportive supervision to the FLWs.
- Support the implementation of Community based management of children with acute malnutrition (CMAM) in selected 5 districts (one in each TSU zone).

GOAL 2: Increased health system capacity to deliver quality MICYN interventions– planning related activities

- Gap analyses at two levels:

- Health Facility Assessment on MIYCN services in 25 HPDs. This will include all delivery points and NRCs.
- KAP study for the community frontline health workers on MIYCN will help in prioritizing the capacity building of the FLWs and the follow up actions.

- Support NHM in including in the PIP the strategies to bridge the gaps in facilities and community health workers

GOAL 3: Increased health system capacity to deliver quality MICYN interventions– implementation related activities (1/3)

- Support the GoUP in training all FLWs (ASHAs and ANMs) in MIYCN practices and counseling.
- Provide on-the-job training and supportive supervision to all FLWs on MIYCN counseling topics.
- Support the GoUP/NHM in establishing strong supervisory and monitoring mechanisms for MIYCN service delivery
- Support GoUP in training all facility staff (Nurse Mentors, Staff Nurses, ANMs and NRC personnel) at all delivery points in MIYCN practices and counseling
- Provide on-the-job training and supportive supervision to all facility staff at all delivery points on MIYCN counseling
- Support GoUP in establishing MIYCN counseling centres at Block level health facilities at all delivery points

Support the management of children with severe acute malnutrition (SAM)

GOAL 4: Increased use of MICYN data for strategic decision-making

- Consultation workshops with the ICDS FLWs and their immediate supervisors on the requirement of information in relation to their goals and objectives, the current challenges in the availability and use of such information and designing of tools and methods to make it easier for them in the collection and use of data for problem solving.
- Support the ISSNIP in the roll out of ICT-RTM in the 11 TSU districts which overlap with the ISSNIP districts.
- Designing and implementing denominator-based, relevant indicators within an information management system for the ICDS that would provide internal data on MIYCN service coverage, quality and utilization.
- Consultation workshops on improving the review mechanisms at the Block, district and state levels and designing and implementing guidelines on the same.
- Development and implementation of dashboards for ICDS, similar to the ones developed by the TSU for health department, to facilitate better performance management.
- Support the use of CBTS data, at the district level, to understand the current levels of coverage and utilization of MICYN services to effect any midcourse program corrections

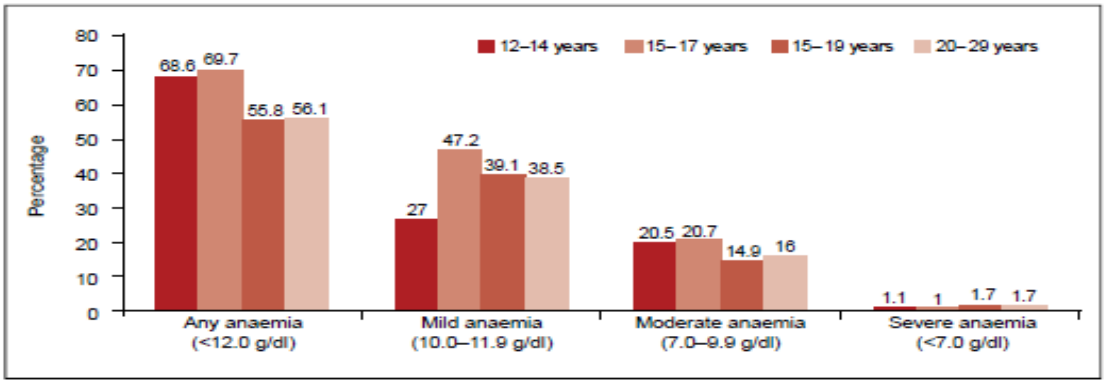
INTRODUCTION

(SECTION -1)

Background

Adolescence is a phase of transition from childhood to adulthood marked by physical and accompanying psychological changes[1]. There are 225 adolescents comprising nearly one- fifth (22 %) of India's total population (census 2001). Of the total adolescent population, 12 per cent belong to the 10- 14 years age group nearly 10 per cent are in the 15- 19 age group. Female adolescents comprises almost 47 % of total adolescent population. More than half of currently married illiterate females are married below the legal age of marriage. Nearly 20 % of 1.5 million girls married under the age of 15 are already mothers (census 2001) and adolescent mothers are at higher risk of miscarriages, maternal mortality and give birth to still born and underweight babies.[2] Adolescent health and nutrition status has an inter- generational effect. The health of an adolescent girl impacts pregnancy while the health of a pregnant woman impacts the health of the new born and the child. The mother's condition before pregnancy is a key determinant of its outcome; half of adolescents girls have below normal body mass index (BMI) and almost 56% of adolescent girls aged 15–19 years have anemia. Prevalence of Neonatal mortality is higher among adolescent mothers. 6 % of all mothers are adolescents and their pregnancy is high risk pregnancy and chances of dying are twice than women over the age of 20[3]. One of the study conducted in Jharkhand stated that adolescents in Jharkhand also face under-nutrition and anaemia, with nearly half of girls in the age group of 15-19 years mildly anaemic, 18 % moderately anaemic and 0.8 percent severely anaemic[4]. The prevalence of anaemia among girls (Hb <12 g %) is alarmingly high as per the reports of NFHS-3 and the National Nutrition Monitoring Bureau Survey. Over 55 per cent of adolescent girls are anaemic.

Fig. 2.2: Prevalence of anaemia among adolescent girls (12–19 years) and young women (20–29 years) in India[6,7]



Source: NFHS-3, 2005-06 and the National Nutrition Monitoring Bureau Survey (NNMBS), 2006

Percentage prevalence of anaemia among adolescent girls in the age group 15–19 years and in the older age group 20–29 years remains almost stagnant at 55.8 per cent and 56.1 per cent respectively.[5]

Psychological disorders such as depression and anxiety start becoming evident in early adolescence with the onset of puberty[6]. Near 27 % of married female adolescents have reported unmet need for contraception and over 35 % of all reported HIV infections in India occur among young people in the age group of 15- 21 years and majority of them are infected through unprotected sex. 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 number of maternal deaths, reducing sexually transmitted infections and reducing proportion of HIV positive cases in 10-19 year age group so overall this will help India in realizing its demographic bonus, as healthy adolescents are an important resource for the economy.[2]

