**Mainstreaming Youth Friendliness in Existing Public Health Services in three states**

1. **Background and Rationale**

Access and availability of health services for young people and adolescents is severely limited at present. In India, 28.6% of women aged 21-24 years were married by the age of 18 years (NFHS-4). According to the youth survey, 66.8% women were married by age of 20 years[[1]](#endnote-1). Women and men in the age group 15-24 years (including married people) face significant challenges in obtaining sexual and reproductive health services[[2]](#endnote-2).

Based on learning to date, a streamlined approach has been suggested for improving access to health services by young people [[3]](#endnote-3), [[4]](#endnote-4), [[5]](#endnote-5). For improving the access of health services for adolescents and young people, including married young people, it would be crucial to make the routine public health facilities more friendly and sensitive to the needs of young people. Such approach has also been demonstrated to be both scalable and sustainable[[6]](#endnote-6).

Mainstreamed adolescent (and youth) friendly health services mean that following elements are incorporated within the existing health services:

**What elements will make existing public health services more youth friendly?**

1. Audio and visual privacy
2. Confidentiality
3. Non-judgmental attitudes on part of providers
4. Offering a wide range of reproductive health services[[7]](#footnote-1), most importantly:

* At least 5 reversible contraceptives (condoms, oral pills, injectables, emergency contraceptive pills, IUD, Centchroman)
* Prevention of unsafe abortion
* STI management

However, most of public health facilities do not have privacy, and the providers may have judgmental attitudes and not maintain confidentiality. For example, a study commissioned by UNFPA in two states revealed that auditory and visual privacy was found in 27-30% of facilities and visual privacy was present in 15-18 % of facilities[[8]](#endnote-7). The same study also revealed that more than 50% providers said that they would consult a family member before providing family planning services to newly married women. Less than a third of providers had received training in adolescent / young people’s health issues.

Several health needs of young people don’t need visit to a facility, but can be addressed at community level. Community level providers such as ASHAs or Anganwadi workers are also in a position to serve the health needs of young people, however, currently ASHAs see their roles as primarily providing maternal and child health services, and are not adequately oriented about the needs of young people. Research has shown that women they avoided contacting ASHAs for their reproductive health needs, because of fear of breach in confidentiality and pressure of sterilization. Hence it is crucial to orient CHWs on providing non-judgmental and confidential SRH services to young people.

1. **Objectives**

To test the feasibility and effectiveness of a pilot intervention on mainstreaming youth friendliness in routine public health services at facility and community level

1. **Geographic coverage:**

The project will be implemented in 3 states, covering 1-2 districts in each of the states.

* Odisha: Gajapati and Rayagada districts
* Rajasthan- Districts to be decided later (one district with high incidence of child marriage, one RKSK district)
* MP - Chattarpur district

In each district, 8-10 facilities will to be covered, details for selection to be decided later in consultation with state government (CHCs / PHCs). For community level interventions (e.g. capacity building ASHAs), population being covered by these facilities will be included. The final selection of facilities will be made after discussions with state government and UNFPA.

1. **Duration** 3 years (Jan 2018- December 2020)
2. **Key interventions:**

1. **Development of standards and guidance materials**: The guidance materials for clinical providers (doctors, nurses), ASHAs and support staff will be developed. An interactive training plan will also be developed. Where possible, attempt will be made to adapt the existing training manuals to local context, align it to the objectives of the project, and to make the training material interesting (e.g. NHM manual for MOs / ANMs on adolescent health, manuals developed by other agencies on youth friendly services). Further, audio-visual materials will also be developed/ adapted for initial training and onsite mentoring. After finalization, the materials will also be translated in local languages.

Standards of youth friendliness will be finalized, for both facility and community levels, focussing on family planning/ RH / MH services.

1. **Development of monitoring / assessment plan**: To measure the impact of intervention, a plan for assessment of project based on key indicators will be developed, along with assessment tools and monitoring formats and will be developed. Efforts will be made to use the existing data that is routine collected at the facilities, although there will also be need to collect some new data.
2. **Training of providers on providing youth friendly services**:
   * Doctors and nurse midwives working at different levels (Primary health centre, community health centre, urban dispensary, district hospital):
   * The support staff (e.g. cleaners/ *ayahs*, registration staff, etc.) will also be oriented on importance of confidentiality and privacy.

Where possible, it will be aligned with providers training on adolescent health under RKSK, with additional elements covered under this intervention.

