

National Consultation on RCH II ARSH Strategy A Report

2nd to 5th
September 2005

Tivoli Garden Resort,
Chattarpur Road, New Delhi

Organized by:



World Health
Organization



स्वास्थ्य एवं परिवार
कल्याण मंत्रालय
भारत सरकार



United Nations
Population Fund

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List of Abbreviations

AFHC	Adolescent-friendly Health Centre	MTP	Medical Termination of Pregnancy
AFHS	Adolescent-friendly Health Services	NACO	National AIDS Control Organisation
AIDS	Acquired Immune Deficiency Syndrome	NACP	National AIDS Control Programme
ANC	Ante-natal Check	NCERT	National Council for Education Research and Training
ANM	Auxiliary Nurse Midwife	NGO	Non-Government Organisation
ARSH	Adolescence, Reproductive and Sexual Health	NIHFW	National Institute of Health and Family Welfare
ART / ARV	Anti-Retroviral Treatment	NPIP	National Project Implementation Plan
AWC	Anganwadi Centre	NRHM	National Rural Health Mission
AWW	Anganwadi Worker	NYK	Nehru Yuva Kendra
BCC	Behaviour Change Communication	OPD	Out-patient Department
BMI	Body-Mass Index	PEP	Post Exposure Prophylaxis
CEDPA	Centre for Development and Population Activities	PHC	Primary Health Centre
CHC	Community Health Centre	PIP	Project Implementation Plan
CMHO	Chief Medical and Health Officer	PPP	Public-Private Partnership
DFID	Department for International Development	PPTCT	Prevention of Parent to Child Transmission of HIV
DH	District Hospital	PRI	Panchayati Raj Institution
EC	European Commission	RCH	Reproductive and Child Health
EHDAG	Environment Health and Development Advisory Group	RMPs	Registered Medical Practitioners
EmOC	Emergency Obstetric Care	RTI	Reproductive Tract Infection
FOGSI	Federation of Obstetric and Gynaecological Societies of India	SACS	State AIDS Control Society
GSACS	Gujarat State AIDS Control Society	SCOVA	Société Coopérative Objectif Vaincre l'Autisme
HIV	Human Immuno-deficiency Virus	SHAHN	Sexual Health and Adolescence Health Network
IAP	Indian Association for Paediatrics	SHG	Self-Help Group
ICPD	International Conference on Population and Development	SRH	Sexual and Reproductive Health
ICDS	Integrated Child Development Scheme	STI	Sexually Transmitted Infection
IEC	Information, Education, Communication	TFR	Total Fertility Rate
IFA	Iron Folic Acid	UNAIDS	United Nations Programme on HIV/AIDS
IMCI	Integrated Management of Childhood Illness	UNFPA	United Nations Population Fund
IMR	Infant Mortality Rate	UNGASS	United Nations General Assembly Special Session
IPC	Indian Penal Code	UNICEF	United Nations Children's Fund
IPD	In-patient Department	UNIFEM	United Nations Development Fund for Women
LHV	Lady Health Volunteer	VCTC	Voluntary Counselling and Testing Centre
MDG	Millennium Development Goals	VHC	Village Health Centres
MHRD	Ministry of Human Resource Development	WCD	Women and Child Development
MMR	Maternal Mortality Rate	WHO	World Health Organisation
MO	Medical Officer	YFHS	Youth-friendly Health Services
MoHFW	Ministry of Health and Family Welfare		
MoYAS	Ministry of Youth Affairs and Sports		

Introduction

The WHO document on Adolescent Friendly Health Services¹ states that adolescents are at risk of early and unwanted pregnancy, of sexually transmitted infections (STIs), including HIV/AIDS, and vulnerable to the dangers of tobacco use, alcohol and other drugs. Adolescents are rendered more vulnerable with millions being denied the essential support to becoming more knowledgeable, confident, and skilled adults. Since they represent a positive force in society, now and for the future, the development needs of adolescents are matters of concern for the whole of civil society. Health services play a specific role in preventing health problems and responding to them; however, changes are warranted in order for health services to become adolescent friendly.

Adolescents in India represent over one-fifth of the population. Though they constitute the healthiest 22.8 percent of the total population of India, they also are a vulnerable group. This is because of the rapid physical, mental and psychological changes occurring in this age coupled with lack of proper sources of information and education from parents, teachers, service providers or peers. Both the National Population Policy 2000 and the Tenth Five Year Plan highlight the need for catering to reproductive and sexual health needs of this underserved group.

In the National Reproductive and Child Health (RCH) Phase II Programme Implementation Plan (PIP), the Ministry of Health and Family Welfare (MoHFW) approved a technical strategy on Adolescent Reproductive and Sexual Health (ARSH). The National Programme Implementation Plan (NPIP) proposes to pilot this strategy in 75 districts of the country. The strategy focuses on reorganizing the existing public health system in order to meet the service needs of adolescents. It aims at improved service delivery for adolescents during routine sub-centre clinics and ensures service availability on fixed days and times at the Primary Health Centre (PHC) level. Along with outreach activities, a core package of services would include preventive, promotive, curative and counselling services. In order to facilitate service delivery for adolescents, key interventions would also include training of service providers, environment building activities and Management Information Systems (MIS).

Two-fold progress has been made towards facilitating the implementation of the RCH II ARSH strategy.

- (i) First, under the guidance of the Adolescent Health Training Sub-group convened by the MoHFW (with UNFPA as the lead agency), a training design has been developed, based on which Medical Officers and Auxiliary Nurse Midwives (ANMs), i.e. service providers, have been trained on a pilot basis in three districts in the states of Gujarat, Rajasthan and Uttar Pradesh.
- (ii) Secondly, preliminary guidelines have been developed for operationalizing the RCH II ARSH strategy.