The strategic approach to adolescent (10-19 years) health as part of the RMNCH+A consists of many community based initiatives implemented since February 2013 in India .These key strategies include Adolescent reproductive health and nutrition counselling by ASHAs & ANMs, Regular school health check-ups, community based services through peer educators and ARSH (Adolescent Reproductive and Sexual Health) clinics, WIFS (weekly iron folic acid supplementation) and Menstrual hygiene scheme, SABLA scheme[7]. VHND is a plateform for intersectoral convergance where health services to adolescent girls provided under all these schemes can be implemented at a single plateform and provided at a site very close to habitation of adolescents so that these services can be easily accessible for them and they can fully utilize these services. Front line workers play a significant role in making implementation of these services a success as these are the people who mobilize community to gather at the site and prepare plan to organize the session and also responsible for providing these services to the community and quality of FLWs skills is directly proportional to quality of health services provided to the community so skilful and knowledgeable front line can bring about dramatic changes in the way that people perceive health and health care practices.[8]

Problem statement

Health systems are most effective when health workers are skilled, motivated, and trained to provide high-quality services. Front line health workers knowledge is one of the crucial aspects of health system to improve the coverage of community based health care programmes and for better service delivery. Various studies has been conducted which had shown that health care practices are positively correlated with knowledge level of front line workers. One of the studies, conducted to assess knowledge of CHWs on essential newborn health care in rural India showed that percentage of coverage of service delivery as well as percentage of behaviour

change in mothers were higher in those villages where visits were done AWWs or ANMs who had better knowledge compared with those with poor knowledge.[9] Another study states the extension of maternal and newborn health care by trained health workers yields improved care provision and self-care behaviours and often contributes to better birth outcomes and reduced neonatal mortality. One study, for example, found that after the introduction of Essential Newborn Care training to community-based birth attendants, the rate of newborn death did not decrease in the week following implementation.[10] one of the study conducted in Chhattisgarh showed an alarming deficiencies in knowledge and performances of skill of the ANMs in relating to antenatal and intranatal care service delivery .[11] One baseline surveys done in Jharkhand showed that Frontline workers had limited knowledge and capacity, including counselling skills, related to the adolescent health issues of delaying age of marriage and anaemia and even during the baseline survey, less than a tenth of mothers and about half the community leaders interviewed were aware of VHNDs.[4] when Orissa government did a Pre post training knowledge assessment of FLWs under 1000 days training and post training follow up assessment which had showed baseline knowledge about key danger signs for women in the postpartum period and knowledge about all IYCF indicators and growth monitoring was low across all FLWs and at VHND counselling related to nutrition, health problems and hygiene was not giving to mothers and adolescents which was resulting in high percentage of anemia, and underweight child and still births and more chances of infection in adolescent girls so each and every study stated above shows that effectiveness of front line health workers performance depends upon their knowledge, attitude and practices.[12]

Rationale

There are no studies conducted in U.P which shows the knowledge and awareness level of FLWs on adolescent counselling at VHND site so there is a need for such study. Since VHND

is a most easily accessible plateform for adolescents to share their problems and gain knowledge about various health issues and different schemes which has been provided to the adolescents by the government so the knowledge and awareness level of front line workers needs to be assess on these topics to know whether they are capable of providing these services to the adolescents which is fundamental to holistic growth of an adolescent and an adequate knowledge level in front line workers will help an adolescent to face life challenges that pubescent girls go through in this phase and there counselling on various facets of life like health, nutrition, lifestyle related behaviour, menstrual hygiene and sexual transmitted infections alongside facilities to promote good health and nutrition can go a long way in easing their transition to womanhood.

LIETRATURE REVIEW

1. **Effect of knowledge of community health workers on essential newborn health care: a study from rural India**

   Praween K Agrawal, Sutapa Agrawal, Saifuddin Ahmed, Gary L Darmstadt, Emma K Williams, Heather E Rosen, Vishwajeet Kumar, Usha Kiran, Ramesh C Ahuja, Vinod K Srivastava, Mathuram Santosham, Robert E Black and Abdullah H Baqui

   This study explored the relationship between the knowledge of community health workers (CHWs)—anganwadi workers (AWWs) and auxiliary nurse midwives (ANMs)—and their antenatal home visit coverage and effectiveness of the visits, in terms of essential newborn health care practices at the household level in rural India. We used data from 302 AWWs and 86 ANMs and data from recently delivered women (RDW) (n¼13 023) who were residents of the CHW catchment areas and gave birth to a singleton live baby during 2004–05. On analysis results showed that Coverage of antenatal home visits and newborn care practices were positively correlated with the knowledge level of AWWs and ANMs. Initiation of breastfeeding in the first hour of life, clean cord care and thermal care were significantly higher among women visited by AWWs or ANMs who had better knowledge compared with those with poor knowledge. Thus CHWs' knowledge is one of the crucial aspects of health systems to improve the coverage of community-based newborn health care programmes as well as adherence to essential newborn care practices at the household level.[9]

2. **Delaying Age of Marriage and Reducing Anaemia Among Adolescent Girls in Jharkhand, Octobar 2012**

Adolescents in Jharkhand also face under-nutrition and anaemia, The Project, led by IntraHealth International, worked to support GOJH in taking knowledge to practice for improved adolescent health. Key findings of base line surveys was Parents and community elders were the primary decision-makers with respect to a girl's marriage. There was no single national or state government policy or plan in place to specifically address the issue of delaying age of marriage. GOJH did not have a Behaviour Change Communication (BCC) strategy or information education communication (IEC) materials on delaying marriage. Frontline workers had limited knowledge and capacity, including counselling skills, related to the adolescent health issues of delaying age of marriage and anaemia. A key obstacle to reducing adolescent anaemia was the lack of a clear plan and programme for distribution and monitoring of iron and folic acid (IFA) supplements to adolescents, either through schools, or for out-of-school adolescents. There were very few adolescent-friendly health services in the state. As a strategy trainings regarding counselling skills improvements in several areas as nutrition, gender related issues, legal age of marriage, the health consequences of early marriages and pregnancy, contraception, adolescent anaemia has been provided by project technical team, Adolescent friendly health clinics expansions, VHND strengthening and IFA supplementation in schools has been done by team. Key findings in end line survey showed lower incidence of early marriage, improvement in knowledge and attitude about age of marriage and girl's involvement in marriage decision, awareness of girls about family planning, birth spacing, healthy eating habits and preventive measures against anaemia so overall endline survey showed improvement in knowledge and attitude of FLW's results big change in health situation of adolescent girls.[4]

