Summary

Investment in adolescent reproductive and sexual health yields dividends in many important ways. The Ministry of Health and Family Welfare, under the Reproductive and Child Health-II project, has included the adolescent reproductive and sexual health strategy to take care of the emerging needs and demands of adolescents. The present case study highlights the successful interventions carried out by the Society for Women and Children’s Health, a national NGO, in partnership with the State government in Yamuna Nagar District of Haryana, India.

Prominent deficiencies existed such as a lack of provisions for privacy and confidentiality in the health centres and hospitals, no special clinic or fixed hours for adolescents, and inadequate information about the adolescents in the available records. The modules developed by the Government of India were used for the training of staff, and the health personnel in the district were trained through three-to-five-day training courses. Peer-group educators were selected according to the criteria developed and were trained in how to address queries by using the “frequently-asked-questions” approach.

Youth melas (youth fairs/festivals) were organized during a period of one year and were attended by adolescents and youths as well as some elders and opinion makers. The youth
Summary (continued)

festivals offered an opportunity to specifically address sexual and reproductive health needs. The organization of these festivals was part of the implementation strategy to help to create awareness of adolescents’ issues.

It was observed that over a period of nine months, a total of 2,851 adolescents (927 males and 1,924 females) visited the general outpatient departments and 283 cases were recorded as referral cases.

Evaluation consisted of household surveys and quality assessments of health facilities based on standards set by the Government. A household coverage survey on 1,200 adolescents in 60 village clusters (30 control and 30 intervention clusters) was carried out, which demonstrated impressive improvements in the intervention villages. Remarkable improvements were demonstrated in the knowledge and use of adolescent-friendly health services and the utilization of public health services and better coverage in the iron deficiency anaemia prevention package, the purchase of sanitary napkins for menstrual hygiene, better access to contraception, knowledge of sexually transmitted infections (STIs) and the use of condoms.

Quality assessment was carried out in 12 health facilities (10 sub-centres and 2 primary health centres) each in the control villages and intervention villages where the adolescent-friendly health centres were established. The scores for different standards varied between 44 and 94 per cent in adolescent-friendly health and counselling service facilities in comparison to 1 to 59 per cent in the control facilities.

Information on the Authors

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BACKGROUND

TARGET POPULATION

Haryana is one of the wealthiest States of North India. According to the 1991 Census of India, three quarters of Haryana live in rural areas. Thirty-seven per cent of the population is below 15 years of age (according to the 2005-06 National Family Health Survey). Eighty-nine per cent of children ages 6 to 14 attend school. The disparity in school attendance by sex grows with increasing age. For example, between 6 and 10 years of age, 93 per cent of boys attend school compared with 90 per cent of girls, and between 15 and 17 years of age, 68 per cent of boys attend school compared with 50 per cent of the girls. Forty-seven per cent of females have some degree of anaemia, 31 per cent are mildly anaemic and 15 per cent are moderately anaemic, the prevalence being higher for rural women. A considerable proportion of females in Haryana still marry before reaching the legal minimum age of 18 years. Twenty-three per cent of women 15 to 19 years old are already married and the proportion for married females is higher in rural areas. More than two out of five women in Haryana did not receive an antenatal check-up for births in the three years preceding the 2005-06 National Family Health Survey. Sixty-three per cent of women from rural areas are aware of all modern methods of family planning (contraception, birth control and spacing) compared to 79 per cent of their urban counterparts.

ORIGIN OF THE PROJECT

The adolescent reproductive and sexual health strategy was implemented as per the National Policy Guidelines by the Government of India in the nine selected districts in Haryana, including Yamuna Nagar.

PROBLEMS IDENTIFIED RELATING TO ADOLESCENT REPRODUCTIVE AND SEXUAL HEALTH

Findings of a Mapping Exercise

A mapping exercise to assess the services provided for adolescents revealed that more than 90 per cent of all the health facilities were far below the standards as recommended in the Implementation Guide of the Government. Some of the prominent deficiencies noted in the provision of adolescent-friendly health services were as follows:

- the providers were not trained in the adolescent-friendly health services package;
- supplies such as iron and folic acid tablets and contraceptives were available (although supplies were erratic) but were not provided to adolescents;
- there were no provisions to maintain privacy or confidentiality in the health centres and hospitals;
- no special clinic or fixed hours for adolescents were observed;
- the available records contained inadequate information on adolescents (the records only identified disease symptoms) and this information was neither analysed nor
reported. Sometimes even the age of the adolescents was not recorded;

- there was very low use by the adolescents of public health services relating to reproductive and sexual health issues;

- the girls who were not going to school demonstrated a high prevalence of anaemia and low coverage of tetanus toxoid; and

- there was a lack of knowledge among service providers of the key issues relating to physical, psycho-social, and reproductive and sexual health.

**Findings of Formative Research**

Formative research revealed the following:

- the attendance rate of adolescents in government health facilities was only 5 to 10 per cent;

- when sick, 64 per cent of girls and 52 per cent of boys reported to village doctors (mostly unqualified) for treatment;

- about 70 per cent of the boys and 45 per cent of the girls were not aware of the physical changes in their body;

- the main sources of information about sexual health were media (television) and friends;

- the main stressors for adolescents were financial problems, fights among parents, tension about studies and relationships;

- prominent health concerns included pain during menstruation (girls), pimples (boys and girls) and physical illnesses;

- 88 per cent of adolescent girls were using home-made pads during menstruation;

- information on sexual activity, especially premarital sex, was difficult to obtain but those who stated that they had had sexual activity did not adopt safe sexual practices;

- a survey of adolescents who were and who were not attending school showed a very high prevalence rate of anaemia; and

- the coverage with tetanus toxoid was 96 per cent in girls attending school and only 44 per cent in girls not attending school.

The mapping exercise and the findings of formative research provided the benchmark information on the gaps and helped to identify specific areas needing intervention and improvement. In order to address these deficiencies, the decision was taken to adopt a multi-pronged strategy in line with the guidelines of the adolescent reproductive and sexual health strategy by the Government of India, as outlined below.

A State Programme Implementation Programme (PIP)\(^1\) was prepared that included the important components relating to planning the adolescent and sexual reproductive health strategy for the State of Haryana. The case study presented was implemented in the selected community health centres/primary health centres/sub-centres in Yamuna Nagar.