1. **Training of community level workers (ASHAs) on providing youth friendly services**:

* ASHAs are already providing several basic SRH services (e.g. pregnancy testing, contraceptives, referral for unwanted pregnancy, etc.). ASHAs will be trained on issues such as privacy, confidentiality and reproductive rights issues, so that they do not impose unnecessary barriers on young women in providing them for RH services.
* For refresher & review of ASHAs, other existing forums such as monthly sector meetings of ASHAs will be used and strengthened, to ensure that various services provided to young people are reviewed regularly and refreshers are provided to regularly sensitise ASHAs, their supervisors and LHVs on youth friendly services.
* In partnership with NHSRC, a module on adolescent health issues for ASHAs might be developed/ adapted.

1. **Physical arrangements in facilities to ensure privacy**: Arrangements will be made to ensure that visual and auditory privacy can be provided during consultation.
2. **Onsite mentoring / handholding for facility based providers:** Regular visits will be made to selected facilities on quarterly / bi-monthly basis, where monitoring of progress will be made, and providers will be provided on site mentoring support to provide youth friendly services. At each facility, a committee (on youth friendly services) will also be formed comprising of different levels of personnel, or any existing committee will be strengthened to integrate the element of youth friendliness. This committee will meet at regular intervals (monthly/ quarterly) to review the progress.
3. Strengthening the institutional mechanisms related to the quality assurance at the facility level: Efforts will be undertaken at the facility level to activate the quality assurance mechanisms that would constantly monitor the quality of the services from all perspectives , especially from the client perspective .
4. Strengthening of Supportive Supervision : The platform of sector meeting of the ANMs and the ASHA meetings will be strengthened in terms of reviewing the various services that are provided to young people and also use this platform to sensitise them regularly on youth friendly services. Apart from this, the supervisors like Lady Health visitors and ASHA supervisors will be sensitized on youth friendly health services and checklists will be developed in terms of providing supporting supervision whenever they undertake field visit.

**Scope of work**

This overall project will be implemented by a national Implementing partner (IP) and 3 state level Implementing partners. The differences in roles of IPs at national level have been outlined below. In Odisha and Madhya Pradesh, agencies implementing the state level interventions will be different**. This scope of work refers to the national IP and interventions in the state of Rajasthan**, since no separate state level IP is planned to be engaged in Rajasthan.

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|  | **Role of National IP** | **Role of State IP** |
| Guidance material | * Develop / adapt / translate guidance materials (including audio-visual materials) and training plan * Develop monitoring formats | * Translation and printing of guidance material in local language |
| Capacity building | * Orientation of state level personnel on intervention * Training of first batch of providers (doctors and nurses) * Oversight of training of district level managers (e.g. ASHA managers, BPMs, etc.) * Oversight of training of ASHAs | * Organize orientation workshops for state level personnel & training of providers at district level * Training of support staff * Training of district level mangers (e.g. ASHA managers) * Training of ASHAs |
| Implementation and monitoring | * Participating in selected monitoring visits and review meetings with ASHAs | * Improving arrangements for privacy * Ensuring regular supplies in facilities and with ASHAs (strengthen supply chain) * Ensure training of providers on other related issues * Quarterly visits to facilities, for monitoring, feedback, onsite mentoring and facilitating corrective actions (e.g. ensuring availability of supplies, arrangement for privacy, etc.) * Review / monitoring with ASHAs |
| Implementation research | * Conducting rapid assessments of main outcomes through facility assessment and provider interviews including ASHA interviews (baseline, and then every 3-4 months) * Preparing periodic reports of changes in the outcomes * Documenting cost efficiency of intervention * Participating in district and state level meetings on the project, sharing findings and discussing implementation challenges * Preparing a report on intervention and its impact * Dissemination of results for scale up |  |

**Key indicators**

1. Proportion of facilities in the selected districcts that have an appropriate package of services for young people (*including at least 5 reversible contraceptives, prevention of unsafe abortion, STI management*) (Target: 20% : MOV: Consultant visit report)
2. Proportion of facilities in UNFPA focused districts with arrangements of privacy in outpatient consultation room (Target: ?: MOV: IP / Consultant visit report)
3. Percentage of clinical providers (doctors, nurses) responsible for providing reproductive health services in public health facilities in selected districts who have received training on youth friendly SRH services in UNFPA focused states (Target: 30 %; MOV: IP report) – Signature indicator
4. Proportion of facilty based providers who respect autonomy of young women (*would be wiling to provide contraceptives services to young married women without consultiing their families*) (Target: 25 %; MOV: IP report & rapid baseline and end line study report)
5. Proportion of ASHAs who would be wiling to provide contraceptives to young married women without consultiing their families(Target: 25 %; MOV: IP report & rapid baseline and end line study report) )
6. Changes in client attendance:

* Percentage increase in the number of adolescent and young people (15-24 years) attending the public health facilities (Target: 40%, MOV: Review of facility records by IP)
* Percentage increase in the number of young people provided specific reversible contraceptives (oral pills, condoms, ECs, injectables) and services on prevention of unsafe abortion (Target: 30% increase ; MOV: Review of facility records by IP )