To take the above process forward, a National Consultation on the RCH II ARSH strategy was organized from 2-5 September 2005, to firm up the operational guidelines, particularly in terms of components related to training, service delivery, communication, quality standards and monitoring. Experiences of tertiary level Adolescent Friendly Health Clinics (AFHCs) being supported in 14 sites of the country were expected to serve as valuable and timely inputs in the process.

Objectives of the Consultation

The overall aim of the Consultation was to develop an implementation framework for the RCH II ARSH strategy. Specific objectives were as follows:

¹ WHO/FCH/CAH/02.14

- To develop operational guidelines for implementing RCH II ARSH strategy in a district setting.
- To build consensus on a framework of standards for quality assurance in service delivery in the context of Indian public health standards.
- To share experiences of AFHCs at the tertiary level.
- To strengthen inter-sectoral linkages and partnerships, in particular, the National AIDS Control Programme III (NACP III) in policy and programming for services for adolescents.

Expected Outcomes

- Detailing of operational guidelines for quality service delivery interventions to be organized at facilities.
- Mapping of standards' framework for quality assurance in service delivery for adolescents.

Participants

Participants included:

- Central Government representatives from the Ministry of Health and Family Welfare (MoHFW), the National AIDS Control Organization (NACO), the National Institute for Health and Family Welfare (NIHFW), the Ministry of Youth Affairs and Sports (MoYAS), and the Ministry of Human Resource and Development (MHRD).
- Representatives from AFHC sites in Bangalore, Baroda, Chandigarh, Kolkata and Lucknow.
- State Government representatives from Gujarat, Tamil Nadu, Orissa, Rajasthan, Uttar Pradesh, and Jharkhand.
- Representatives from professional associations like the Federation of Obstetric and Gynecological Societies of India, the Indian Association of Pediatrics and the Indian Medical Association.
- Representatives from development partners – UNICEF, World Bank, DFID, European Commission, UNIFEM, UNESCO and UNAIDS
- Resource persons from WHO, UNFPA and external experts.

Methodology

The methodology of the workshop was interactive and participatory. Keeping in mind the expected outcomes, the Consultation was divided into distinct sections which included, sharing the different aspects of operational guidelines and standards' framework through presentations and discussions. The Consultation also included poster presentations on tertiary level AFHC experiences. Participants were divided into groups for working in depth on different components of the operational guidelines, which were followed by group presentations and plenary discussions. This report aims at capturing the processes as well as the technical content deliberated upon during the workshop.

Inaugural Session

The inaugural session started with Mr. Chaitanya Prasad, Deputy Secretary, MoHFW, setting the context. The opening remarks were delivered by Mr. Hendrik van der Pol, UNFPA and Dr. Salim J Habayeb, WHO. The keynote address was delivered by Mr. P. K. Hota, Secretary, MoHFW.

Setting the Context – Mr. Chaitanya Prasad, Deputy Secretary, MoHFW

In his opening remarks Mr. Chaitanya Prasad, Deputy Secretary, MoHFW, spoke on how the year 2005 was a milestone for MoHFW, with the NRHM being launched on 12 April as the flagship programme of the ministry and the operationalisation of RCH II on 1 April. Introducing the rationale and need for ARSH, he brought out with the help of clear statistics, the urgent need for health programmes in the country to focus on adolescents. Introducing the keynote speaker, Mr. Hota, he spoke on how the Secretary, MoHFW, had been able to successfully guide the programme such that a strategy on ARSH had been incorporated into the RCH II PIP.



This Consultation was to work towards identifying a road map to position the strategy in the context of realities. He emphasized that one of the most important aspects was the integration of HIV/AIDS into RCH II. Thus in the RCH II ARSH Strategy, focusing on the adolescent health component involves the following:

- Reorganizing the existing public health system.
- Working towards meeting the needs of adolescents.
- Reducing total fertility rate (TFR) and maternal deaths among teenage mothers.
- Reduced prevalence of RTS/STIs.
- The need for a deliverable strategy looking at different stages of development, needs and problems of adolescents.

He added that the concept of adolescent reproductive and sexual health has been accepted by the states as a part of RCH II. Now there was a need to develop a common understanding of the concept, its components and implementation strategy by:

- Reaching the grassroot level in implementation.
- Establishing a good data system.
- Integrating and complementing the strengths of NACO and the Ministry for better service delivery.
- Improving on the component of behaviour change communication in RCH II.

He also brought out the fact that the needs of adolescents differ according to different areas, states and countries which is why the ministry cannot have a uniform plan for all the states which would subsequently impact financial plans, etc.

Opening Remarks – Mr. Hendrik van der Pol, UNFPA Representative

Mr. van der Pol reiterated that the issue which the Consultation aimed at addressing was something that everybody would identify with – the needs, risks and anxieties of adolescence. He expressed his belief in the fact that adolescents should receive correct health information and timely services to cope with the challenges of growing up. He commended the efforts of the Ministry of Health and Family Welfare in developing a strategy for adolescents in RCH II, which responded to various pressing issues like early marriage, teenage pregnancies, unmet contraceptive needs, growing incidences of HIV/AIDS, and so on. He emphasized that RCH II ARSH was a great opportunity to provide these services to the young people and stressed that it was important to identify practical interventions to reach out to this group. RCH II provided a platform to address the needs of adolescents in totality.

