

Use of a public health approach to adolescent friendly health services in a rural community in Haryana

1. Introduction

Adolescents face numerous risks and problems relating to reproductive and sexual health including HIV/AIDS; substance abuse; violence and injury; nutrition and psychological and behavioral problems relating to the rapid changes during this period. The rapid changes during adolescent period also makes them vulnerable. Adolescents comprise of more than 23% (about 230 million) of India's population. More than 70% of the country's population lives in the rural areas where the literacy rates especially amongst the females are low. According to national data, more than half of the illiterate currently married women are married below the legal age of marriage. Nearly 20% of the 1.5 million girls married under the age of 15 years are already mothers (Census 2001). Twenty seven percent of married female adolescents have reported unmet needs for contraception (NFHS II). Over 35% of all reported HIV/AIDS infections in India occur amongst young people 15-24 years age.

The 10th five year plan recognizes adolescents as a distinct group deserving of policy and programme attention. Adolescents are identified as underserved group in the national population policy 2000. The national youth policy (2003) identifies 13-19 years as a distinct group to be covered by various sectors (education, health, science and technology). Intersectoral linkages are recommended under the National Rural Health Mission (NRHM) and Reproductive and Child Health II (RCH II). The National Aids Control Programme III provides for operational linkages.

Despite the impressive inputs in expansion of the infrastructure in physical terms, the health and information needs of adolescents remain ignored due to constraints at different levels of the system. These relate to lack of sustained political will, policy support, poor management of services, and inadequate health services for adolescents. Besides the inadequacies in the health system, the help and health seeking behavior of adolescents is poor. There are numerous barriers to the use of public health services by adolescents. This was borne out by the formative studies by SWACH supported by MOHFW in Haryana (2001-2004).

For the health services to be termed Adolescent Friendly, the main user perspectives are that they should be easily accessible and acceptable i.e. the services meet their expectations. From the providers perspective health services for adolescents should be (a) appropriate (b) effective (c) equitable and (d) comprehensive.

Investments in adolescent friendly reproductive and sexual health will help in delaying the age at marriage, reducing teenage pregnancy, meet the unmet

needs for contraception, reduce the incidence of HIV/AIDS and STIs and contribute to reduction of maternal, neonatal and perinatal mortality rates.

The GOI proposes to operationalize a package of interventions for improving adolescent health. An implementation guide and orientation package has been produced to enhance the capacity of the health system. Implementation research to operationalize the package of adolescent friendly reproductive and sexual health services will be useful in providing experiences, constraints and opportunities. This research should be done in the rural areas to help expand the services.

2. Objectives

- To operationalize the package of Adolescent friendly reproductive and sexual health services recommended by Ministry of Health and Family Welfare (MOHFW) in selected health facilities in a district in Haryana.
- To assess innovative approaches to increase the utilization of adolescent friendly services.
- To monitor the quality of adolescent friendly services provided by using the guidelines provided in the implementation guide provided by MOHFW.
- To document the lessons learnt, constraints and successes.

Study Area

The study was carried out in 2 PHCs i.e. Shahzadpur and Pathreri in Ambala district, Haryana. Selection was done after a rapid mapping of the health facilities and was also guided by the interest of the staff. The study area included 16 subcenters and 72 villages. The estimated population in the two PHCs is 70,000.

Activities Carried Out

1. Mapping of providers and facilities

AFHS facility assessment questionnaires were prepared for mapping, the PHCs, sub-centres and Angangwari centres. Mapping of 11 PHCs in the district, 16 sub centres, and 62 Anganwari centers was done to assess the services for the adolescents. More than 90% of all the health facilities mentioned above were far below the standards recommended in the implementation guide of GOI. Prominent deficiencies in the provision of AFHS were (1) providers were not trained on AFHS packages (2) supplies like IFA and contraceptives were available but not provided to adolescents (3) no provisions existed for privacy or confidentiality, (4) no special clinic or fixed hours for adolescents were observed (5) the records had inadequate information on adolescents (the records only identified disease symptoms) and this information was neither analysed nor

reported. It was clear from the mapping that the project can bring about limited improvements.

The mapping provided benchmark information on the deficiencies and helped to identify areas that need to be improved.