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\(^1\) PIP is the standard title used by the States for developing future implementation programmes relating to health.
District in Haryana in 2008-2009. The operational area was selected in consultation with the Chief Medical Officer and District Nodal Officer, Haryana.

**Intervention Area**

District: Yamuna Nagar
Population: 100,000 (estimated)
Villages: 88
Primary health centres: Kot, Kharwan, Kalanaur and Burhia
Community health centres: Khizrabad and Naharpur
Sub-centres: 17

**Objectives of the Intervention**

The objectives of the intervention were to:

- improve the reproductive health and well-being of youths and adolescents in the selected districts through a multisectoral and integrated approach,
- strengthen the ability of youths and adolescents to delay marriage and make informed decisions about reproductive health matters, especially among girls, and
- increase the access of married and unmarried adolescents to modern family-planning and reproductive-health information and services.

**Strategy Formulation**

A comprehensive package (box 1) of adolescent-friendly reproductive and sexual
health services was planned as per the recommendations by the Ministry of Health and Family Welfare.

**PARTNERSHIP WITH NON-GOVERNMENTAL ORGANIZATIONS**

The implementation of the strategy was undertaken by adopting the partnership approach in which six mother non-governmental organizations (NGOs) were selected to work with the Government. The role of the NGOs was primarily community mobilization and training of health providers and other stakeholders including the peer-group educators in the districts selected. The Society for Women and Children’s Health implemented the innovative adolescent reproductive and sexual health strategy in Yamuna Nagar, Haryana.

### Box 1  The innovative adolescent reproductive and sexual health strategy at a glance (continued).

<table>
<thead>
<tr>
<th>Capacity-building</th>
<th>Health-care providers.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication with</td>
<td>Peer-group educators;</td>
</tr>
<tr>
<td>adolescents through</td>
<td>Addressing adolescents</td>
</tr>
<tr>
<td>convergence</td>
<td>attending and not</td>
</tr>
<tr>
<td></td>
<td>attending school;</td>
</tr>
<tr>
<td></td>
<td>Letter-box approach;</td>
</tr>
<tr>
<td></td>
<td>Frequently-asked-</td>
</tr>
<tr>
<td></td>
<td>questions (FAQs)</td>
</tr>
<tr>
<td></td>
<td>approach.</td>
</tr>
</tbody>
</table>

| Environment-building      | Establishing adolescent|
|                          | action groups;         |
|                           | Community involvement; |
|                           | Youth festival/cultural|
|                           | show/competitions/debates| |
|                           | on key issues.          |

| Monitoring and            | Household Survey;      |
| evaluation               | Quality assessment of   |
|                          | adolescent-friendly    |
|                          | health services as per |
|                          | the seven standards     |
|                          | recommended by the      |
|                          | Government of India.    |

### Innovations: Description of Activities

Adolescent-friendly health clinics were selected and established at the sub-centre/primary health centre/community health centre level and at the district level based on the criteria contained in the standards recommended by the Government. The innovative strategy consisted of the following activities carried out simultaneously.

### Organizing Effective Services

The following were ensured:

- adequate service providers in place;
- a Notice Board outside the centre in a prominent position;
- posters displaying the services offered and visible to the clients;
• adequate waiting space and reasonable cleanliness;
• availability of the specified supplies, equipment and basic amenities such as clean water and a clean toilet facility; and
• reasonable privacy and confidentiality.

Conducive Environment

A conducive environment was created through the following:

• designated staff were present, and punctuality and regularity were ensured;
• registration was required for all adolescents;
• privacy and confidentiality were ensured;
• a special clinic day and time were established as decided by the community; and
• reading material was displayed on relevant issues.

Service Delivery Package

As part of promotive care, focused antenatal care was provided to all adolescent pregnant mothers. Counselling information, advice on and the supply of contraceptives, sexual and reproductive health issues and the common concerns of the adolescents (both boys and girls) were addressed. Service for toxoid, iron and folic acid tablets and counselling for nutritional anaemia were provided. Wherever required, the adolescents were referred to a primary health centre/community health centre for treatment of common reproductive-tract infections/sexually transmitted infections and for voluntary counselling and testing for HIV/AIDS.

Two types of outreach services were added: periodic health check-ups under the school health programme and community camps, and information about the health services provided by the peer educators.

During the period under review, 13 such clinics were established at various levels. The peer-group educators and health workers at the village level ensured that the demand for health services by the adolescents was created. Clients availing themselves of services were also contacted to assess their satisfaction level. Over a period of 10 months (June 2008-March 2009), a total of 1,676 cases attended the adolescent-friendly health and counselling services (544 male and 1,132 female) and 1,175 cases (383 male and 792 female) in the General Outpatient Department (total number of cases = 2,851). During this period, 283 referred cases were addressed. The attendance of females outnumbered that of males more than twofold. One major reason for this was the reluctance of the male adolescents to be seen by a female provider. Another reason for the higher number of consultations by females related to menstrual problems. The types of problems addressed are summarized in table 1.
CAPACITY-BUILDING OF THE ADOLESCENT-FRIENDLY HEALTH-CARE PROVIDERS

Health-care providers form the backbone of the health system and many of them could be tapped and designated to become providers of adolescent-friendly health services in the community. They include the doctors, auxiliary nurse midwives, anganwadi workers, peer-group educators and teachers. Capacity-building of these health-care providers was undertaken by providing training. The purpose of the training was to orient the health-care providers with respect to the adolescent-friendly health and counselling services so that they would become a pull factor in attracting the adolescents and encourage them to avail themselves of the health-care services. The training also focused on how to improve the quality of services rendered.

The following criteria were set for the selection of adolescent health-care providers:

- has been trained in adolescent-friendly health services (has participated in the full training package);

Table 1 | Types of problems addressed in health facilities (General Outpatient Department and Adolescent-friendly Health and Counselling Services).