He reiterated the UNFPA's commitment to the Government of India and the State Governments in taking this process forward at both the Central and the State levels. Also, he said that working on issues of adolescents was an integral part of the life cycle approach to RCH and reinforced UNFPA's commitment to the International Conference on Population and Development (ICPD) and the National Population Policy goals. He added that UNFPA had been very happy to collaborate so closely with the MoHFW for developing this strategy and initiating the process of operationalizing it. He applauded the efforts of partner departments like the Departments of Secondary and Higher Education, Youth Affairs and Women and Child, which brought into limelight the need and value of addressing an adolescent's life in totality.



In his final remarks, he added that the inadvertent bulge on account of this sizeable young population on India's population pyramid was, through efforts such as the RCH II, being converted into a demographic bonus, a bulge of hope and opportunity for India.

Opening Remarks – Dr. Salim J Habayeb, WHO Country Representative

In his opening address, Dr Salim J Habayeb emphasized the need to recognize the rights of children and adolescents to attain good health and access the best of services. He spoke of how the needs of this group differed across regions and countries and that there were knowledge gaps, which is why research was of utmost importance, especially in risk behaviour groups. He applauded the efforts of the GoI in recognizing the need to address this productive group of society and the courageous steps which had been taken to address the same and build capacity. He also expressed that this Consultation was enriched by the presence of experts from multi-sectoral agencies, state colleagues and development partners and would aim to reach a consensus to develop meaningful operational guidelines for the RCH II ARSH strategy.



Keynote Address – Mr. P. K. Hota, Secretary, MoHFW

The Consultation was inaugurated by Mr. P. K. Hota, Secretary, MoHFW. In his keynote address, Mr. Hota emphasized how adolescents formed an underserved social section in society. They were not children anymore and not yet adults, therefore their needs were different. He underlined that there was a need for a shift from existing programme perspectives towards addressing the needs of the adolescents who were in a transitory, formative and vulnerable stage of life. They passed through well-described physical, psychological and sexual maturation stages. For most adolescents this became a period of psycho-social stress, which made them very vulnerable.

Some of the services adolescents required were different from those provided for adults or children. Services needed a greater emphasis on information, psycho-social support, promotive and preventive health services – as was appropriate for a maturing population. He also pointed out that the needs of adolescents had to be mainstreamed into different sectors like education, not just health, which was why it had become an issue of multi-sectoral convergence. He emphasized the need for the health system to address the multi-disciplinary requirements of this section of society in the context of a life cycle



approach and in a multi-sectoral initiative, involving other related ministries like education, youth, affairs and sports, women and child development and so on. He spoke of prioritizing and distinguishing between community tasks, parental tasks, and health system tasks and aiming at long-term achievements and results. He touched upon the issue of cost effective, regularized service delivery mechanisms, and said that in this direction this National Consultation would be looking at a marketable service delivery model. In the process some interventions like capacity enhancement of the systems could be taken up in a phased manner. He also stressed on how HIV/AIDS was a growing threat to this most productive human resource group and reiterated that the deliberations and valuable advice coming from the Consultation would be followed up at the ministry level.

Session 1: Services for Adolescents in RCH II ARSH

The following presentations were made in this session:

- Indian Context - Mr. Chaitanya Prasad, Deputy Secretary, MoHFW
- Global AFHS Overview - Dr Chandramouli, WHO HQ, Geneva
- Youth Friendly Health Services for RH & HIV/AIDS: The South Asia Context - Dr Farah Usmani, Adviser, Reproductive Health & HIV/AIDS, UNFPA CST for South and West Asia, Kathmandu
- AFHS Pilots in India - Dr Arvind Mathur, WHO, India

Indian Context - Mr. Chaitanya Prasad, Deputy Secretary, MoHFW

The presentation brought out various key issues pertaining to access to information and skills, access to health care services, and so on from the perspective of addressing adolescent reproductive and sexual health. According to Mr. Prasad, the rationale for ARSH focus was borne out of the following statistics: One-fifth of India's population are adolescents; more than half of illiterate currently married females are married below 18 years; fertility in age group of 15-19 years contributes to 19 percent of the TFR; 27 percent of married adolescents have reported unmet need for contraception, and over 35 percent of reported HIV infections occur in 15-24 years age group. These facts laid to rest the skepticism that adolescent-related services need not be a part of prioritized health care services. In fact, it brought out the point that without optimally addressing the health concerns of all groups of the population, no health services could be complete.

Further, adolescents in India formed a very diverse segment of population, with their being at different stages of development, in different circumstances, with varying needs and diverse problems.

ARSH and RCH-II

The presentation brought to the fore that in RCH-II, the Department of Family Welfare gave special focus on meeting health service needs of adolescents. The overall objective of ARSH Strategy was to contribute to the RCH-II goals of reduction of infant mortality rate (IMR), maternal mortality rate (MMR) and total fertility rate (TFR). This objective was planned to be met by reducing teenage pregnancies, meeting unmet contraceptive needs, reducing number of teenage maternal deaths, reducing incidence of STIs and reducing the number of HIV positives in the 10-19 age group. For this purpose, the MoHFW had proposed a two-pronged strategy:

- Incorporate adolescent issues and vulnerabilities in all RCH training programmes and communication and behaviour change communication (BCC) material
- Improve service provision for adolescents on fixed days and timings at PHCs/Community Health Centres (CHCs) and routine sub-centre clinics along with establishing referral linkages.