2. Training and Capacity development

Training of the health care providers as well as the community members on the Adolescent Friendly Reproductive and Sexual Health was done on an ongoing basis. The model proposed for training was to use OP modules in 5 days training. During the period under review 4 ANMs were trained for a period of 5 days at SWACH. The capacity of 4 project staff members was also increased through this 5 days training. The state has not yet initiated the training of staff on AFHS although the state proposes to implement the recommendation of GOI. During the project period the state organized an orientation meeting for one day but only the chief medical officer participated in the meeting. The efforts made to train the doctors, ANMs and AWWs by 5 days training were not successful since the district and state authorities did not agree to relieve the staff. The OP modules were translated and field tested towards the end of the project. These are in the process of printing. The implementation of project helped SWACH to sustain the interest of state health department to plan for development of capacity for adolescent friendly sexual and reproductive health services.

Since the training could not be done by using the 5 day training courses, it was done once in a month during the meetings that are regularly organized by the PHC doctors and supervisors of ICDS. The training material used was adapted from the OP modules prepared by GOI. One module was covered on one day. During the training the participants were given hands on experience with communication and counseling to strengthen their skills and to improve their motivation. During each training session the issues relating to adolescent friendliness were stressed and reinforced. At least five times during the project duration, SWACH field staff could reinforce the learning on adolescent friendly sexual and reproductive services.

These staggered trainings are not a replacement for the training approved by the GOI but serve as an add-on to the modular trainings. These have been very useful since the capacity was built progressively and by providing an opportunity to the participants to practice the skills learnt and then address the problems identified by the health workers and doctors for solution during the next session which is held once in a month.

(a) Training of health care providers

The training for the health care providers has been divided into 8 rounds. These 8 rounds covered 8 topics of AFHS. These included the following:

- (i) Growth and development in adolescents
- (ii) Communicating with adolescents
- (iii) Adolescent Friendly Health Services
- (iv) Sexual and reproductive health concerns of the adolescents
- (v) Nutrition and anaemia in adolescent
- (vi) Contraception for adolescents
- (vii) Pregnancy and unsafe abortion in adolescents
- (viii) RTIs and STIs and HIV/AIDS in adolescents

Content of these topics differ for each category of trainees i.e. Doctors, ANMs, AWWs and School teachers. The content of training for the medical doctors was focused on clinical aspects while the content for health workers and for others like the AWWs and teachers was concentrated on provision of accurate knowledge to the adolescents.

In the programme setting it may not be possible to provide exclusive training on AFHS. The challenge is to integrate and highlight the issues relating to AFHS in the monthly meetings of health workers. This needs to be highlighted during each meeting to serve as a reminder and stress its importance. The key content of sexual and reproductive health care, nutrition and anaemia, RTI/STI, HIV/AIDS, contraception and care during pregnancy and child birth can be stressed as one topic each month.

Table No. 1: No. of training sessions conducted

Sr. No.	Category of Trainees	No. of Trainees	No. of Training session	
			Targeted	Achieved
1.	Doctors	04	8 Rounds	8 Rounds
2.	ANMs	16	8 Rounds	8 Rounds
3.	AWWs	92	8 Rounds	8 Rounds
4.	Teachers	06	8 Rounds	8 Rounds

More than 90% of the above categories of health care providers have participated in the above training sessions and the target of at least 5 training has been fully met.

(b) Training of peers group educators (PGEs)

68 PGEs were selected in AFHS project from villages covered by Shahzadpur and Patreri PHCs in collaboration with the community. The trainings of PGEs was divided into 10 rounds. The training covered the topics like anaemia, nutrition in adolescents, menstrual problems and menstrual hygiene among the adolescent girls, substance abuse, safe sex, STIs/RTIs, HIV/AIDS in adolescents, etc. It is to be noted that the subject areas for training of PGEs are similar to the topics for health workers and doctors. However, the content of training is not technical. While the stress in training of health workers and doctors was on clinical management, the emphasis of training of PGEs was on communication and counseling which aims at provision of accurate knowledge and supporting adolescents in referral to AFHS facility. During every interaction the PGEs were encouraged to make conversation with adolescents and make an effort to remain adolescent friendly.