<table>
<thead>
<tr>
<th>Serial No.</th>
<th>Problem</th>
<th>Male No. (%)</th>
<th>Female No. (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Menstrual problem</td>
<td>-</td>
<td>404 (21.0)</td>
</tr>
<tr>
<td>2.</td>
<td>White discharge</td>
<td>8 (0.9)</td>
<td>173 (9.0)</td>
</tr>
<tr>
<td>3.</td>
<td>Itching in and around genital area</td>
<td>66 (7.1)</td>
<td>76 (3.9)</td>
</tr>
<tr>
<td>4.</td>
<td>Lower abdominal pain</td>
<td>15 (1.6)</td>
<td>138 (7.2)</td>
</tr>
<tr>
<td>5.</td>
<td>Facial blemishes</td>
<td>8 (9.2)</td>
<td>174 (9.0)</td>
</tr>
<tr>
<td>6.</td>
<td>Burning micturition</td>
<td>71 (1.6)</td>
<td>100 (5.2)</td>
</tr>
<tr>
<td>7.</td>
<td>Weakness</td>
<td>133 (14.3)</td>
<td>185 (9.6)</td>
</tr>
<tr>
<td>8.</td>
<td>Diarrhoea</td>
<td>51 (5.5)</td>
<td>66 (3.4)</td>
</tr>
<tr>
<td>9.</td>
<td>Boils on the skin</td>
<td>68 (7.3)</td>
<td>104 (5.4)</td>
</tr>
<tr>
<td>10.</td>
<td>Acute respiratory illness (ARI)</td>
<td>110 (11.9)</td>
<td>136 (7.1)</td>
</tr>
<tr>
<td>11.</td>
<td>Fever</td>
<td>149 (16.1)</td>
<td>163 (8.5)</td>
</tr>
<tr>
<td>12.</td>
<td>Abdominal pain</td>
<td>80 (8.6)</td>
<td>103 (5.3)</td>
</tr>
<tr>
<td>13.</td>
<td>Mouth ulcer</td>
<td>91 (9.8)</td>
<td>102 (5.3)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>927</strong></td>
<td><strong>1,924</strong></td>
</tr>
</tbody>
</table>
keeps and uses the training material given to him/her;
- is functional in sharing information, maintains records and provides data;
- participates in meetings and provides feedback;
- promotes adolescent-friendly health services; refers adolescents to adolescent-friendly health service facilities regularly and follows them up; and
- participates in promotional activities for adolescents, i.e., anaemia prevention and control, tetanus prevention, menstrual hygiene, family planning and prevention of sexually transmitted infections and HIV/AIDS.

The training was carried out using the training package developed by the Ministry of Health and Family Welfare. A five-day State-level training programme on adolescent reproductive and sexual health was undertaken by the Society for Women and Children’s Health in collaboration with the State government. This was followed by training of trainers comprising medical officers/dental surgeons/counsellors in collaboration with the district trainers for a period of three days in 2008. These trainers in turn trained the lady health visitors/auxiliary nurse midwives/anganwadi workers in the district through five days of training. The details of the training sessions organized in Yamuna Nagar are given in table 2.

<table>
<thead>
<tr>
<th>Serial No.</th>
<th>Category of Trainer</th>
<th>No. of Trainees</th>
<th>Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Medical Officer</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>2.</td>
<td>School Medical Officer/Medical Officer</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>3.</td>
<td>Dental Surgeon</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>4.</td>
<td>Counsellor</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5.</td>
<td>Lady Health Visitor/ Auxiliary Nurse Midwife</td>
<td>40</td>
<td>5</td>
</tr>
<tr>
<td>6.</td>
<td>Anganwadi Worker</td>
<td>20</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>75</strong></td>
<td></td>
</tr>
</tbody>
</table>

**Table 2** | Capacity development in adolescent reproductive and sexual health (total number of training courses: 3).

**COMMUNICATION WITH THE ADOLESCENTS: PEER-GROUP EDUCATORS**

Adolescents/young people prefer to discuss sensitive issues with their peers. Keeping this in mind, the peer-group educators were selected to serve the school children/out-of-school adolescents in the community to deal with issues of a sensitive nature, to participate in selected
public health efforts (distribution of iron and folic acid tablets, tetanus toxoid, contraceptives, clean pads) and to increase use of adolescent-friendly health service centres. The criteria used for the selection of peer-group educators were as follows: is a good communicator, is acceptable to adolescents, is interested in work, is able to understand the problems of adolescents, has a good personality, and is confident and ready to work on a voluntary basis.

A total of 200 peer-group educators (100 males and 100 females) were selected from 88 villages and training was provided once a month by the Society for Women and Children’s Health. Details of topics covered in the various rounds/phases of training and participants are summarized in Table 3.

### Table 3 | Topics covered and participants in the training of peer-group educators.

<table>
<thead>
<tr>
<th>Rounds/Phases</th>
<th>Topic Covered</th>
<th>PGE (M)</th>
<th>PGE (F)</th>
<th>Total PGEs</th>
<th>ASHA</th>
<th>AWW</th>
<th>ANM</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Selection Round</td>
<td>100</td>
<td>100</td>
<td>200</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>2. Body Image</td>
<td>88</td>
<td>92</td>
<td>180</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>3. Nutrition and Anaemia</td>
<td>86</td>
<td>86</td>
<td>172</td>
<td>41</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>4. Health Problems</td>
<td>90</td>
<td>97</td>
<td>187</td>
<td>39</td>
<td>2</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>5. Menstrual Problem</td>
<td>88</td>
<td>95</td>
<td>183</td>
<td>50</td>
<td>4</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>6. Friendship, Love and Marriage</td>
<td>87</td>
<td>88</td>
<td>175</td>
<td>54</td>
<td>20</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>7. Psychological Issues</td>
<td>92</td>
<td>86</td>
<td>178</td>
<td>53</td>
<td>10</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>8. RTI, STI and HIV/AIDS</td>
<td>83</td>
<td>90</td>
<td>173</td>
<td>47</td>
<td>23</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>9. STI, Sexual Health, HIV/AIDS</td>
<td>69</td>
<td>74</td>
<td>143</td>
<td>48</td>
<td>16</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>10. Accidents</td>
<td>54</td>
<td>65</td>
<td>119</td>
<td>32</td>
<td>7</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>11. Adolescent Pregnancy and Abortion</td>
<td>53</td>
<td>59</td>
<td>112</td>
<td>36</td>
<td>9</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>12. RTI/STI/ Safe Sex</td>
<td>40</td>
<td>64</td>
<td>104</td>
<td>26</td>
<td>11</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>13. Education, Employment and Work Plan</td>
<td>21</td>
<td>22</td>
<td>43</td>
<td>13</td>
<td>06</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

**Number of Participants**

**Addressing the Adolescents**

**Attending and Not Attending School**

A sizeable proportion of adolescent girls and boys (about 35 per cent) were not attending school; therefore, school-based interventions were not expected to cover them. Keeping this in mind, peer-group educators were trained to raise awareness of the youths and peers to enhance the demand for services for the out-of-school adolescents.