The strategy involved building capacities of the health system by imparting training in skills of service providers and improving their sensitivity to adolescent-related issues and providing services for adolescents to cover preventive, promotive, curative and counselling services. It also involved sensitization among the adolescents through extensive IEC and BCC activity and production of materials. Another important aspect of the strategy was monitoring and evaluation (M&E) for which MIS indicators had also been identified as per specific objectives of the ARSH strategy as a result of which India could soon have sufficient data to support the strategy. Programmatic interventions under the strategy included inter-sectoral linkages with NACP and National Rural Health Mission (NRHM).

In terms of progress, this strategy had been approved as part of National RCH-II PIP and had been incorporated in State RCH-II PIPs with variations. Further a self-learning module for rural youth and health care providers had been developed based on this strategy. The MoHFW RCH-II ARSH Training Sub-Group had been constituted, and had developed a training design document. Members included the NIHFW, UNFPA (as the lead development partners), WHO-India, and experts.

Capacity Building for RCH -II

Further, an orientation package had been developed for Programme Managers, Medical Officers and health frontline functionaries (ANMs/LHVs). This package had been pre-tested in three districts of Uttar Pradesh, Rajasthan and Gujarat with the assistance of CEDPA and UNFPA. The consequent feedback had already been incorporated, based on which the training package had been revised. Preliminary guidelines for operationalizing the RCH-II ARSH Strategy were presently under development. These guidelines are expected to be used by State & District Programme Managers.

The strategy is to be implemented in 75 selected districts across the states. NACP III had identified 111 critical districts proposing that HIV/AIDS would be one of the criteria for the selection of 75 districts. The states have positioned the concept of adolescents effectively at the policy level. The presentation emphasized that as a future step it became essential to closely track the implementation of ARSH Strategy in 75 districts to collect evidence and scale up.

Global AFHS Overview - Dr Chandramouli, WHO HQ, Geneva

The second presentation of the session brought out relevant definitions and concepts related to AFHS, along with the findings about what had been learnt about making health services adolescent-friendly.

The presentation touched upon the Global Goals relevant to young people. These included:

- **The goals of UNGASS HIV/AIDS**
 - ♦ By 2005, ensure that at least 90 percent (& by 2010...95 percent) of young people...have access to ... **information** ... **skills** ... & **services** they need...to reduce their **vulnerability** to HIV...
 - ♦ By 2005... **HIV prevalence** among young people (15-24 years) reduced by 25 percent in the most affected countries ... by 2010 ... reduce prevalence by 25 percent globally.
- **The Millenium Development Goals on HIV/AIDS and Maternal Mortality**
 - ♦ Have halted by 2015 and begun to reverse the spread of HIV/AIDS (HIV prevalence in pregnant 15-24 years as a specified indicator).
 - ♦ Reduce by three-quarters the 1990 maternal mortality ratio by 2015.

Drawing on the basic definition of adolescents being young people who are no longer children and not yet adults, Dr. Chandramouli's presentation was woven around a few key questions. For example, "What do adolescents need to grow and develop in good health? What is the special contribution that the health sector needs to make? What do we mean by adolescent-friendly health services?"

What Adolescents Need: Information and Skills

As identified earlier, adolescents need information and skills, a supportive environment and in the form of a safety net, health and counselling services. Dr. Chandramouli emphasized that the health sector needed to collect, analyze and disseminate data required for advocacy, policies and programmes and on the basis of these support the development of evidence-informed policies and strategies that provide vision and guidance. It also need to provided services that include a focus on prevention, treatment and rehabilitation and mobilize and support other sectors.

"...services are youth-friendly if they have policies and attributes that attract youth to the facility or programme, provide a comfortable and appropriate setting for serving youth, meet the needs of young people, and are able to retain their youth clientele for follow-up and repeat visits".²

Making Services Adolescent-Friendly

The second part of the presentation brought out answers to the question 'What have we learnt about making services adolescent-friendly?'

In the absence of extensive data, it is indeed difficult to clearly perceive, how close the movement has been towards the MDGs. Encouragingly, studies from Uganda and Juventa, Russia, indicate that health-seeking behaviour of adolescents in terms of accessing information and health-care centres has steadily increased in past few years. However, this depends a lot on the approaches to provision of information and health care. In Mexico, a field study points out that three different approaches to providing contraceptive information and services attracted three different groups of adolescent girls and boys. Thus, no one single approach can be adopted to reach a heterogeneous and divergent adolescent population. The key to increased utilization of services lies in increasing supply and demand through social marketing, social franchising, and voucher schemes or through approaching parents. Generally, world-wide there is a growing understanding of what works and what does not.

On this basis, the following assumptions can be made:

- Efforts to make health services adolescent-friendly must be set within the context of a broader strategy.
- In many places, adolescents are reluctant to seek help, especially from health facilities in the public sector.
- There is a growing number of promising initiatives in improving the utilization of health services by adolescents.
- There is no 'single solution' to reach all groups of adolescents with the health services they need.
- Initiatives to make health services adolescent-friendly need to be accompanied by initiatives to improve the quality of service provision.
- There is emerging evidence that the provision of health services to adolescents leads to tangible public health benefits.
- In many places, the majority of adolescents are not able to obtain the health services they need.

A literature review shows learnings from interventions that have successfully increased utilization of services by adolescents. According to this review, actions to improve the accessibility of services include obtaining the support of community members, informing adolescents where they could access health services, and linking health services with other interventions (media, educational institutions, work places, etc). Actions to increase the acceptability of health services included making health service providers and support staff more motivated and able to work with adolescents; ensuring privacy and confidentiality; providing informational materials at the point of delivery; and involving adolescents in the assessment and provision of health services.