The participation of PGEs in training was on a voluntary basis. The attendance was high. In the beginning the SWACH staff had to spend a lot of time to locate and inform the adolescents, this task became easier after 3-4 sessions since the PGEs started to take a lot of interest in training

Table No. 2: No. of training sessions organized for PGEs and their participation

Sr. No.	No. of PGEs	No. of trainings done	
		Targeted	Achieved
1.	50	10 Rounds	10 Rounds
2.	7	10 Rounds	8 Rounds
3.	11	10 Rounds	7 Rounds
Total	68		

(Out of 68 PGEs 50 had completed 10 rounds of training).

(c) Training Material used for Health workers and PGEs

The orientation package for ARSH recommended by Ministry of Health and Family Welfare, GOI consists of two modules – facilitator’s guide and handouts. For ANMs and AWWs, these modules have been prepared in Hindi. From these modules, a simple handout was prepared. This comprises of key messages and a summary of the module. The hand out is distributed to the participants at the end of each training to serve as a ready reference. For the orientation of PGEs, IEC material on different issues/concerns of the adolescents as well as FAQs prepared in Hindi were used and shared.

(d) Training of PGEs by using FAQs (Frequently asked questions)

PGEs are being trained by using FAQs that were developed during the earlier project supported by the GOI. The FAQs were developed based on the common questions asked by students in 6 schools during a period of 6 months. A total of 105 questions were selected for inclusion in the FAQs. The FAQs are organized in 8 sections –

- (i) Body image
- (ii) Food and eating habits
- (iii) Health related concerns
- (iv) Substance abuse and its consequences
- (v) Problems related to menstruation
- (vi) STI/HIV/AIDS and sexual health
- (vii) Friendship love and marriage
- (viii) Psychological and emotional problems

In each training, PGEs were asked to select one question from each section. The questions that are selected by consensus are discussed after reading out the question and the answer. By this method, the other adolescents who were selected as PGEs but were curious and participated in the session also become aware of the problem and the solution. There were about 3-4 adolescents who participated in one or more sessions in addition to the adolescents. During the training, a role play was organized to illustrate the key principles of communication and counseling. This helped the PGEs to develop and improve their communication skills and overcome any problems and hesitation regarding communication. One PGE was requested to note down the questions that have been discussed during training. Subsequent training did not cover the questions that have already been covered. After the discussion, a plan of action was made by the PGEs to contact the adolescents and provide accurate knowledge during each interaction. There was discussion on the different ways in which interaction could be organized using all available opportunities. The PGEs were also trained in filling up the record forms. This had to be done more than once since many PGEs were unable to understand the system of record keeping. Follow up of their work was done by reviewing the record forms and solving any problems. Record forms are collected; problems that they experience during work are identified, and possible solutions are discussed. They are motivated to continue the work. The PGEs are also reminded to refer any adolescents where provision of knowledge will not be enough or the problem of the adolescent would require medical treatment. The PGEs also participate in the programme for control of anaemia and promotion of menstrual hygiene. They have contributed by distributing iron and folic acid tablet and promote the use of sanitary napkins.

(e) Benefits of staggered trainings

Staggered trainings have helped in the regular interaction with the health care providers and PGEs. It also ensures their regular follow up, further leading to reinforcement of their knowledge base, solution of their problems and last but not the least, their motivation level is sustained. However, it should not be construed

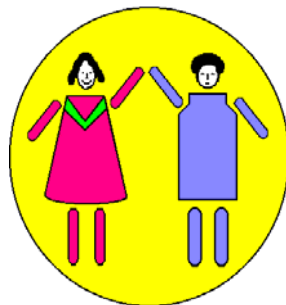
as a substitute or a replacement for the 3 days or 5 days formal orientation programme.

(3) A package for advocating AFHS locally

In order to promote AFHS in the two PHCs (Shahzadpur and Patreri), the following innovations were used.

(a) Logo

A logo on AFHS was prepared and finalized after getting the views of the community including the adolescents. In order to make it comprehensible to the adolescents and the community members, it was named as 'KISHORE SWASTHYA SURAKSHA'.



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Logo for AFHS

The above logo has been included in the identity cards, posters as well as signboards of AFHS. This approach provides an identity to the effort. Adolescents become aware of AFHS when they see the logo displayed.