3. Enhancing the Ability of Frontline Health Workers to Improve Health in Nigeria

Principal investigator Salisu Mohammed Ishaku Senior Program Manager, Reproductive Health, Nigeria

Bauchi and Cross River states in Nigeria face particular challenges. Both states have poor infrastructure and lack the health workers necessary to provide high-quality health care. Training institutions in both states do not have functioning libraries and laboratory facilities, the nursing and midwifery schools have not been fully accredited because of substandard teaching conditions, and professional development opportunities for staff do not exist. Compounding these problems, the human resources for health (HRH) units in the federal and state ministries of health do not have adequate staff trained in human resources. Council researchers are undertaking and evaluating the activities in Bauchi and Cross River states: Reviewing and updating health worker training curricula at five schools of nursing/midwifery and two schools of health technology to meet Nigeria's official accreditation standards; Working with professional associations and state health administrations to develop and implement in-service training and continuing education programs for frontline health care workers; Providing technical assistance to state and federal ministries of health to conduct surveys and analyses of current HRH policies, and using findings to develop improved policies and strategic plans for human resources for health; and training key institutions to better deploy, manage, and retain health care workers. Findings will be shared with the ministries of health in Bauchi and Cross River states and at the federal level and will be used to improve Nigeria's HR policies and processes and the management of the health workforce.[13]

4. **To assess the knowledge and skill, about antenatal and intranatal care among paramedical workers posted in health center of tribal area of chhattisgarh.**

Rakesh nahrel, Hemlata Thakur, Meena armo, Sachin pandey

NHM seeks to provide effective health care to the entire rural population with special focus on 18 high focus state including Chhattisgarh. In this study all study subject posted in tribal area are trained under NRHM. An Objective of the study is Pre training evaluation of knowledge and skill of paramedical Workers about antenatal and intranatal care, To assess the impact of "Skill Birth Attendant" training on these PMW. A cross sectional hospital based study was conducted in medical college during "Skill birth attendent training" of para medical workers. The total 190 PMWs were assess for knowledge and skill, regarding antenatal and intranatal care. On the basis of analysis it was found that maximum number of participant are ANM (67.8%) and belongs to tribal area 153(79.6%), knowledge assessment of antenatal and intranatal care revealed that before training it was not satisfactory but their performance were improved after "SBA" training significant. The fact that, even the freshly trained PMW were found to be ill-equipped for this essential function which was indeed disturbing. We need to take a fresh look at their training. So ongoing continuous competency based in-service training program should compulsory for all level of paramedical worker.[11]

5. An evaluation of ASHA worker's awareness and practice of their responsibilities in rural Haryana

P K Garg, Anu Bhardwaj, Abhishek Singh, S. K. Ahluwalia

Present study was conducted to access the socio-demographic profile of ASHA workers and to assess the knowledge, awareness and practice of their responsibilities. The study was conducted in the rural field practice area of the department of community medicine, MMIMSR, Mullana. All 105 ASHA workers in the area were included in the study and were interviewed using a self-designed semi-structured questionnaire. Data was

analyzed using SPSS and valid conclusions were drawn. Majority of ASHA workers were aware about helping in immunization, accompanying clients for delivery, providing ANC and family planning services as a part of responsibility. Only 17-19% of ASHAs knew about registration of births and deaths, assisting Auxiliary Nurse Midwife (ANM) in village health planning, creating awareness on basic sanitation and personal hygiene. Outcome of this study is that ASHAs do provide constellation of services and play a potential role in providing primary health care but still they need to put into practice their knowledge about while providing services and/or advice to negotiate health care for poor women and children.[14]

6. Assessment of Services Rendered to Antenatal Women at Village Health and Nutrition Day in Rajkot District, Gujarat, India

Rakesh D Ninama, Mayur Vala, A. M. Kadri

A cross-sectional is done to find the gaps in service delivery at Village Health Nutrition Day. Study done by multi-stage sampling method in Rajkot district which is comprised of seven blocks and from each block two PHCs are randomly selected. So total 14 VHND were observed. Out of 14 VHND observed, 10 were organized at AWC, 2 at FHW,s home, 1 at primary school and 1 at panchayat office. The key staff Female health worker was present at 92% of VHNDs. Adult weighing scale, BP instrument, urine strip, pregnancy kit, Needle hub cutter, thermometer, all essential drugs required at VHND and Hemoglobin meter is available in working condition at all Mamta sessions. Need of weight measurement and TT immunization was not explained to any beneficiaries. Procedure coverage with proper technique and precautions with its proper entry in Mamta card and register is done for more than 90% of beneficiaries. . Iodized salt advice is given to none of the beneficiaries. Finding showed that all services are

which are to be noted down on register are provided completely but information regarding importance and advices are overall lacking and counselling part was very poor.[15]

7. Awareness, perception and practice of stakeholders in India regarding Village Health and Nutrition Day

Sandeep Kumar Panigrahi, Bijayeeni Mohapatra, Kaushik Mishra

Village Health and Nutrition Day (VHND) is a community-based health service package delivered on a fixed day approach. Services like early registration of pregnancy, regular antenatal care and postnatal care, growth monitoring and referral of sick children, discussion of health topics to generate awareness, and convergence between health and ICDS, are delivered every month at VHND at the Anganwadi Center. This study explores the awareness, perception and practice of service providers, and beneficiaries, regarding VHND. It was a cross-sectional study conducted in Odisha during December 2009-November 2010. Personal interviews were conducted at the VHND sessions with 111 beneficiaries and 45 service providers using a semi-structured schedule to know their awareness, perception and practice regarding VHND sessions. Data analysis was done and reported as simple percentages. Most of the health worker females and anganwadi workers considered health awareness as a key component of VHND. 52% of HWFs and 41% of AWWs had misconception about additional roles and responsibilities. 34% of beneficiaries had knowledge regarding fixed day approach of VHND, while 24% did not have knowledge regarding any of its purpose. Only 8% of referral cases had complete knowledge on the reason of referral. There was significant difference in between awareness and practice among the blocks. Service providers' orientation should be improved. Behaviour change communication activities

should also be increased by the state. Referral cases should be properly counselled. The community believed that such a program should continue with better package and quality of services.[16]

RESEARCH QUESTION AND OBJECTIVES

(SECTION-3)

RESEARCH QUESTION:

What is a knowledge level of ASHA, AWW and ANM about adolescent counselling given by them?