The challenge

Ministries of health, in growing number of countries, are taking up the challenge of making health care more accessible. The governments in Tanzania, Sweden, and Bangladesh have developed standards for AFHS; they are trying to expand coverage of an evidence-based package of health interventions. IMCI studies in cost-effectiveness in Brazil, Peru, Tanzania, Bangladesh and Uganda indicate that management

² Source: Making Reproductive Health Services Youth-Friendly (Focus on Young Adults, 1999).

of the programme and training of health care personnel make all the difference. In India some existing initiatives have been transformed to be more responsive to meet needs of adolescents as in case of AFHC in the medical college in Kolkata and Safdarjung Hospital, New Delhi.

There have been a growing number of promising initiatives, from different sectors including non-health, private and NGO sectors, to meet the needs of 'well and ill adolescents'. These initiatives bring out a range of possible delivery points along with ushering a shift from health to non-health settings. There is a tendency to conceive adolescence related problems and needs as a part of growing-up, rather than ill-health and these can be effectively addressed with consultation and advocacy, along with treatment. The real challenge remains to document and disseminate concrete and positive experiences to create a knowledge base that would help handle and subvert the problems of adolescents.

Youth-Friendly Health Services for RH & HIV/AIDS: The South Asia Context - Dr Farah Usmani, UNFPA CST for South and West Asia, Kathmandu

The third presentation focused on:

- Situation of RH and HIV among young people in the region
- Youth-friendly health services: Programming experiences on RH/HIV/AIDS from Asia and lessons learned
- Reflections and recommendations

Data shows that of the world's 1.6 billion young people (10-24 years), 1.4 billion live in developing countries and in SAARC countries, young people, 10-24 years, comprise about *one-third* of the population. Regional focus on young people in South Asia was incorporated in the **SAARC Social Charter**, which says that '*State parties shall find ways and means to provide youth with access to education, awareness on HIV/AIDS, STIs*' (January 2004).

Situation on RH and HIV among young people in the region: Selected ASRH/HIV services indicators show that there is a large unmet need for family planning in the 15-19 year age group; the highest number of women who had given birth by age 20 were illiterate; the largest percentage of adolescent girls in South Asia are married before 20 years of age. In several Asian countries, young people constitute over 60 percent of indirect sex workers. Both boys and girls are vulnerable to sexual violence, including abuse and exploitation. In Nepal, half of the 50,000 people injecting drugs were 16-25 years.

Currently, fewer than *one in five* people at risk of infection globally have access to basic prevention services, such as voluntary counselling and testing, condoms, treatment of sexually transmitted infections, strategies to prevent mother-to-child transmission of HIV and harm reduction programmes for injecting drug users. Stigma and discrimination prevent many young people from accessing health services, as they may fear a lack of confidentiality or discrimination from providers. Further, social taboos related to sexuality inhibit open discussion.

Programming experiences: The magnitude of problems adolescents face in South Asia has instigated a surge in interventions directed towards them. These organized interventions display varied programming approaches on operationalizing youth-friendly health and information services. These experiences have been briefly enumerated below.

In the public sector:

- ASRH services in tertiary hospital settings - Bir Hospital, Kathmandu- dedicated SRH clinic for young people at scheduled timings, linkages with other hospital services; India, Safdarjung Hospital Adolescent Network [SHAHN] and other country experiences.
- In Thailand, Youth Friendly Corners were set up for selected services to young people under the national programme of the Ministry of Public Health. In addition, 'friend corners' provided primary

preventive information, counselling and basic health care. These are also used for screening and referral of adolescents to secondary and tertiary centres. Linkages to Thailand's regional health centres, provincial and community hospitals and through local networking with NGOs were established.

NGO models and partnerships:

- The EC/UNFPA Reproductive Health Initiative for Youth and Adolescents (RHIYA) www.asia-initiative.org support to the YFHS in several countries in Asia – Nepal, Bangladesh, Cambodia, and others
- The Nepal YFHS services in 19 districts, 55 YFS Centres – NGO clinic: Sunaulo Parivar Nepal (SPN) and Public Health Concert Trust (PHECT) have separate allocated time for youth only – certain time of the day or certain day of the week, YFHS trained service providers, and linkages with hospital for referrals; three Nepal NGOs (AMK, BPMHF, Samjhauta) YFHS interventions in collaboration with government health post, sub health post and primary health care; services on evenings and weekends; YFHS at municipality ward clinics, services free of charge, staff, clinical and logistics support by RHIYA.

Non – Health Government Settings:

- Youth Clubs [Ministry of Youth] – Youth Club, YFHS 'Youth Café', a package of services dedicated to young people as part of the larger youth club (Maldives); National Youth Council –Model YFHS in NYC in one district [Referral linkages with government health facilities] (Sri Lanka); Youth Clubs for SRH information and counselling only (Bangladesh).
- Ministries of Social Justice/Empowerment: Services for young IDUs– Drug using populations for HIV/AIDS prevention and condom programming through youth centres.
- School Settings: Models for provision of package of services through school health services (primarily information and RH counselling and referrals).

Private Sector Collaborations:

- The Family Planning Association of Sri Lanka and the RHIYA Sri Lanka partners, programming to link with private doctors in the districts for YFHS services to young people from the counselling and information activity centres. Selected private doctors are oriented and provided materials.
- Model just initiated in Nepal of partnering with private doctors in two districts with NGO-Private sector partnership under a UNFPA project for package of SRH and HIV related services for young people.