**Letter-box Approach**

To encourage conversation on the issues and concerns of the adolescents and
maintain confidentiality, letter boxes were set up in selected schools and in selected villages. The adolescents were briefed that they could put the question, issue or any problem relating to health in the box without identifying themselves but that they should mention the class. A similar strategy was used for out-of-school adolescents by the peer-group educators. The letter boxes were opened once in a week and the answers were provided by project staff and subsequently by teachers and thereafter by the peer-group educators. It was observed that initially the questions asked were not related to reproductive or sexual health concerns but as a result of friendly discussion with the peer-group educators, more questions and concerns relating to sexual and reproductive health were gradually expressed to the project staff.

**Frequently-asked-questions Approach**

More than 10,000 questions were received. Based on these, a total of 105 most-frequently-asked questions and their responses were consolidated in the form of a simple book in English and in Hindi as a resource and material for training of selected peer-group educators. The training was participatory and the focus was on hands-on practice and on improving communication and counselling skills. It focused mainly on being able to provide accurate and adequate knowledge to the adolescents. It was stressed that wherever it was felt that the knowledge provided was inadequate or the adolescent did not appear convinced and/or there was a need for medical intervention, the peer-group educators should immediately refer such adolescents to the Medical Officer or the auxiliary nurse midwife.

During the monthly interactions, the peer-group educators were trained in how to fill out the Record Form. The follow-up of their work was done by reviewing the Record Form filled out by the peer-group educators and their ability to solve the adolescents’ problems. An assessment of the work done was undertaken regularly by a community coordinator/counsellor in collaboration with health workers.

The peer-group educators were not remunerated for their work although they received 100 rupees as motivation to attend meetings and to cover the expenses that they incurred on travel to the place of training as well as expenses. All the key health-care providers and peer-group educators were given an identity card that helped the adolescents to identify them as adolescent-friendly health-care providers.

In the beginning, most adolescents approached the peer-group educators for their general health problems. These were addressed by referral and by taking the ill adolescents to local village doctors or auxiliary nurse midwives. After about six months, the trend had changed and the concerns reported were more psychosocial or reproductive and sexual in nature. This showed that the peer-group educators were able to increase the awareness of and demand for services. Besides the provision of accurate information, the
increase in demand for services was also attributable to the following: availability of trained and motivated providers who were adolescent-friendly; provision of services and supplies to adolescents; and the organization of a dedicated clinic on a fixed day and time of the week. The increased referral of about 271 adolescents by providers, volunteers and peer-group educators was an impressive contribution towards creating a demand in a population for availing the health facilities for reproductive and sexual health issues. It is important to emphasize here that the adolescents were reluctant to use these services before the intervention.

**Environment-building through Community Involvement of Adolescent Action Groups**

Involvement of community is essential to the sustainability of any intervention. The decision was taken to identify interested persons from the community (villages) and obtain their agreement to become adolescent-friendly providers. Therefore, community-based voluntary groups were established in 12 villages. They were called “adolescent action groups”. The adolescent action group was formed as a voluntary group of 9 to 13 members comprising care providers and care recipients in the villages. The care providers included the auxiliary nurse midwives, *anganwadi* workers, accredited social health activists and school teachers. The care recipients included Mahila Panch (women’s group), peer-group educators (male and female) and teachers.

The idea was to bring convergence to the health and development of adolescents. An agreement was made to meet once in a month on a voluntary basis and participate in the activities that improve adolescent health and development.

**Planning**

A handout written in simple Hindi relating to the above-mentioned subjects was distributed. The plan identified a SMART objective to be achieved and included details of what, why, by whom, when and where. A detailed plan for implementation during the next one month was chalked out, which listed the roles and responsibilities of each member. A copy of the written plan was left with the peer-group educator or a member chosen by the group members for ease of reference and follow-up meetings. The programme of meetings also included the agenda to review the previous month, with identification of achievements and gaps.

From the beginning of the project, eight meetings were held for each action group and were attended by more than 77 per cent of the group members. In order to provide recognition to the action groups, efforts were made to take up the adolescent sexual and reproductive health issues with the village health and sanitation committee. The experience showed that these health and sanitation committees had not been constituted or were not functional. Therefore, the adolescent action group served as the starting point for the functioning of such a committee.
The subjects covered in the meetings of adolescent action groups included: prevention and control of anaemia; menstrual problems and menstrual hygiene; adolescent pregnancy and unsafe abortion; and prevention of reproductive tract infections, sexually transmitted infections and HIV/AIDS among the adolescents and young people.

The adolescent action group succeeded in bringing about convergence in the services, an improved understanding among the providers of services and a supportive community attitude towards the goals and objectives of the adolescent health and development programme. It helped to remove any doubts and misgivings concerning the sensitive nature of the issues to be addressed in the community and it was enthusiastic in providing cooperation in supporting different aspects of the implementation of various adolescent reproductive and sexual health activities in the village. The adolescent action group took the initiative to establish intersectoral convergence wherever it did not exist and strengthen existing linkages wherever they were already in place.

**Organization of Youth Melas (Youth Fairs/Festivals)**

Youth melas (youth fairs/festivals) were organized as per the State programme Implementation Plan as a partnership between district health authorities and the Society for Women and Children’s Health. During the one-year implementation period, six such fairs were organized, with the objective of mobilizing the adolescents and youths in the community. The intent was to increase the awareness of and enhance the demand for services. The attendance at the youth festivals was as follows: 550 persons at Kot, 573 at Kharwan, 601 at Khizrabad, 327 at Primary Health Centre Bhurian, 356 at Naharpur and 486 at Kalanaur.