RESEARCH OBJECTIVES:

- To assess knowledge level of ASHA, AWW and ANM on different topics of adolescent counselling.
- To develop a scoring scale for knowledge assessment

METHODOLOGY

(SECTION-4)

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STUDY TYPE: Descriptive cross sectional study

STUDY DURATION: February 2016 to April 2016

STUDY AREA: This study was conducted in 2 blocks Ujjhani and Jagat of Badaun district of Uttar Pradesh. It is proposed to conduct the study in the assigned districts to the researcher.

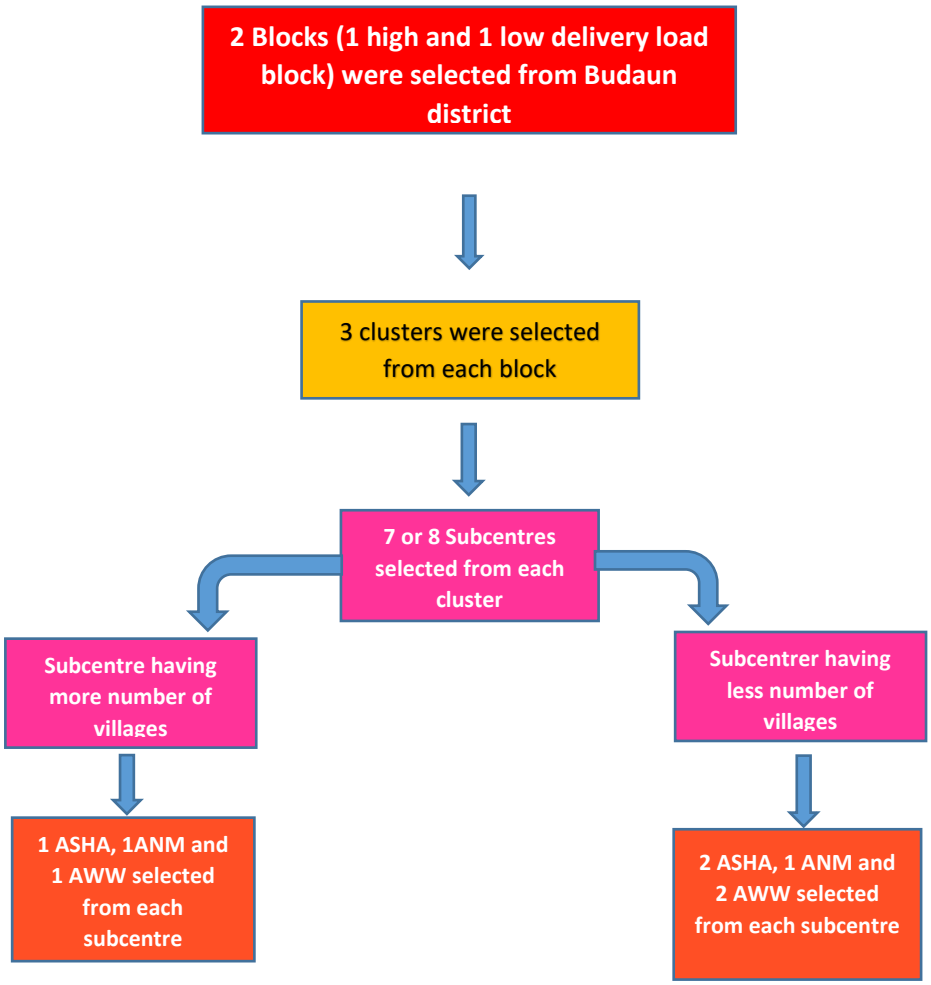
SAMPLING PROCEDURE:

Two blocks were selected in Badaun district out of which one is high delivery load block known as Ujjhani and second one is of low delivery load block known as Jagat and both were selected through convenient sampling. From each block, 3 clusters were selected which are made by organization itself on the basis of total number of subcentres in a block as in Ujjhani there are 21 subcentres which were divided in 3 clusters i.e. each cluster has 7 subcentre then one ASHA, one AWW and one ANM is selected from each each subcentre and those subcentres which has comparatively more number of villages from those subcentres two ASHA and AWW were selected in place of one.

STUDY RESPONDENTS: ASHAs, AWWs and ANMs

SAMPLE SIZE: Sample size is 164 which was selected through convenient sampling.

Steps of Sample collection



TOOLS AND TECHNIQUES

Data collection tool- An Interview schedule was used to collect the data. The data collection formats was adapted from RMNCH+A guidelines and NHM website for assessment of adolescent counselling.

Data analysis tool- Excel and SPSS softwares were used for data analysis. Descriptive statistics (Mean, Frequency, Percentage), One sample t-test and chi square test were used to analyse the data.

Limitations;

- Recall bias may occur

DATA ANALYSIS

(SECTION-6)

Indicators Used to collect data of adolescent counselling to assess knowledge level of ASHA, AWW and ANM are;

- IFA and Albendazole distribution- About benefits of taking IFA and Albendazole and harms of nonconsumption, dosage, recognition of Anemia, reasons and symptoms of worm manifestation
- Menstrual hygiene- About Importance of knowledge about hygiene, how to maintain it, use of napkins etc
- An appropriate age of marriage
- Counselling of HIV/ STD related infectious diseases- About reasons of HIV/STD, ways to prevent, need of giving information
- ARSH clinic- About Importance of ARSH clinic, services provided by it etc
- Physical and mental changes during adolescent age- What are the changes, need of giving information, what type of nutrition in this age

For each satisfactory answer score 1 was given which was coded as △ and for each unsatisfactory answer a score of 0 was given which was coded as □