(b) Identity Cards (I-Cards)

I-cards have been prepared for the recognition of individuals as adolescent friendly. Criteria have been identified and agreed. Those who fulfill the criteria for adolescent friendliness are given these I-cards. The health care providers, personnel from other sectors and PGEs retain these cards as long as they comply with the agreed criteria for adolescent friendliness. The I cards are given as soon as an individual has met the criteria of being adolescent friendly and it is withdrawn if the person is no longer adolescent friendly.

It gives to the providers an identity and sense of belongingness to be promoters of AFHS. The PGEs and most health care providers feel proud to be a part of AFHS effort in their village/township.

Criteria for providing I-cards

A person is given an I card if he/she is :

- (a) Trained in AFHS (has participated in the full training package)
- (b) Keeps and uses the training material given to him/her.
- (c) Is functional in sharing information, maintains records and provides data.
- (d) Participates in meetings and provides feedback.
- (e) Promotes AFHS
- (f) Refers adolescents to AFHS facilities regularly
- (g) Participates in promotional activities for adolescents i.e. anemia prevention and control, tetanus prevention and menstrual hygiene

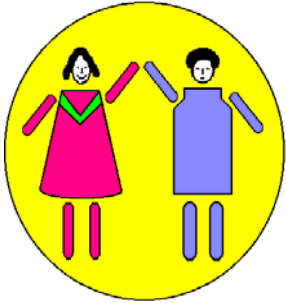
Table No. 3: Number of people who have received I-cards

S. No.	Category of Recipients	No. of I-cards issued
1.	Doctors	1
2.	ANMs	6
3.	Teachers	6
4.	PGEs	25
5.	Counselor	2
6.	Field workers	2
	Total	42

Out of the I cards distributed, t/o date 37 providers have retained the I cards since they have met the criteria and conform to the standards agreed. They can be considered as adolescent friendly health care providers. They are health workers, workers from other sectors and volunteers.

(c) Posters and sign boards

A poster consisting of 10 standards to be observed by a health center to be regarded as adolescent friendly has been prepared in **HINDI**. Similarly, signboards have been prepared indicating '**KISHORE SWASTHYA SURAKSHA KENDRA**'. The posters and signboards have been displayed in 15 health care centers. These are the symbols of identity for the adolescent friendly centers/facilities.



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- 3 Isok izca/d dk nksLrkuk O;ogkj A
- 4 fd'kksjksa dh leL;kvksa dksa Iqusa] le>sa vkSj Iqy>k,i A
- 5 Iq>koksa dks dk;Z esa ykus dh ;kstuk cuk,i A
- 6 t+:jrean fd'kksjksa dk Qksyks&vi djsa A
- 7 leL;kvksa dk fjdkMZ cuk,i A
- 8 xksiuh;rk dk ikyu djsa A
- 9 fd'kksjksa Is i;kZlr ,dkUrrk esa ckrphr djsa A
- 10 fd'kksjksa Is futh tkudkjh ysus Is igys mudh Igefr ysa A

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(4) Adolescent Friendly Health Facilities

Health Care providers have fixed a day in the week and timings for providing adolescent friendly sexual and reproductive health services to the adolescents. The benefits of fixing the timings for adolescent clinic are as follows: -

- (1) Easy registration of the adolescents.
- (2) Health Care Providers get adequate time for the adolescents. Communication and counseling are possible since adequate time is available.
- (3) Privacy and confidentiality are maintained.
- (4) Adolescents open up with the providers relating to their problems. They get an opportunity to bring up issues which they would not like to discuss in a busy clinic/OPD.

Table No. 4: Adolescent Friendly Health Facilities

S. No.	AFS Facility	Number
1.	PHC	2
2.	Sub-Centres	8
3.	Anganwari Centres	12
4.	Schools	4
Total		26

While designating the above facilities as Adolescent Friendly, by and large we were guided by the standards framed by the MOHFW, GOI. The main criteria that have been taken into consideration while designating these facilities as AFHS facility as follows:

1. Counseling and provision of reversible contraceptives.
2. Information/advice on SRH issues including addressing the common concern of the adolescents both boys and girls.
3. Services for Tetanus Immunization
4. Services for IFA against nutritional anemia and nutritional counselling.
5. Treatment for common RTIs/STIs available and accessible to adolescents.
6. Referral service to VCTC.
7. Periodic health check-ups under school health programme and community camps.
8. Adequate service providers in place. At least one provider is trained on AFHS.
9. Adequate waiting facilities at PHC level.
10. Special clinic day/time for adolescents.
11. Reasonable privacy and confidentiality are maintained.