The activities were comprised of debate competitions, poster competitions and slogan competitions on topics relating to adolescent and other issues of concern such as: the right age for marriage, sexually transmitted infections, HIV/AIDS, substance abuse, alcohol and tobacco addiction, female foeticide and education of the girl child, short height, the dowry, climate change and nutrition. Cultural shows were also organized during the youth festivals that dealt with prominent issues relating to adolescent health by organizing role plays, street plays and folk dances.

**Important Outcomes of Peer-group Educators**

During the monthly interactions with peer-group educators and other village-based health workers, the adolescents seen in Yamuna Nagar District were reviewed by the staff of the Society for Women and Children’s Health. Male peer-group educators reported having addressed 13,193 problems and concerns of the male adolescents. The female peer-group educators reported having addressed 20,653 problems and concerns of female adolescents. Accredited social health activists reported having handled 3,317 concerns, i.e., 9.8 per cent of the
total cases. The types and numbers of problems and concerns addressed by peer-group educators and health workers are summarized in table 4.

### Table 4 | Types and numbers of problems and concerns addressed by peer-group educators.

<table>
<thead>
<tr>
<th>Serial No.</th>
<th>Type</th>
<th>Male No. (%)</th>
<th>Female No. (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Body image</td>
<td>6,308 (47.8)</td>
<td>9,535 (46.2)</td>
</tr>
<tr>
<td>2.</td>
<td>Food and eating habits</td>
<td>249 (1.9)</td>
<td>333 (1.6)</td>
</tr>
<tr>
<td>3.</td>
<td>Health-related concern</td>
<td>4,645 (35.2)</td>
<td>6,002 (29.1)</td>
</tr>
<tr>
<td>4.</td>
<td>Substance abuse and its consequences</td>
<td>157 (1.2)</td>
<td>26 (0.1)</td>
</tr>
<tr>
<td>5.</td>
<td>Problem relating to menstrualation</td>
<td>-</td>
<td>2,915 (14.1)</td>
</tr>
<tr>
<td>6.</td>
<td>Sexually transmitted infection, HIV/ AIDS and sexual health</td>
<td>604 (4.6)</td>
<td>492 (2.4)</td>
</tr>
<tr>
<td>7.</td>
<td>Friendship, love and marriage</td>
<td>56 (0.4)</td>
<td>67 (0.3)</td>
</tr>
<tr>
<td>8.</td>
<td>Psychological and emotional problems</td>
<td>973 (7.4)</td>
<td>1,148 (5.6)</td>
</tr>
<tr>
<td>9.</td>
<td>Economic problem</td>
<td>201 (1.5)</td>
<td>135 (0.6)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>13,193 (100.0)</strong></td>
<td><strong>20,653 (100.0)</strong></td>
</tr>
</tbody>
</table>

**Assessment and Evaluation**

**Monitoring Mechanism**

Monitoring was undertaken by using the reporting formats provided by the State government on a regular basis. Each volunteer, worker and doctor was contacted at least once a month. This provided an opportunity to review the progress of the work, identify problems and decide about the possible solutions.

**Evaluation Mechanisms**

Two types of evaluation were conducted to identify the impact of the interventions: the household survey and the quality assessment of the adolescent-friendly health services.

### Evaluative Results of the Household Survey

The evaluation of the impact of adolescent reproductive and sexual health innovations was undertaken with the help of a household survey conducted in Yamuna Nagar 10 months after the implementation of the project. The tool for this survey included a questionnaire, which was developed by the Society for Women and Children’s Health, with technical and financial support from the World
Health Organization Headquarters. The household survey was carried out in two areas of the Yamuna Nagar District, Haryana. One area represented the implementation site of the adolescent reproductive and sexual health interventions and the other a control area where the interventions had not been implemented. In both areas, 30 village clusters each with a total of 600 adolescents were covered. After thorough training of the surveyors, the survey was carried out in November 2008 in a two-week period during which 1,193 adolescents were interviewed.

The findings of the household survey on various indicators are as follows:

**Coverage of adolescent-friendly health services**

- The awareness of adolescent-friendly health services in the intervention area (68 per cent) was more than eight times that in the control area (8 per cent).
- The use of government health facilities was 55 per cent in the intervention area compared to 36 per cent in the control villages. Among the government health facilities visited, the sub-centre topped the list, followed by the community health centre and the district hospital.
- The supply of contraceptive services to unmarried adolescents was denied to a majority both in the control as well as in the intervention area.
- A higher proportion of adolescents in the intervention area (83 per cent) understood the explanations about the health problems compared to 42 per cent in the control area.
- Only 39 per cent of adolescents in the control area reported the availability of medicines while this figure was 80 per cent in the intervention area. Furthermore, a large proportion of adolescents visited private providers (qualified and unqualified) in the control area.

**Coverage for the prevention and control of anaemia**

- Awareness of anaemia and understanding about it were substantially higher (82.6 per cent) in the intervention area than in the control area (49.4 per cent). In the intervention area, almost all the adolescents were aware of the role of iron and folic acid tablets and a good diet in the prevention and control of anaemia.

According to adolescents, the availability of iron and folic acid tablets is greater in the intervention area (94 per cent) than in the control area (73 per cent). About 89 per cent of the adolescents received the deworming tablet free of cost in the intervention area while only 52 per cent received the same in the control area.

**Coverage in the use of sanitary pads**

- Sanitary pads were used by 56.3 per cent in the intervention group in comparison to only 29.6 per
cent in the control villages. Local peer-group educators and volunteers were popular providers in the intervention villages.

- In both areas, the reasons for not using the sanitary napkins were:
  - too embarrassed to obtain the pads;
  - lack of knowledge about their availability;
  - too expensive; and
  - did not perceive any problems with current practice of using home-made pads.

Coverage of sexually transmitted infections, HIV/AIDS and contraceptives

- Although more than 85 per cent of adolescents in both areas were aware of HIV/AIDS, the knowledge of sexually transmitted infections was substantially higher in the intervention villages (73 per cent) compared to the control villages (27 per cent). The main source of information was the peer-group educator in the intervention area. The knowledge of the role of the condom in preventing HIV/AIDS was 20 percentage points higher in the intervention area compared to the control area. The knowledge about contraceptive availability was higher in the intervention villages (90 per cent) compared to the control villages (64 per cent).