DATA ANALYSIS AND INTERPRETATION

a. Analysis regarding demographic information and knowledge score mean

Demographic Information	Frequency	Percent	Mean value of Knowledge score
1. Age			
- Below 30	**- 53**	**- 32.7**	**- 22.09**
- Above 30	**- 109**	**- 67.2**	**- 22.85**
2. Designation			
- ASHA	**- 60**	**- 37.03**	**- 21.27**
- AWW	**- 60**	**- 37.03**	**- 22.77**
- ANM	**- 42**	**- 25.92**	**- 24.29**
- Total	**- 162**	**- 100**	**- 22.6**
3. Education level			
- Matriculation	**- 64**	**39.5**	**21.38**
- Intermediate	**- 29**	**- 17.9**	**- 21.59**
- Graduate and above	**- 69**	**- 42.6**	**- 24.17**
4. Last training period			
- 2000- 2014	**- 62**	**- 38.3**	**- 21.85**
- 2015	**- 44**	**- 27.2**	**- 21.7**
- 2016	**- 55**	**- 33.9**	**- 24.22**

Interpretation: The tool had a total of 33 questions with 6 different topics "adolescent counselling". For each right answer the score allotted was 1. Higher score on any topic would indicate a higher level of knowledge on that particular topic. An analysis was done to see if there are differences in knowledge level across different demographic groups. While analysing the data across two age categories ie. Below and above 30 years of age, it was found that the there is no noticeable difference in their knowledge level regarding adolescent counselling both having mean of 22.09 and 22.85. While analysing data as per designation of FLWs it was found that ASHAs (21.27) and AWWs (22.27) were comparatively less knowledgeable then ANMs (24.29),While analysing data across education level categories it was found that those who were graduates had a noticeably higher knowledge level as compared to those who were who were educated upto intermediate level. It was also found that those who were recently trained (in 2016) were having higher knowledge level (24.22) regarding adolescent counselling as compare to those who were trained either in 2015 (21.70) or before (21.85).

Finding: finding shows that ANM, graduates and recently trained in 2016 has higher level of knowledge as compare to other FLWs, those who were intermediates or below educated, trained before 2016.

b. Percentage of Knowledge score in surveyed sample

Knowledge level	Frequency	Total	Percent
Low (1 to 10 satisfactory answers out of 33)	2	162	1.2
Moderate (11- 18 satisfactory answers out of 33)	6	162	3.7
High (19- 33 satisfactory answers out of 33)	156	162	95.1

Interpretation: The whole sample was categorized into 3 categories Based on the scores achieved. Given the maximum score of 33, the three categories were created based on the given criteria viz. a viz. those who had scores in between 1 to 10 were categorized as having a low knowledge level, those who scored between 11 to 18 were categorized as having a moderate level of knowledge and those who scored above 19 were put in high knowledge category. The sample had maximum respondents falling in the high knowledge level category (95.1%) followed by moderate level (3.7%) and low level (1.2%) category.

Findings: Based on the above analysis it was found that the overall knowledge level of the surveyed sample is satisfactory based on the criteria used for creating different categories.

c. Knowledge assessment of ASHA, AWW and ANM about each and every topic

Knowledge level on topic	Satisfactory answers	ASHA	AWW	ANM
Knowledge of topic 1	Number of satisfactory answers	711	763	560
	Out of	900	900	630
	%	79	84.7	88.8
Knowledge of topic 2	Number of satisfactory answers	230	241	166
	Out of	360	360	252
	%	63.8	66.9	65.8
Knowledge of topic 3	Number of satisfactory answers	119	119	84
	Out of	120	120	84
	%	99.1	99.1	100
Knowledge of topic 4	Number of satisfactory answers	36	63	81
	Out of	180	180	126
	%	20	35	64.2
Knowledge of topic 5	Number of satisfactory answers	0	1	3
	Out of	300	300	210
	%	0	0.3	1.4

Knowledge of topic 6	**Number of satisfactory answers**	180	179	126
	Out of	180	180	126
	%	100	99.4	100
Overall Knowledge of topic	**Number of satisfactory answers**	1046	1125	854
	Out of	2040	2040	1428
	%	51.27	55.14	59.8

Interpretation: the knowledge level of FLWs (ANM, AWW and ASHA) was assessed across six specific topics. The data suggested that they have different level of knowledge for different topics of adolescent counselling. The most remarkable difference was for the fourth topic (counselling for HIV/ STD related infectious diseases). FLWs showed a little bit of difference on the topics "IFA and Albendazole distribution" (ASHA= 79 %, ANM= 88.8% and AWW= 84.7) and "Menstrual hygiene" (ASHA= 63.8%, ANM= 65.8% and AWW= 66.9%). There was no noticiable difference of knowledge level on the topics topic "An appropriate age of marriage" (ASHA= 99.1%, ANM= 100% and AWW= 99.1%) and topic "Physical and Mental changes during adolescent age" (ASHA= 100%, ANM= 100 % and AWW= 99.4 %)

Findings: Knowledge on topic 5th is considerably low, there is a markable difference in level of knowledge on topic 4 and level of knowledge on topic 3 and 6 is quite satisfactory as compare to others while knowledge on topic 1 and 2 is noticeably difference.

c. **Knowledge assessment of FLW on each subtopic of all topics of adolescent counselling**

To Assess the knowledge level of FLWs on adolescent counselling at VHND				
s.no	**Topics and subtopics**	**Frequency of satisfactory answer**	**Total**	**% of satisfactory aanswers**
1	**IFA and Albendazole distribution**			
A	Benefits of giving IFA to adolescent	161	162	99.4
B	losses of nonconsumption of IFA in adolescent	161	162	99.4
C	Benefits of giving IFA to adolescent pregnant	161	162	99.4
D	losses of nonconsumption of IFA in adolescent pregnant	161	162	99.4
E	Sympotms of anemia in adolescents	159	162	98.1
F	Of which colour Fe tablet should be distributed to adolescent?	38	162	23.5
G	Of which colour Fe tablet should be distributed to Adolescent who is pregnant?	162	162	100
H	What is dose of Fe tablet for an adolescent girl?	32	162	19.8