Workplace & Outreach interventions:

- In Cambodia clinical services are provided in collaboration with five garment factories employing young migrant women to make reproductive health services available at factory clinics. Premises and equipment upgraded and clinic staff trained and supported to provide basic RH services.
- The FPAN Nepal made available a package of condoms and information to young factory workers to increase condom usage and target young boys and men.
- Pathfinder Bangladesh outreach and referral programme for all newly married couples for information, services and referrals led to an increase in contraceptive use among newly wed adolescents in the targeted areas from 19 percent in 1993 to 39 percent in 1997.

As may be seen from the above, the WHO, the European Commission (EC) and the UNFPA have supported different models of Youth Friendly Services in terms of building capacities and provisioning of services in several countries. Referral linkages with the GO and networking between the NGOs have proved to be very fruitful in Thailand and Nepal. Logo branding like 'youth café' is initiated in Maldives and Bangladesh for promoting the AFS and ownership among the adolescents is achieved by involving them in the programmes. Newly married adolescent couples have been especially targeted for outreach in Bangladesh.

Lessons Learned: A review of the need for involving young people in South Asia suggests that their token participation in policy making and planning is redundant. They need to be actively involved in advisory boards, as peer promoters, in developing and pre-testing material, and development of advocacy policy. Building leadership skills is also a key regional component in Nepal and Bangladesh for the UNFPA Global Youth Partners' initiative for HIV/AIDS and SRH. When effective training, supervision and quality check are in place, and quality ARSH services are integrated into existing services, the service statistics show that youth are also willing to utilize the public sector clinics. As young people continue to show increasing trends in HIV infection and SRH goals continue to evade in the region, there is a need to develop strategies to focus on vulnerable / poor young people. At the regional level there is also a pressing need to conduct large-scale programmes that will meet the need of the increasing number of young people. Process documentation of the small-scale demonstration projects, which includes evidence on programme results, is crucial for up scaling and replication of the processes into wider programmes.

AFHS Pilots in India - Dr Arvind Mathur, WHO India

Dr. Mathur took the audience through the evolution of the first AFHC, which was initiated at the Pediatric Department of Safdarjung Hospital, New Delhi. Initially, the services offered by this centre included an evolving package of curative services. However, it followed a typical medical approach (with urban bias) with the assumption that adolescents would start walking into the clinic on their own. Gradually, health care providers for curative services were provided orientation, and sensitization of health care providers and gatekeepers was taken up. Later the centre was expanded as the Safdarjung Hospital Adolescent Health Network (SHAHN).

Building on existing experiences and recognizing the need for more evidence, the GoI-WHO supported establishment of more centres at different sites across India. It also implemented a set of common broad guidelines with flexibility in programme development and implementation. Health needs assessment, including health seeking behaviour, was studied at these sites.

The presentation brought out the salient characteristics of AFHCs in India as follows:

- Accessibility - Information about the centres is displayed at prominent and important places in the hospitals and outreach networking schools; flexi-timing usually afternoon, after school hours.
- Adolescent Friendly Health Facility - Usually a separate and spacious room providing safe environment with convenient location; appealing setting; privacy; provide information and education material; convenient working hours.
- Availability of Adolescent-friendly health care providers - Technically competent providers; promotion, prevention, treatment and care is available; variable inter-personal and communication skills; providers devote time to clients and patients; provide information.
- Involvement of adolescents - Through networking in schools; involvement in needs assessments; dissemination of information about services available.
- Community-based (working with slums population), outreach through schools and community-based organizations.

Dr. Mathur also touched upon the lessons learned from the various AFHCs across India:

- AFHC as a vertical model does not really lead to reaching out to adolescents.
- It is important to make the health system adolescent friendly and make AFHC an integral part of the system.
- Standards of quality services need to be stated to have uniformity.
- It is important to adapt and modify the model to develop linkages and foster partnerships with schools, community-based organizations and NGOs.

- Service mix needs to be responsive and flexible.
- Services could be provided in both health and non-health settings.
- There are important non-health activities that need to be addressed for overall adolescent health and development.
- Involvement of gatekeepers is critical for the effective coverage.
- Partnership with multiple stakeholders is key and involvement of civil societies and private sector in reaching out to adolescents would be essential.
- Concurrent IEC/BCC activities need to be undertaken to popularize the available services.
- Measurement and monitoring indicators of adolescent programme interventions are to be incorporated in the programme from the beginning.

Session 2: Operationalizing Health Services for Adolescents

Implementing the ARSH strategy

Ms. Mandeep Janeja and Dr. Dinesh Agarwal, UNFPA India

A draft implementation guideline prepared by MoHFW and UNFPA was presented to the group for comments, inputs and review. The presentation broadly covered the following issues – context setting, organizing services & capacity building, IEC activities, and monitoring and supervision. The presentation looked at the implementation of the RCH II ARSH strategy at the state and district levels.

ARSH Strategy

The two-pronged ARSH strategy focuses on (i) the integration of adolescent issues and vulnerabilities into the communication and training material, and (ii) looking at ways to organize services through the public health system.

When one looks at the issue of 'How to organize services?' the strategy is based on the following basic premises:

- It is not about revamping services or setting up something entirely new.
- It is about reorganizing the public health system to bring it closer to adolescents.
- A combination of routine sub-centre clinics & teen/adolescent clinic on fixed day & timing at PHC/CHC levels for providing services.
- Referral linkages with district hospital & outreach activities.

Organizing routine clinics through sub centres combined with adolescent/teen clinics on fixed days and timings at the PHC and CHC level— for nutrition counselling, menstrual hygiene guidance, RTI/STI and HIV/AIDS prevention and management, anaemia control and management and antenatal care for young mothers is a part of the core RCH II ARSH strategy.