The findings of the household survey showed the positive effect of the implementation of the adolescent-friendly health services strategy in the District. It also provided a benchmark for the control area. The survey showed a very low proportion of married adolescents and an extremely low proportion of pregnant adolescents. The fact that awareness of adolescent-friendly health services was high in the intervention area was attributed mainly to the influence of peer groups and locally available health services from health-care providers.

Evaluative Results from Quality Assessment

Quality assessment was done based on the seven standards of adolescent-friendly health services set out in the Adolescent Reproductive and Sexual Health Implementation Guide of the Ministry of Health and Family Welfare about 15 months after establishing adolescent-friendly health services. These are summarized below. A comprehensive tool was developed for assessment of the standards of adolescent-friendly health services covering all seven standards recommended in the Implementation Guide by the Government of India. The tool provided information on the general performance of the provision of health services at the sub-centre and primary health-centre levels as well as information on the quality of adolescent-friendly health services.

The objectives of the quality assessment of adolescent-friendly health services were to:

- assess the current status of the quality of care delivered under
adolescent-friendly health services at selected health facilities in Haryana;

• determine the availability of key types of health system support required for implementation of the adolescent-friendly health services;

• identify the principal barriers to effective implementation of adolescent-friendly health services; and

• compare the quality of health-care services provided to adolescents in the identified adolescent-friendly health service facilities and non-adolescent-friendly health service facilities.

Seven standards set by the Government of India were used for the quality assessment of adolescent-friendly health services:

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

2. Health facilities deliver effective services to adolescents.

3. Adolescents find the environment at health facilities conducive to seeking treatment.

4. Service providers are sensitive to adolescent needs and are motivated to work with them.

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

6. Adolescents are well informed about the health services.

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

The key findings of the quality assessment of the performance of facilities where adolescent reproductive and sexual health services were implemented for about one year showed substantial achievement in all the standards set for the quality of care of services for adolescents as compared to facilities where the programme had not been introduced. Noticeable differences were observed in the implementation of all seven standards (graph 1). The majority of the adolescent-
friendly health service facilities scored above 50 per cent and as high as 94 per cent, whereas all non-adolescent-friendly health service facilities scored below the average and as low as 1 per cent.

As stated earlier, the success of the adolescent reproductive and sexual health strategy in the District of Haryana has been attributed to implementation of all seven standards set for the quality of care of services for the adolescents. The differences in the attainment of standards by adolescent-friendly and non-adolescent-friendly health services are summarized in box 2.

### Box 2 Differences in the attainment of standards by adolescent-friendly and non-adolescent-friendly health facilities.

<table>
<thead>
<tr>
<th>Key Indicator</th>
<th>Survey Result</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Standard 1: Health facilities provide the specific package of health services that adolescents need.</strong></td>
<td></td>
</tr>
<tr>
<td>Dedicated adolescent-friendly health service clinics</td>
<td>Nine out of ten centres were organizing adolescent-friendly health services for a period of at least 2 hours per week.</td>
</tr>
<tr>
<td>Referral services</td>
<td>Referral services and procedures were in place in 60% of the health facilities in the intervention area and were found to be functional.</td>
</tr>
</tbody>
</table>
Box 2 | Differences in the attainment of standards by adolescent-friendly and non-adolescent-friendly health facilities (continued).

<table>
<thead>
<tr>
<th>Key Indicator</th>
<th>Survey Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outreach services</td>
<td>Health services and health-education activities were being organized as outreach services in 69% of the intervention-area facilities while some health-related activities were reported in 27% of the control-area facilities.</td>
</tr>
<tr>
<td>Equitable services</td>
<td>Services to the adolescents were reported to be equitable (i.e., they were provided irrespective of age, sex or social status) in 77% of the health facilities in the intervention areas as compared to 44% in the control areas.</td>
</tr>
</tbody>
</table>

**Standard 2: Health facilities deliver effective services to adolescents.**

<table>
<thead>
<tr>
<th>Key Indicator</th>
<th>Survey Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff adequacy and training relating to adolescent-friendly health services</td>
<td>More than 60% of the staff in the intervention villages considered themselves competent and skilled to manage the problems of adolescents while this proportion was only 25% in the control villages. The reason for this lower percentage is that only some of the staff members in the control villages had received some training that related to adolescent health.</td>
</tr>
<tr>
<td>Drugs and supplies</td>
<td>Drugs and supplies were available to the adolescents in a higher proportion (81%) in the intervention areas compared to only 54% in the facilities where the programme was not implemented. Some staff members in the intervention areas agreed to give iron and folic acid tablets to adolescents and condoms by making condoms accessible without embarrassing the staff or the adolescents.</td>
</tr>
<tr>
<td>Waiting time and medical consultation</td>
<td>According to the perception of the 120 adolescents interviewed, the waiting time and the time spent during consultation were satisfactory and acceptable to more than 90% in both the control and intervention groups.</td>
</tr>
</tbody>
</table>

**Standard 3: Adolescents find the environment at health facilities conducive to seeking treatment.**

<table>
<thead>
<tr>
<th>Key Indicator</th>
<th>Survey Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic amenities and conveniences of adolescent clients</td>
<td>Basic amenities as assessed by the adolescents were considered satisfactory by 85% of the adolescents interviewed in the intervention area while the comparable proportion was 32% in the control area.</td>
</tr>
</tbody>
</table>
Box 2 | Differences in the attainment of standards by adolescent-friendly and non-adolescent-friendly health facilities (continued).