I	What is dose of Fe tablet for an adolescent girl who is pregnant?	159	162	98.1
J	What is dose of Fe tablet for an adolescent girl who is an anaemic?	151	162	93.2
K	Tablet should be taken before or after meal?	157	162	96.9
L	Benefits of giving Albendazole to adolescent	156	162	96.3
M	Reasons of worm infestation in adolescent girls	137	162	84.6
N	symptoms of worm infestation in adolescent girls	143	162	88.3
O	How many times albendazole is distributed to adolescent girls	96	162	59.3
2	**Menstrual hygiene**			
a.	importance of giving menstrual hygiene related information to adolescen girls	162	162	100

b.	what information should be given to adolescent girls related to mestrual hygiene	162	162	100
c.	"Use of sanitary napkin is better than a cloth", why?	150	162	92.6
d.	correct Way to use sanitary napkin	160	162	98.8
e.	How many sanitary napkins are distributed to adolescent girls at VHND session in one month	2	162	1.2
f.	Are these sanitary napkins chargable if yes then what are the selling prices?	1	162	0.6
3	**An appropriate age of marriage**			
a.	What is an appropriate age for an adolescent girl?	162	162	100
b.	What can be the difficulties she will face in future due to early marriage?	160	162	98.8
4	**Counselling for H.I.V/STD related infectious diseases**			
a.	Main reason for H.I.V/ S.T.D	70	162	43.2

b.	Need for giving an information regarding these infectious diseases	38	162	23.5
c.	ways to prevent infection from these diseases	72	162	44.4
5	**ARSH Clinic**			
a.	Do you know or ever heard about ARSH clinic /Kishori paraamarsh Kendra	2	162	1.2
b.	What is an Importance of ARSH clinic?	0	162	0
c.	What are services provided by an ARSH Clinic?	1	162	0.6
d.	What are the topics undertaken during counselling?	1	162	0.6
e.	What is a schedule or timings of ARSH clinic	0	162	0
6	**Physical and Mental changes during adolescent age**			
a.	What are the phyisical and mental changes happen during adolescence?	162	162	100

b.	Need of giving information to adolescent girls regarding phyisical and mental changes happen during adolescence?	161	162	99.4
c.	What information should be given to adolescent girls regarding nutrition?	162	162	100

Interpretation: while exploring the individual topics to identify where the respondents had performed very poorly, there were 12 sub-topics where the responses were below satisfactory. For 2 sub-topics of topic "IFA and Albendazole distribution" (1f= 23.5 and 1h= 19.8) and "Menstrual hygiene" (2e= 1.2 and 2f= 0.6) all subtopics of topics "Counselling for H.I.V/STD related infectious diseases" and "ARSH Clinic" were below 50%

Findings: FLWs had least knowledge on topic 4 it may be due to social stigma and also in sub topics f and h as there was no training regarding blue IFA tablets of topic 1 and sub topics e and f of topic 2 respectively as no training on distribution of sanitary pad at VHND all by MOIC.

CONCLUSION:

It was found that the overall knowledge was satisfactory although the data reveals a noticeable gap between the recently trained in 2016 and trained before 2015 it shows that retention of knowledge level was comparatively low. It was also found in study that knowledge level on topic of sexual infectious diseases is comparatively low as compare to other topics the reason might be social stigma Main lack of knowledge was found in areas where there was unavailability of stocks as blue Fe tablets for adolescents, Unavailability of sanitary pads and there is no ARSH clinic infrastructure.

RECOMMENDATION:

- Unavailability of stocks should not be a ceiteria of training but training should be provided on each and every topic as per the guidelines of VHND.
- Advocacy for establishment of ARSH clinic is needed.
- IEC and BCC can be a medium to create awareness about HIV/ STDs like infectious diseases so it can be accepted by the community and it can be a part of VHND counselling then discussion of this knowledge at VHND may help in retention of this topic knowledge.

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For Research Purpose only

Survey ID: .....

INFORMED CONCEPT FORM

मेरा नाम रचना शर्मा है और मैं भारतीय संस्थान (IIHMR), से स्वास्थ्य प्रबंधन रिसर्च कर रही हूँ ! मैं किशोरियों को VHND सत्र पर दिए जाने वाले परामर्श के विषय में फ्रंट लाइन वर्कर्स का ज्ञान स्तर जानने हेतु रिसर्च कर रही हूँ, जिसे मैं उत्तर प्रदेश के बदायूं जिले में कर रही हूँ व् मैं इंडिया हेल्थ एक्शन ट्रस्ट की एक कंसलटेंट हूँ व् बदायूं में डी. ऐन. एस के पद पर नियुक्त हूँ और IHAT के सहयोग के लिए आभारी हूँ !इस अनुसंधान के भाग के रूप में हम आपका किशोरियों को VHND सत्र पर दिए जाने वाले परामर्श के विषय में ज्ञान स्तर जानने हेतु 10 मिनट के लिए साक्षात्कार करेंगे !इस साक्षात्कार में आपकी व्यक्तिगत जानकारी को एकदम गुप्त रखा जाएगा और इस अध्ययन में भाग लेने पर आपको किसी प्रकार की हानि नहीं होगी ! आप किसी भी समय साक्षात्कार रोक सकते हैं या किसी भी सवाल का जवाब देने के लिए मना कर सकते हैं ! इस अध्ययन में भाग लेने से आपका कोई सीधा लाभ नहीं होगा लेकिन इस जानकारी को स्थानीय अधिकारियों को दिया जाएगा जो किशोरियों के स्वास्थ्य सम्बन्धी सेवाएं उपलब्ध कराने के लिए जिम्मेदार हैं !

यदि अनुसंधान में आपको कोई समस्या या कोई प्रश्न हो तो आप मुझे ८४३९२१६१८२ इस नंबर पर संपर्क कर सकते हैं !

क्या आप इस अनुसंधान में भाग लेने के लिए तैयार हैं ?

1. नहीं ☐ (प्रतिवादी को उनके समय के लिए धन्यवाद दें और छोड़ दें !)
2. हाँ ☐ (हस्ताक्षरित सहमति लें और सर्वेक्षण को आगे बढ़ाएं !)

मैं प्रतिवादी फॉर्म को सही ढंग से समझ गई हूँ और अध्ययन में भाग लेने के लिए स्वेच्छा से सहमत हूँ !

प्रतिवादी के हस्ताक्षर :

प्रतिवादी का नाम : दिनांक.....

(अनपढ/ अलग ढंग से विकलांग के मामले में हस्ताक्षर एक गैर मामूली गवाह से प्राप्त किया जाना चाहिए)

साक्षी के हस्ताक्षर :

गवाह का नाम : दिनांक :.....

Section – A: Personal Information

प्रतिवादी का नाम : .....

उम्र : .....

पद : .....

शिक्षा स्तर : .....

कार्यकाल : .....

ब्लॉक का नाम : .....

क्लस्टर का नाम : .....

स्वास्थ्य केंद्र का नाम : .....

गाँव : .....