Essential characteristics of adolescent-friendly services include –

- Easy availability and accessibility of services to adolescents.
- Service delivery in an equitable manner regardless of age, caste and marital status.
- Encouraging unmarried adolescents (boys and girls) to access services and ensuring that the services meet the expectations and are relevant to their needs.
- Comprehensive package of services with referral to social & other relevant services; Services to cover the continuum of prevention and treatment.
- Ensuring policy support – for equitable service provision, privacy and confidentiality, appropriate management systems, competency of service providers and convenient location of facilities in terms of suiting the timings and needs of adolescents.
- Involvement of adolescents in every stage of implementing the RCH II ARSH strategy at the state and district level.

In an analysis of the ARSH strategy in 20 states' RCH-II PIP documents, it has been found that adolescent health has been incorporated as a technical strategy. In 80% of the state documents, organizing of adolescent clinics at the PHC and CHC level and district hospitals in a phased manner has been proposed.

In the case of Gujarat, the State Government is planning state wide AFHS to concretize and operationalize the RCH-II strategy.

Services Package

The presentation also elaborated on the service package, organizing services and capacity building aspects of operationalizing the strategy. With reference to service package accessibility, availability, affordability, appropriate technology and working closer to the community have been important considerations while designing the service package. The package includes the following range of services:

- Promotive services - Focused care during prenatal period, counselling and provision for emergency contraception, counselling and provision of reversible contraceptives, including dual protection, information/advice on sexual and reproductive health issues.
- Preventive services - Services for tetanus immunization, service for prophylaxis against nutritional anaemia, nutrition counselling, services for early and safe termination of unwanted pregnancy.
- Curative services - Treatment for common RTIs/STIs, treatment and counselling for menstrual disorders, treatment and counselling for sexual concerns of boys, management of sexual abuse amongst adolescent girls.
- Referral Services - VCTC (Voluntary Counselling and Testing Centre), PPTCT (Prevention of Parent to Child Transmission), ART (Anti-Retroviral Therapy).

With regard to capacity building, the following progress has been made:

- RCH II Training Sub group on ARSH set up to steer trainings.
- Sub group has developed a training strategy document.
- Main focus of trainings is on perspective building and capacity building for providing need based adolescent friendly services within framework of RCH programme.
- Training package has been developed for (i) Programme Managers (ii) Medical Officers (iii) ANMs/LHVs. This training package was field tested in three districts: Dahod (Gujarat), Alwar (Rajasthan), Lucknow (UP), covering 26 Programme Managers, 45 Medical Officers and 52 ANMs/LHVs. Systematic feedback and reporting systems were used with participants, facilitators and observers.
- Lessons emerging from the field testing included - Separate orientation packages are required for different cadres of providers; handouts need to be translated into the regional language, wherever necessary, and should be sent to participants in advance; and trainers should be skilled in using participatory methods for the training. In addition it was also found that service providers needed refresher training in technical areas of maternal health, contraception and STIs/HIV.

Communication Activities

The presentation also brought out that communication activities are an essential pre-requisite if adolescents are to interface with health system. There needs to be concurrent and continuous conduct of communication activities by the health department. It also recommended that the government undertake communication activities at the levels of the community and adolescents.

At the community level there could be orientations for the district level officers, and Zila Panchayat members. At the block level, there could be meetings involving the Medical Officer and the PRIs/WCD/ Education/Youth Affairs officials for creating a supportive environment. At the ANM and the PHC level, there could be orientation activities for the SHG members and networking activities with ASHA, AWW and community functionaries.

At the level of adolescents, outreach sessions could be organized once a month for group communication activities. At the Sub-centre level, once a month group communication activities could be organized with

schools and youth groups, along with health check-up in schools organized once in six months by the PHC Medical Officer. In addition, District Chief Medical Health Officer must ensure that all Sub-centres and PHCs are equipped with communication materials handy for service providers and adolescents. Proper signage, branding and logo must be developed for communicating clearly what is to be provided to adolescents— in short client convenience where they can ask questions freely, and a quality package of services is available.

Inter-sectoral linkages

Suggested steps for piggybacking the work of other departments and establishing inter-sectoral linkages were outlined. Core monitoring indicators were suggested keeping in mind the existing load of the MIS and the proposed data flow system in RCH II. Monitoring and supervision are based on positive input indicators (such as number of SCs and PHCs having ready reckoners, communication and counselling material for access by adolescents, etc.) and process indicators (such as number of teenage pregnant women attending antenatal care, adolescents referred to CHC/DH). Output and outcome indicators, (for e.g. unmet need for contraceptives, prevalence of anaemia among young pregnant women and teenage pregnancy rates) can be captured through rapid annual household surveys and assessment studies. Training and communication activities also need to be monitored. Scope of monitoring should cover whether or not minimum standards of quality assurance in ARSH services are met.

Day 2

Recapitulation of Day-1:

The session on the second day included presentations, as well as group work. The proceedings highlighted the link between adolescent health and education. The day was, however, mainly devoted to the issues pertaining to standards and quality of adolescent-friendly health services.

The day began with the participants being handed out cards to write their comments and opinions about the previous day's sessions. Most of the participants were appreciative of the organization of the event, profile of resource persons and participants and the deliberations during the proceedings. Some participants felt that the beneficiaries i.e. adolescent boys and girls, should have been represented. However, one should not stop at tokenism but find ways of meaningful representation of adolescents at appropriate level in forums for planning programmes related to them.