12. Adolescents are well informed about the health services mostly by peer educators.

13. Data collection and its analysis done by SWACH. It has not been institutionalized.

All the facilities do not meet all the criteria. SWACH considers that at least 10 of the above criteria are met to be considered adolescent friendly.

In addition to the services provided during the special timings for adolescent friendly clinics the providers in the above mentioned facilities are adolescent friendly to those who drop in during the general OPDs. Thus adolescents get the services even if they do not come to visit the special clinics for adolescents.

(4) ROLE OF THE PEER GROUP EDUCATORS

The experience in the project shows that most of the times adolescents/young people prefer talking with their peers about sensitive issues. Keeping this in mind, 68 PGEs (39 Females + 29 Males) have been selected from 30 villages of the areas of Shahzadpur and Patreri. They were oriented to promote AFHS. In addition to their orientation, they are followed up regularly to assess the work done, identify the problems, provide training and motivate them for further work. This is the beginning of supportive supervision and feedback system at the most peripheral point of service delivery.

Eligibility criteria for PGEs

A Peer group educator should be :

- (i) A good communicator
- (ii) Acceptable to the group
- (iii) Interested in the work
- (iv) Able to understand the problems of adolescents
- (v) Having a good personality
- (vi) Confident
- (vii) Not expecting money in return for the voluntary work performed

Drop-outs

Due to the regular training and interaction with the PGEs, their dropout rate has probably been curtailed. Out of 68 PGEs, 50 PGEs are functional and the rest 18 are either semi-functional or non-functional. Efforts are being made to reduce the drop out rate. In the female PGEs the drop outs occur due to marriage while in the males employment outside the village is a reason for drop out.

Experience of working with PGEs

- Adolescents contact them as first contact person for the solution of their problems and concerns i.e. PGEs identify and recognize the problems and concerns of the adolescents. They decide with the adolescent whether the problem can be addressed by discussion with the PGE or it requires expert advice of a health care provider.
- The PGEs are provided a list of service providers who are participating in AFHS and the services they can provide. They have also been given referral cards to enter the key information.
- Earlier, most of the cases seen by the PGEs were referred to the health care providers but with regular trainings, PGEs are able to sort out most of the problems through communication and discussion with the adolescent who have problems and concerns. Over a period of time –generally about 3 months the PGEs have learnt basic skills of communication and counseling and become confident to begin to address and solve common problems and concerns of the adolescents.
- Since December 2006 to August 2007, a total of 1466 cases have been recorded by the PGEs, out of which 271 cases have been referred to the health care providers. These conditions have included amenorrhoea, dysmenorrhoea, skin problems, fever, breathlessness, severe anemia, vomiting during menstrual periods, burning micturition etc. The remaining 1195 cases have been either solved by PGEs themselves or in consultation with ANMs, AWWs, teachers etc. 77% of the problems of adolescents like minor menstrual problems, nightfall, masturbation, safe sex, information related to STI, HIV/AIDS, hair falling, problems related to body image, nutrition in the adolescents were handled by the PGEs themselves.
- Out of the cases referred 217 utilized the referral facility and came back to the PGE to report their experience. This provided an opportunity to the PGEs to follow up with the adolescents so that they could comply with the treatment and advice given in the referral facility. For PGEs all identified adolescent friendly were considered as referral facility.
- During the consultation initially, the vast majority of the problems were diseases or health problems. Now in addition, the psycho-social problems are also included and these are progressively increasing. This is an indication of better understanding between the adolescents and the PGEs.
- In majority of the cases, PGEs seek consultation of ANMs. In this way they get an opportunity to learn more. e.g.
 - i. A married adolescent girl did not stop bleeding even after the one month of her delivery. ANM was able to sort out her problem
 - ii. An adolescent girl with height 5'5 inches and weight 60 kgs was informed by the AWW that her excessive weight needed to be addressed through changes in her diet.
 - iii. An 18 years old girl has not started having her menstrual periods. She was referred to the hospital for a check up and investigations.