गाँव की आबादी : .....

अंतिम बार प्रशिक्षण की अवधि : .....

फ्रंट लाइन वर्कर्स का वी.एच.इन.डी सत्र पर किशोरियों को दिए जाने वाले परामर्श सम्बन्धी ज्ञान स्तर जानने हेतु अनुसूची

1. आयरन व फॉलिक एसिड एवं एल्बेंडाजोल सम्पूरण	a. किशोरियों को आयरन एवं फॉलिक एसिड देने से उन्हें क्या लाभ होगा ? • खून की कमी नहीं होती • अन्य	
	• Remark	
	b. किशोरियों के आयरन एवं फॉलिक एसिड न ग्रहण करने से उन्हें क्या नुक्सान है ? • एनीमिया/ खून की कमी होने का खतरा • शरीर में कमजोरी कोने के कारण एकाग्रता की कमी अतः पढ़ाई-लिखाई का भी नुक्सान होता है • अन्य	
	• Remark	
	c. किशोर गर्भवतियों को आयरन एवं फॉलिक एसिड देने से क्या लाभ होगा ? • खून की कमी नहीं होती • अन्य	
	• Remark	
	d. किशोर गर्भवतियों के आयरन एवं फॉलिक एसिड न ग्रहण करने से उन्हें क्या नुक्सान है ? • एनीमिया/ खून की कमी होने का खतरा • बच्चे के जन्म के दौरान माँ और बच्चे दोनों को खतरा हो सकता है जैसे समय से पहले बच्चे का जन्म या माँ और बच्चे दोनों की जान को खतरा भी हो सकता है • अन्य	

	• Remark	
	e. किशोरियों में खून की कमी होने के क्या लक्षण हैं ? • शरीर में कमजोरी व् थकावट • नाखूनों व् हथेलियों में पीलापन • मासिक धर्म का अनियमित हो जाना • आँखों में सफेदी • अन्य	
	• Remark	
	f. किशोरियों को किस रंग की आयरन की गोली देनी चाहिए ? • नीली	
	• Remark	
	g. किशोर गर्भवतियों को किस रंग की आयरन की गोली देनी चाहिए ? • लाल	
	• Remark	
	h. किशोरियों को आयरन की गोली कितनी बार खानी चाहिए ? • हफ्ते में एक बार (45 mg)	
	• Remark	
	i. किशोर गर्भवतियों को आयरन की गोली कितनी बार खानी चाहिए ? • पहले त्रिमास के बाद से दिन में एक बार (100 mg)	
	• Remark	
	j. एनीमिक किशोरियों एवं किशोर गर्भवतियों को आयरन की गोली कितनी बार खानी चाहिए ?	

	• दिन में दो बार (200 mg)	
	• Remark	
	k. किशोरियों को आयरन की गोली खाने से पहले खानी चाहिए या बाद में खानी चाहिए ? • गोली खाने के बाद ही खानी चाहिए (स्कूलों में किशोरियों को आइरन की गोली मिड- डे मील के बाद दी जाती है)	
	• Remark	
	l. एल्बेंडाजोल किशोरियों को किसलिए दी जाती है ? • ये दवाई पेट के कीड़ों से मुक्ति के लिए दी जाती है	
	• Remark	
	m. पेट में कीड़े होने के क्या कारण होते हैं ? • खाने से पहले अच्छे से हाथ ना धोने से • शौच में नंगे पैर जाने से • अपने आस पास गंदगी रखने से • गन्दी व् संक्रमित जगह पर रहने से • अन्य	
	• Remark	
	n. पेट में कीड़े होने से क्या परेशानियां होती हैं ? • यदि पेट में कीड़े होते हैं तो भूख नहीं लगती, पेट में दर्द रहता है, वजन कम होने लगता है, एनीमिया/ खून की कमी व् शारीरिक व् मानसिक वृद्धि ठीक से नहीं होती साथ आँतों में परजीवी संक्रमण का भी खतरा होता • अन्य	
	• Remark	

	o. किशोरियों को एल्बेंडाजोल की गोली कितनी बार बाँटी जाती है ? • साल में दो बार गोली (400 mg) खानी चाहिए,6 माह के अंतराल में	
	• Remark	
2. मासिक धर्म स्वच्छता	a. किशोरियों को मासिक धर्म की स्वछता की जानकारी देना क्यों जरुरी हैं ? • यदि इन दिनों साफ़- सफाई का ध्यान न रखा जाए तो इन्फेक्शन (RTI/ UTI)होने का खतरा होता है • अन्य	
	• Remark	
	b. किशोरियों को मासिक धर्म की स्वछता के विषय में क्या जानकारी देना जरुरी हैं ? • इन दिनों सेनेटरी नैपकिन का प्रयोग करना चाहिए • यदि नैपकिन उपलब्ध न हो तो स्वच्छ व् धुप में सुखे कपडे का प्रयोग करना चाहिए • नैपकिन अथवा कपडे को प्रयोग के बाद उसका उचित निष्कासन करना चाहिए • शौच के बाद साबुन से अच्छे से रगड़कर हाथों को धोना चाहिए • अन्य	
	• Remark	
	c. सेनेटरी नैपकिन का उपयोग कपड़े के उपयोग से अधिक उचित क्यों हैं ? • नैपकिन की सोखने की क्षमता कपड़े से कहीं अधिक् होती है • कपड़े प्रयोग करने से इन्फेक्शन की सम्भावना अधिक होती है • नैपकिन का उपयोग करना कपड़े से आसान होता है • अन्य	
	• Remark	

	d. सेनेटरी नैपकिन का सही उपयोग किस प्रकार किया जाता हैं ?	
	• Remark	
	e. किशोरियों को वी.एच.इन.डी सत्र पर एक माह में कितने सेनेटरी नैपकिन दिए जाते हैं ? • 6 सेनेटरी नैपकिन का एक पैकेट हर माह दिया जाता है	
	• Remark	
	f. सेनेटरी नैपकिन किशोरियों को सत्र पर मुफ्त दिए जाते हैं या इनका कुछ मूल्य भी लिया जाता हैं, अगर हाँ तो कितना मूल्य लिया जाता हैं ? • 6 रुपय का एक पैकेट हर माह दिया जाता है	
	• Remark	
3. विवाह की सही उम्र	a. लड़की के विवाह की उचित उम्र क्या हैं ? • 18 साल	
	• Remark	
	b. उचित उम्र से पहले किशोरी का विवाह होने पर किशारी को क्या परेशानियां हो सकती हैं ? • किशोरावस्था में किशोरी गर्भवती हो जाती है व् शारीरिक व् मानसिक रूप से इस जिम्मेदारी के लिए अक्सर तैयार नहीं होती • विवाह के बाद स्कूल जाना बंद हो जाता है जिस कारण किशोरी का व्यक्तिगत रूप से भी विकास नहीं हो पाता • किशोरी एक वयस्क स्त्री से ज्यादा संवेदनशील एवं नाजुक होती है जिस कारण उसके घरेलु हिंसा का शिकार होने की कहीं अधिक सम्भावना होती है • अन्य	