<table>
<thead>
<tr>
<th>Key Indicator</th>
<th>Survey Result</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Provision of privacy and confidentiality</strong></td>
<td>Adolescents were satisfied about the privacy and confidentiality during consultation with health-care providers (8 to 9 out of 10 adolescents) in the intervention area as compared to three out of 10 in the control area.</td>
</tr>
<tr>
<td><strong>Standard 4: Service providers are sensitive to adolescent needs and are motivated to work with them.</strong></td>
<td>The interpersonal skills of providers were used to demonstrate supportive and non-judgmental care in 88% of the instances in the intervention area compared to only 38% in the control area.</td>
</tr>
<tr>
<td><strong>Standard 5: An enabling environment exists in the community for adolescents to seek services.</strong></td>
<td>Communication materials relating to adolescent reproductive and sexual health were available and distributed to 80% of stakeholders in the intervention villages and none in the control areas. Linkages with 70% of stakeholders in the community were established in the intervention villages and with only 40% in the control villages. Mass media and folk media were playing a minimal role in the control as well as the intervention villages.</td>
</tr>
<tr>
<td><strong>Standard 6: Adolescents are well informed about the health services.</strong></td>
<td>There was no evidence of awareness-generating activities in the control area. In the intervention area, awareness was being created through anganwadi workers, accredited social health activists, peer-group educators and other outreach mechanisms.</td>
</tr>
<tr>
<td><strong>Standard 7: Management systems are in place to improve/sustain the quality of health services.</strong></td>
<td>Records for adolescents were maintained in all facilities but were not kept confidential. Efforts were made to keep separate records in 40% of the facilities. Even though the data were collected, they became a part of information only in 30% of the facilities in the intervention villages. Supportive supervision was claimed to have been undertaken by 40% of the managers in the intervention area and only 10% in the control area.</td>
</tr>
</tbody>
</table>
Recommendations by the project implementing authority regarding quality assessment, were as follows:

- The tool for quality assessment needed to be reviewed and revised (a) for quality assessment for planning adolescent health services at the State/national level, and (b) because a greatly simplified version was required for quality assessment and quality improvement at the local level. If possible, the simplified tool should be integrated with the Reproductive and Child Health-II project. In addition, the tool needed to be translated into local languages.

- The quality assessment tool should add on an observation element and focused group discussion to improve it further.

- Additional tools for assessment of clinical skills needed to be developed.

**Successes and Lessons Learned**

**Successes**

The success of the interventions is attributable to the adoption of a three-fold strategy:

- addressing the intended beneficiaries of the adolescent-friendly reproductive and sexual health services (target group);
- addressing the health problems/issues that need to be addressed (service package); and
- involvement of the service providers of the health facilities.

**Pull-and-push Approach**

The Intervention adopted a dual strategy of “pull and push”. The “pull” strategy attracted the adolescents to avail themselves of the health services, which were made more adolescent-friendly. The “push” strategy focused on enhancing the service delivery package and organizing the effective services by the Government of India.

**Quality Services**

The intervention focused on improving the quality of services rendered. Success was demonstrated by the implementation of the seven standards set forth in the Implementation Guide mentioned earlier.

**Assuring Accessibility**

The case study clearly demonstrated that assuring access to the adolescent-friendly health clinics on the dedicated days resulted in an increase of a substantial number of cases seen and referrals made to the primary health centres.

**Adolescent-friendly Health Services**

Another reason for the success of the intervention was the adoption of the adolescent-friendly approach and the attitude of the health workers in the general Outpatient Departments. The health personnel addressed the issues with appropriate counselling and maintained confidentiality and privacy.
Providing Information about the Health Services to Adolescents

Youth festivals provide an opportunity for adolescents and young people to advocate for adolescent health and address social issues such as early marriage, sex selection, dowry, household violence and the dangers of HIV/AIDS. Advocacy measures used during the programme such as the logo, the setting up of notice boards to identify adolescent-friendly health clinics, the display of posters that articulate the services available for the adolescents, and the provision of identity cards to adolescent-friendly providers were found to be extremely useful.

Delivering Effective Services to Adolescents

Capacity-building of the health personnel is an important aspect of delivering effective services. A systematic approach to building the capacity of all health personnel and peer-group educators was adopted by conducting training. The training sessions were assessed for quality, which was rated as high.

Regular Supply of Essential Items

The timely supply of items such as condoms is an important measure of the quality of services. If the supplies meant for adolescents are not provided regularly in the health facility, this dampens the enthusiasm of newly inducted peer-group educators.

Intersectoral Convergence

Forming “adolescent action groups” and engaging them for voluntary work for a period of about one year demonstrated that the caregivers (auxiliary nurse midwives, accredited social health activists, anganwadi workers, teachers, etc.) and the community (peer-group educators, Mahila Panch (women’s group), other activists in the village) can bring about a convergence in the services for adolescents.

Monitoring and Evaluation

The monitoring of adolescent reproductive and sexual health services focused on problem identification, solving problems through appropriate activities, and tracking the progress made on the take off and use of adolescent reproductive and sexual health services. For this purpose, the monthly adolescent reproductive and sexual health-service register was created, which reflected the progress in training and communication activities.

Health Management Information System

In the Indian context, although the information about the adolescents is recorded in the registers and the information on adolescents visiting the public health facilities is available, the information is incomplete and never analysed. It is not included in the reporting format of the Reproductive and Child Health project. There is a need to insist that the healthcare providers collect data accurately and incorporate them into the information system. This should become a part of the monthly reporting format.

This case study provides an example of policy planning and adopting and implementing an adolescent-friendly
approach in line with the National Rural Health Mission and the Reproductive and Child Health-II project. It demonstrates that this is only the first step and that the application of the best practice through continuous innovation is necessary for the success of the programme.

**Lessons Learned**

The following lessons can be drawn from the implementation of the innovative practice described in this case study:

- Training of all levels of health-care providers is essential to make the health service adolescent-friendly. However, one-time training is not sufficient. Regular, follow-up, interactive training and supportive supervision are equally necessary to sustain it.

- Age- and sex-disaggregated data, particularly on adolescents, are still not maintained. The existing health information management system has not yet internalized the data.

- The peer-group-educator model works well in addressing adolescents’ concerns provided that the educators receive quality training followed by regular contact and support to keep their motivation level high.

- The performance of school-going peer-group educators shows a decline during examination days.

- The adolescent action group can be a good advocacy mechanism at the grass-roots level to improve adolescent health.

- Awareness and advocacy can bring behavioural change among adolescents provided that there is a regular supply of essential commodities, e.g., iron and folic acid tablets, sanitary napkins and condoms.

- With respect to addressing the concerns of male peer-group educators, one of the lessons learned is that, although the services to the adolescents have been provided equitably, the adolescent males were at a disadvantage since all the service providers were females below the primary health-centre level. Male adolescents were reluctant to consult the female health-care providers, especially when the reason for the visit related to sexual or reproductive health concerns as well as psycho-social problems. Even though male peer-group educators assisted in addressing the problems of male adolescents, there was still a big difference in the number of adolescents who contacted them in comparison to females. This concern needs to be addressed by the programme since male involvement is crucial to the success of the reproductive and sexual health of male adolescents.