- The PGEs maintain the records of the problems/concerns of adolescents and submit them regularly to SWACH and participate in the trainings.

(6) ATTENDANCE OF THE ADOLESCENTS VISITING HEALTH CARE CENTERS BEFORE AND AFTER AFHS PROJECT

To assess the impact of interventions (trainings, subsequent follow-ups given to the health care providers as well as PGEs, ensuring provision of supplies, etc.) on the number of adolescents accessing the health facilities, a comparison was made. Data was collected from the OPD registers of the health centers for the months of April, May and June in 2006 and it was compared with the cases reported during the same period in 2007. The following table reveals that there has been a substantial increase in the number of adolescents accessing health care services this year as compared to the previous year.

Table No. 5: Attendance of adolescents in 3 different levels of health facilities in the months of April, May and June 2006 and 2007

Sr. No.	Name of the Health Center	No. of adolescents reported	
		2006	2007
1.	CHC, Shahzadpur	164	289
2.	PHC, Patreri	152	234
3.	Sub-center, Banondi	37	140
4.	Sub-center, Patreri	70	270
5.	Sub-center, Baribassi	52	285
6.	Sub-center, Pilkhani	47	297
7.	Sub-center, Korwa Khurd	33	275
		555	1790

Reasons for an increase in the number of adolescents visiting the health facilities

1. Awareness generation among the adolescents through PGEs i.e adolescents have been made aware of their own needs, concerns and problems.
2. Developing a system of referral by the PGEs, AWWs and ANMs
3. Availability of the services required by adolescents, in the health facilities e.g. IFA, T.T, contraceptives, etc. Provisions were made that the health care providers do not deprive the adolescents of the services that they

- need for their condition because of misperceptions among the health care providers.
4. Change in the attitude of the health care providers regarding the concerns and problems of the adolescents' i.e. adolescent friendly behavior of the services providers.
 5. Organization of special clinics exclusively for adolescents where privacy and confidentiality is maintained.

Shift in the pattern of problems/concerns amongst adolescents

An analysis of the information collected from PGEs indicate that there is a shift in the nature of complaints with which adolescents come to PGEs. Initially the complaints were common symptoms e.g. fever, cough and cold, abdominal pain. body aches, diarrhea, skin rashes etc. Now the problems are more adolescent specific e.g. menstruation related problems, body image (acne, black patches below the eye) among the girls and sexual and drug abuse among the boys..

**Table No. 6: Nature of Problems
(N=1445)**

Problem	%age
Health (fever, cough cold sneezing, abdominal pain diarrhea, skin rashes etc)	33.5%
Menstrual Problem	20.5%
Body Image	17.1%
Psycho-social	16.1%
Sexual	8.9%
Drug abuse	2.0%
Nutritional	0.8%
Love relation concerns	0.2%

(7) CONTROL OF ANEMIA (PROVISION OF IFA AND ALBENDAZOLE)

Out of 7 senior secondary schools in the townships of Shahzadpur and Patleri, the provision of IFA and Albendazole has been started in three Senior Secondary Schools for the classes XI & XII. Weekly IFA is provided to both boys and girls. For this purpose, Wednesday is fixed as a day for providing medicines and 2 teachers in each school have been assigned duties to provide IFA & Albendazole to each. Under the Kishori Shakti Yojna in ICDS 9 villages are covered with IFA for a period of 6 months on a rotation basis. The PGEs have been requested to distribute IFA to out of school adolescents.

Table 7 : Distribution and consumption of IFA and Albendazole among the school going adolescents.

Sr. No.	Name of the School	Total No. of students (11 th & 12 th)	IFA		Albendazole	
			Distributed	Consumed	Distributed	Consumed
1.	GSSS, Patleri	88 (70) *	570	560	90	88
2.	GSSS, Korwa Khurd	66 (61) *	700	488	70	61
3.	GSSS, Shahzadpur	253 (248) *	1012	992	253	248

(* No. of students who consumed IFA regularly)

More than 90% target was reached and there were no problems regarding acceptance.

The targets for Albendazole have also been reached.

Similarly, 3288 IFA and 616 Albendazole tablets were distributed among the out of school adolescents through PGEs. The beneficiary adolescents mostly come to the PGEs on a fixed day of the week to collect and consume IFA. Those who could not come are covered by the PGEs themselves.