	• Remark	
4. एच. आई. वी / यौन सम्बन्धी संक्रामक रोगों हेतु परामर्श	a. एच. आई. वी / यौन सम्बन्धी रोगों के संक्रमण का प्रमुख कारण क्या है ? • असुरक्षित यौन सम्बन्ध इन रोगों के संक्रमण का प्रमख कारण हैं • अन्य	
	• Remark	
	b. इन रोगों के संक्रमण को रोकने की जानकारी किशोरियों को देना क्यों आवश्यक हैं ? • पुरुष में यदि रोग है तो उससे संक्रमण से बचने के लिए • अन्य	
	• Remark	
	c. इन रोगों का संक्रमण किस प्रकार रोका जा सकता हैं ? • सुरक्षित यौन सम्बन्ध द्वारा इन रोगों को फैलने से रोक जा सकता है जिसके लिए कंडोम्स, सर्वाइकल कैप अथवा डायफ्राम का प्रयोग करना चाहिए • अन्य	
	• Remark	
5. ए.आर.एस.एच. क्लीनिक (ARSH क्लीनिक)	a. क्या आप किशोरी परामर्श केंद्र के बारे में जानते हैं ? • हाँ • नहीं • अन्य	
	• Remark	

	b. ARSH क्लीनिक का क्या महत्त्व है ? • इस क्लीनिक पर किशोरियों को विभिन्न सेवायें प्रदान की जाती हैं साथ ही उन्हें कई महत्वपूर्ण विषयों पर परामर्श दिए जाते हैं एवं जो परेशानियां एक किशोरी अपने घर में नहीं बता पाती वे भी वहाँ बता पाती है और उनको परेशानियों को दूर करने के उपाय भी जान सकती है • अन्य	
	• Remark	
	c. ARSH क्लीनिक पर कौन कौन सी सेवायें प्रदान की जाती हैं ? • क्लीनिक पर एल्बेंडाजोल, आयरन व् फॉलिक एसिड, सेनेटरी नैपकिन, कॉन्ट्रासेप्टिव्स एवं टी. टी इंजेक्शन आदि सेवाएं प्रदान की जाती हैं साथ ही यहाँ पर किशोरियों में होने वाले अति कुपोषण, यौन सम्बन्धी रोगों,असंक्रामक रोगों एवं घरेलु हिंसा आदि में लगने वाली चोटों आदि का उपचार व् इनसे सम्बंधित परामर्श भी दिए जाते हैं • अन्य	
	• Remark	
	d. ARSH क्लीनिक पर किन- किन विषयों पर परामर्श दिया जाता है ? • किशोरावस्था के दौरान होने वाले शारीरिक व मानसिक परिवर्तन • विवाह की सही उम्र की जानकारी • मासिक धर्म के समय में साफ़ सफाई का ध्यान रखने की जानकारी • आयरन व फॉलिक एसिड एवं एल्बेंडाजोल को लेने के फायदे एवं नुक्सान • अन्य	
	• Remark	
	e. ARSH क्लीनिक खुलने का दिन एवं समय क्या है ?	

	• ARSH क्लीनिक हर ब्लॉक की PHC पर हर हफ्ते 8 बजे से 2 बजे तक खुलता है • CHC में क्लीनिक हर रोज़ 2 बजे से सांय 4 बजे तक 2 hr के लिए खुलता है • जिला अस्पताल में क्लीनिक हर रोज़ 2 बजे से सांय 4 बजे तक 2 hr के लिए खुलता है • Medical college में क्लीनिक हर रोज़ 9 बजे से सांय 4 बजे तक खुलता है • अन्य	
	• Remark	
6. किशोरावस्था के दौरान होने वाले शारीरिक व मानसिक परिवर्तन	a. किशोरावस्था के दौरान होने वाले शारीरिक व मानसिक परिवर्तन कौन-कौन से होते हैं ? • मासिक धर्म का शुरू हो जाना • स्तनों का आकर बड़ा हो जाना • अन्य	
	• Remark	
	b. किशोरियों को इस उम्र में होने वाले शारीरिक एवं मानसिक परिवर्तनों के बारे में जानकारी देना क्यों आवश्यक है ? • किशोरावस्था में होने वाले शारीरिक एवं मानसिक परिवर्तनों के बारे में जानकारी होने पर किशोरी मानसिक रूप से इन परिवर्तनों के लिए तैयार रहती हैं व महावरी सम्बन्धी प्रचलित सभी भ्रांतियों से दूर रहती है साथ ही उसके आत्मविश्वास में वृद्धि होती है • अन्य	
	• Remark	
	c. किशोरावस्था के दौरान किशोरियों को पोषण के विषय में क्या जानकारी दी जाती है ? • किशोरियों को हो रहे शारीरिक व् मानसिक विकास के लिए प्रचुर मात्र में हरी सब्जियां और फल खाने के लिए कहा जाता है ताकि	

	उनमें खून की कमी नहीं हो ! मेथी, पलक, बथुआ इत्यादि आयरन से भरपूर होते हैं • कुछ फल जैसे संतरा, मोसम्बी आदि में विटामिन सी की प्रचुर मात्र होती है जो आयरन के अवशोषण में मदद करते हैं • खाने के आधे घंटे पहले या बाद में चाय/ कॉफी नहीं लेना चाहिए क्योंकि ये आयरन अवशोषण में अवरोध पैदा करते हैं • गेहूं, दालें, दूध व् दूध, से बने खाद्य पदार्थों में प्रचुर मात्रा में प्रोटीन होता है जो शारीरिक वृद्धि में सहायक होता हैं • अन्य	
	• Remark	