**Future Plans: Extensions**

**Strengthening the Clinical Skills**

In addition to the adoption of an adoles-
cent-friendly health services approach, it would be necessary to strengthen the clinical skills of the providers trained in adolescent-friendly health services. The credibility of health-care providers would increase only when they were able to effectively and convincingly treat and counsel the adolescents in addition to using an adolescent-friendly approach.

**Adding Climate Change to the Training Curriculum**

Climate change and its adverse impact on health constitute a problem that concerns all adolescents. The youths and adolescents can play a meaningful and decisive role in addressing this problem.

**Efforts to Improve the Nutritional Status of Adolescents**

Efforts to improve the nutritional status of adolescents and tackle the widespread problem of anaemia can contribute to nation-building in addition to addressing the health and reproductive problems of adolescents and youths. A supportive and specific policy in the form of once-a-week iron and folic acid supplementation as a package for anaemia control and mid-day meal programmes as an entry point for achieving optimum potential for physical growth should contribute to the scaling up of the programme to include a large number of beneficiaries. This would contribute significantly to higher educational attainments and productivity in employment.

**Use of Sanitary Pads and Napkins**

Even though efforts have been initiated to promote and popularize the use of clean pads during menstruation, these need to be scaled up and sustained. The main challenge to be addressed is not so much demand creation or unaffordable cost; rather, it is related to lack of access.

**Replicability**

**Prerequisites for Replication**

- **Supportive policy.** A support policy to ensure supplies to adolescents that relate to basic rights of all adolescents irrespective of age, sex, caste or creed is the basis for improving the quality of services rendered to adolescents.

- **Strategic information.** Strategic information would be required for replicability in order to quantify the felt needs based on age and disaggregated by sex. Further, the assessment of coverage and assessment for quality improvement based on the seven standards articulated in the Implementation Guide would have to be set forth based on felt needs and baseline data.

- **Resources.** Additional resources would be required to add value to the existing sexual and reproductive health services within the framework of the National Rural Health Mission. It would be crucial to recognize the vast unmet
needs of adolescents. In this context, resource commitment is to be considered as a critical investment.

- **Capacity development of male health-care providers.** Limited provisions for the male adolescents to be able to obtain guidance and treatment for their personal, sexual and reproductive problems and concerns from males have been one of the major weaknesses. There are no male health workers or volunteers below the level of primary health centres. Therefore, in the majority of the cases, the closest accessible place for the males is a public health centre. This situation deprives the male adolescents of access to information and services close to the place of their residence.

  Without male involvement, the success of the adolescent reproductive and sexual health programme cannot be achieved to its fullest. Capacity development with a focus on community-based providers to meet the enormous needs of this large population by training more male peer-group educators would ensure increased success of the programmes.

- **Sustainable partnerships and partnership with a mentoring agency.** Partnership with key sectors such as education and the media and entities such as village health and sanitation committees, the Department of Women and Child Development, the Department of Youth and Sports, and Panchayati Raj institutions would have to be created and sustained. The NGOs could take a forward-looking role in mentoring, initiating and sustaining intersectoral linkages.

- **Role of NGOs.** This case study highlights the value addition from the partner NGO with substantial and sustained efforts along with the government staff at all levels. The evidence-based innovations have helped to sharpen the implementation of the Programme Implementation Plan, with the government and the NGO partner contributing to demand-generation and quality improvement. Such mentorship should be taken forward to bring optimal returns on the investments made.

**Experiences of Replication in Other Areas and Contexts**

In the programme context, adolescent reproductive and sexual health is a new addition to the Reproductive and Child Health-II project. In terms of implementation, the experiences are only beginning to emerge. The Society for Women and Children’s Health, in partnership with the State of Haryana and district authorities, has implemented most of the recommendations of the Ministry of Health and Family Welfare as articulated in the national strategy and Implementation Guide of the Government of India, with the addition of some innovations in programme implementation.

The experience can be replicated in other areas and contexts with greater
optimism since the intervention package, tools for capacity development, knowledge of what works, and tools for monitoring and evaluation have been developed, tried and tested. However, it would be wise to plan for a limited implementation initially rather than widespread rapid expansion. Carefully monitoring and reviewing the experience of implementation in selected areas of districts representing different geographical areas would also be crucial. Until the programme is widely implemented, partnership with a mentoring agency such as the Society for Women and Children’s Health would be of critical importance.

**Suggested Steps for Replication**

Suggested steps for replication are as follows:

- conduct a mapping exercise to undertake a situational analysis and needs assessment of the adolescents and the community;
- plan and implement an adolescent reproductive and sexual health strategy (adolescent-friendly health and counselling services) in selected areas for at least one year before expanding it to other areas. Expansion should build on the experience and lessons learned;
- involve a mentoring agency for guidance, capacity development, close monitoring and evaluation to facilitate effective implementation, expansion and future planning;
- undertake an annual review of progress at the State level and a quarterly review at the district level based on the standards for quality assurance;
- incorporate quality assessment and quality improvement into the programme as an ongoing process and integrate them with the reproductive and child health programme;
- increase coverage progressively over a period of the next five years to ensure full coverage by the end of that period and undertake mid-course corrections on a yearly basis as guided by the experience.

**Potential for Partnerships**

Selected partnerships should be explored with the departments that already have high stakes in adolescent health. These include Education, Women and Child Development, Youth and Sports, and Media as well as Panchayati Raj institutions/elected leaders.

The following collaborating departments/institutions have also undertaken many related activities such as:

- conducting the annual school health examination: Education;
- *kishori shakti yojna*: Women and Child Development;
- mid-day meal programme: Education;
- cultural and other activities: Youth and Sports;
- media exposure: Media; and
• village health and sanitation committees: Panchayati Raj institutions.

These activities serve as building blocks for the sustainability of partnerships and further development of inter-sectoral coordination and networking. The Health Department should contribute to the capacity development of key persons in the above-mentioned departments by providing accurate information and essential health-related supplies and participate in the periodic review of progress.

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