**Data Sources:**

* Quarterly periodic visits:
  + - Provider interview (for provider attitudes),
    - Facility assessment (for availability of supplies and services, and privacy)
* Reports of RH service provision (including contraceptive distribution) from ASHAs

1. **Expected Results**
2. It is expected that this intervention would lead mainstreaming youth friendly services in the public health system, and would lead to higher footfalls of clients in facilities and young clients attended by ASHAs
3. Given the urgent need to improve access of SRH services among young people, results of this intervention will be scale up and contribute to addressing the SRH needs (esp. FP) of young people in India.
4. **Potential for replicating and scaling up the interventions:** It is expected that once a pilot model for increasing access of young people is developed, the lessons will be scaled up in larger public health system and RKSK. It is likely to have very low additional cost implications, hence potential for replicating is high.
5. **Approvals and ethical considerations**

The agency will ensure that all approvals from the authorities are in place. State UNFPA offices will facilitate the process.

The assessment tools, and consent forms will be ethically reviewed by an ethical review committee (IRB) prior to the start of the assessment.

All interviews with providers will be one-to-one interviews conducted and strict attention will be paid to confidentiality during the interviews. Proper written and verbal consent will be sought prior to starting the interview. All ethical procedures will be followed.

1. **UNFPA’s support in Rajasthan**

UNFPA is the lead development partner for implementation of RMNCH+A initiative in the state and supporting DMH&FW in strengthening of RMNCH+A initiative in high priority districts. UNFPA is also supporting strengthening the implementation of FP programme and RKSK initiative in the State. Besides this, UNFPA has supported establishment of two skill labs for strengthening of pre-service midwifery education and capacity building of in-service health service providers in the state.

In the CP-9, UNFPA will continue to work to create enabling environment for provision and utilization of FP services in the state & protection of client’s rights and choices. UNFPA will support Government in strengthening the implementation of large scale initiatives including RMNCH+A, FP2020 and Mission Parivar Vikas in the state. UNFPA will also support in improving the roll-out of FPLMIS and newer contraceptives in the state. Besides that, UNFPA will facilitate the development of model initiative at the field level showcasing best practices in the convergence.

Rajasthan is a state with high TFR and there is significant unmet need of FP services in the state. State also have one of the highest child marriage rate among girls in the country, which is resulting in high number of adolescent pregnancies and there by putting their and the child’s health at risk. Besides that, studies undertaken by the UNFPA in the state shows that there are significant gaps in terms of availability and quality of RH services for the young people... There is need to orient service providers on the RH need of young people and to make them more sensitive towards their need. The need of providing youth friendly services would result in the improvement of the RMNCH outcomes In this regard, the intervention will be undertaken through the identified partners at national and state level to make the services youth friendly in identified districts & facilities. The learning from the initiative will be scaled up across the State with NHM’s resources and PIP support.

1. IIPS and Population Council. Youth in India: Situation and Needs, 2006–2007. Government of India, Ministry of Health and Family Welfare. [↑](#endnote-ref-1)
2. United Nations Population Fund (UNFPA). State of the world population 2014. The power of 1.8 billion: adolescent, youth and the transformation of the future. New York: UNFPA; 2014. [↑](#endnote-ref-2)
3. Denno DM, Hoopes AJ, Chandra-Mouli V. Effective strategies to provide adolescent sexual and reproductive health services and to increase demand and community support. J Adol Health. 2015;56(Suppl 1):S22-S41. Available from: http://dx.doi.org/10.1016/j.jadohealth.2014.09.012 [↑](#endnote-ref-3)
4. Kanesathasan A, Cardinal LJ, Pearson E, Das Gupta S, Mukherjee S, Malhotra A. Catalyzing change: improving youth sexual and reproductive health through DISHA, an integrated program in India. Washington, DC: International Center for Research on Women; 2008. [↑](#endnote-ref-4)
5. Chandra-Mouli V, Mapella E, John T, Gibbs S, Hanna C, Kampatibe N, et al. Standardizing and scaling up quality adolescent friendly health services in Tanzania. BMC Public Health. 2013;13:579. [↑](#endnote-ref-5)
6. Adolescent friendly contraceptive services: Mainstreaming Adolescent Friendly Elements into Existing Contraceptive services. Family Planning High Impact Practices Brief. Available at: https://www.fphighimpactpractices.org/sites/fphips/files/hip\_afcs\_brief.pdf [↑](#endnote-ref-6)
7. Elements of client friendliness will also be incorporated into maternal health where possible. [↑](#footnote-ref-1)
8. UNFPA, Youth friendliness of public health facilities in Odisha and Rajasthan. 2017. [↑](#endnote-ref-7)