The supply of the above shown IFA and Albendazole was initially made by SWACH. While a system was being established, negotiations were done with the health care providers and doctors to make provisions for the supply of IFA and Albendazole for the school as well as non-school going adolescents on a sustainable basis. The doctors and other health care providers are beginning to understand the importance of prevention of anaemia amongst adolescents but they are constrained because they have not been provided in their guidance from the state that adolescents are also the beneficiaries of iron and folic acid and albendazole tablets. Efforts need to be intensified to enhance the coverage as a part of the programme. On the demand side it would be important to convince the village health and sanitation committees to support this effort and demand for the ongoing supply of these products from the health centers.

(8) PROMOTION OF MENSTRUAL HYGIENE

Sanitary napkins were introduced among the rural adolescents as a measure to promote menstrual hygiene in May, 2007. This was promoted through the PGEs under social marketing programme. This means that the providers serve as depot holders and are provided the sanitary napkins by SWACH on an ongoing basis. The depot holders sell the sanitary napkins at a predetermined price that does not exceed the market price. The added component is the provision of accurate knowledge about the importance of the product and the method of its correct use.

For the convenience of the clients and also to make it more affordable, sanitary napkins are also sold loose i.e. in pieces. The clients purchase it as per their requirement for that particular menstrual cycle. The seed money was provided and the initial supply was made by SWACH from the project resources. After that the effort is made through cost recovery by the PGEs in the form of a revolving fund. This strategy is used as a supplement to improve the skills of the adolescents to manage the menstruation and clarify their problems and concerns relating to the event. This is also used as an entry point to discuss the key issues relating to sexuality, contraception and pregnancy.

SUMMARY OF ACHIEVEMENTS OF THE PROJECT

- i. A total of 4 Medical Officers, 2 LHVs, 16 ANMs, 96 Anganwari Workers and 6 school teachers were trained using MOHFW, GOI guidelines.
- ii. 68 Peer Educators were trained out of which 50 are functional. They are working on a Voluntary basis and addressing the common concerns of the adolescents and refer those cases to adolescent health facility which they can not deal with.
- iii. All the health facilities in the project area i.e. 2 PHCs and 16 Sub Centres do not report stock-out of medicine and commodities. They are eager to provide medicines and other products available with them to the adolescents.
- iv. 26 health facilities i.e. PHC-2, Subcentres – 8, Anganwari Centre – 12 and schools – 4 were certified as Adolescent Friendly.
- v. In 4 schools certified as Adolescent Friendly, the questions of adolescents are answered by 6 teachers trained on ARSH.
- vi. In all the villages (70 in number) the concerns of the adolescents are addressed by ANM/AWW/PGE. However, in the villages where PGEs are functional and active, the situation is better.
- vii. Intervention carried out under the project has led to increase in the attendance of adolescents in the AFHS facilities. A comparison of 3 months data between the previous year and current year has confirmed this.
- viii. There is change in the trend in the patterns of problems for which adolescents seek health services. Earlier adolescents were coming to AFHS facility more with complains of fever, diarrhea, abdominal pain, cough and cold, etc. In addition to the above health problems adolescent are reporting for concerns relating to menstrual problems, acne, black circle below the eye, short height, night falls, masturbation, weakness attributed to sexual activity etc.

Problems :

1. Use of prescribed reporting format and provision of age and sex disaggregated data on adolescents could not be institutionalized. This can be possible only when the adolescent programme is implemented on a large scale by the state government and makes it an integral part of recording and reporting system.
2. Partnership with various stakeholders in the private, government and NGOs in the health and other sector as proposed could not be established during the project period. However, with minimal funding support, it is proposed to establish adolescent friendly action groups which would comprise of village based health care provider like ANM, ASHA, AWW, Dai and some active adolescents. This group will work in coordination with Village Health Committee as envisaged under NRHM.
3. The provision of iron folic acid, albendazole, contraceptives, treatment of RTIs and STIs has improved but needs to be taken further by ensuring

regular supplies and removing the doubts of the health care providers. There is a need to expand this effort so that larger number of adolescents have a greater access to supplies and products that are of public health importance to the adolescents

4. There is a need to further institutionalize supportive supervision and feedback and include written feedback as an integral part of the programme.