Dr Chandramouli, while referring to the previous day's proceedings mentioned that this meet was a first step in finalising the guidelines for ARSH— there was need to prioritize the target groups and focus on their vital concerns in order to arrive at a package of health services that could be offered. He also added that the service package needed to relate to the health outcomes aimed at.

Interventions by MHRD and NACO representatives

Mr. Keshav Desiraju, Joint Secretary, Ministry of HRD, Department of Secondary & Higher Education, expressed that along with the entire school machinery, NGOs could play a major role in addressing the needs of adolescents. In a compartmentalized atmosphere, there was a chance of confusion, in terms of which agency undertakes what task. He added that the states should make use of work done by NACO, UNFPA, and NPI to produce IEC material, since awareness building was important for inducing safe behaviour and preventive measures among adolescents. He stressed collaborations and partnerships with non-health sectors, NGOs, civil society, community and the adolescents themselves in the form of peer educators, etc., which would be the key for an effective health care delivery provision and health promotion among 14-19 years age group of girls and boys.

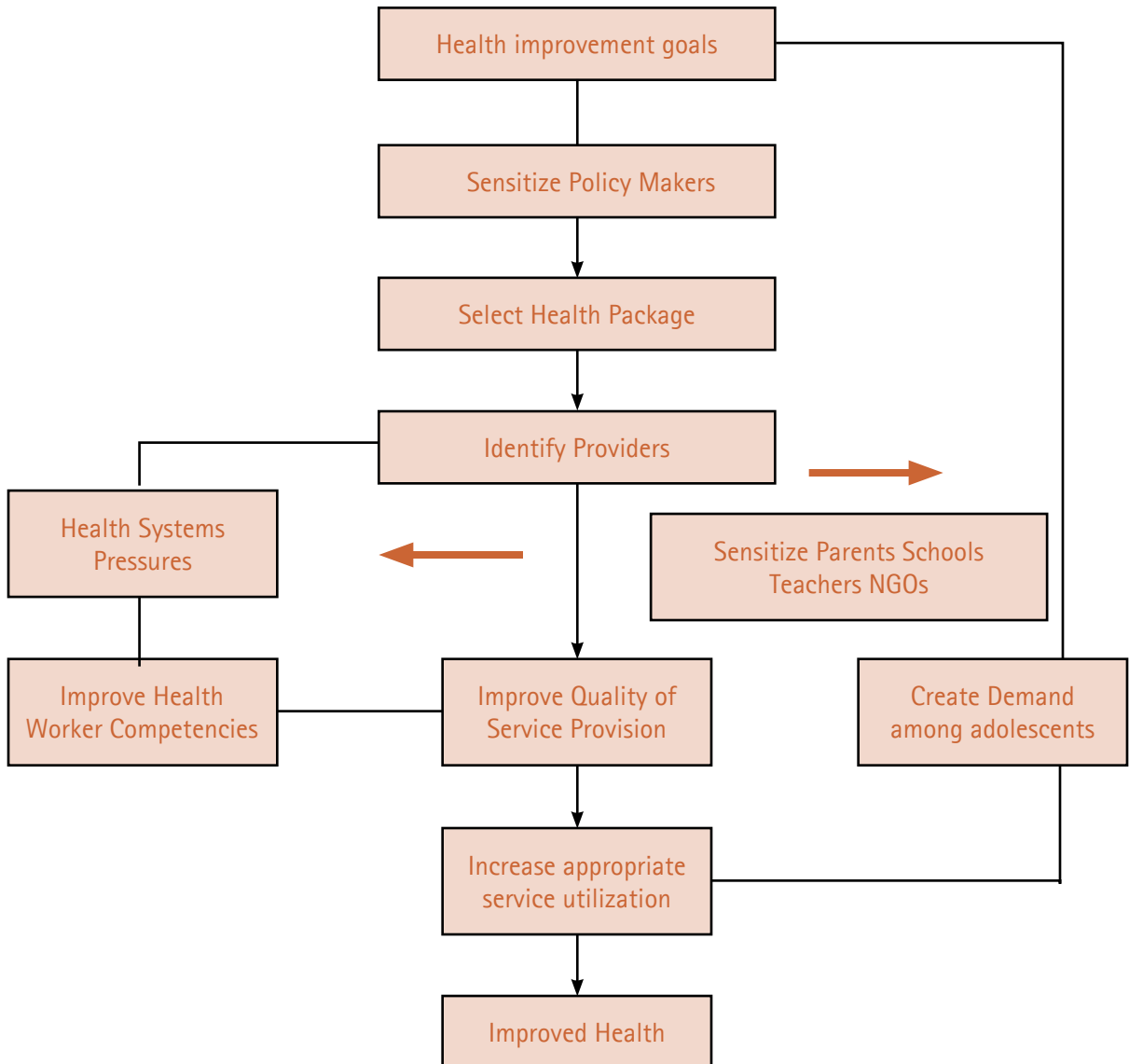
Mr. Bhagwan Prakash, Team Leader, NACP III, from NACO shared that six out of eight educational goals already reflected the coordination between the health and education aspects of adolescent's development. There was still the issue pertaining to out-of-school children and community level sensitization that need to be addressed. He also underscored that adolescent males were still neglected, as there were not enough schemes and programmes focusing on them and sensitive to their needs. This was in contrast to adolescent girls, who had special schemes like Kishori Shakti Yojana and other pilots. Mr Prakash assured the participants that this consultation was very important and that inputs and recommendations from this four-day interaction would feed into the planning of NACP III. He also shared that there was a need for developing district level databases for better programme design and service delivery.

Group Work

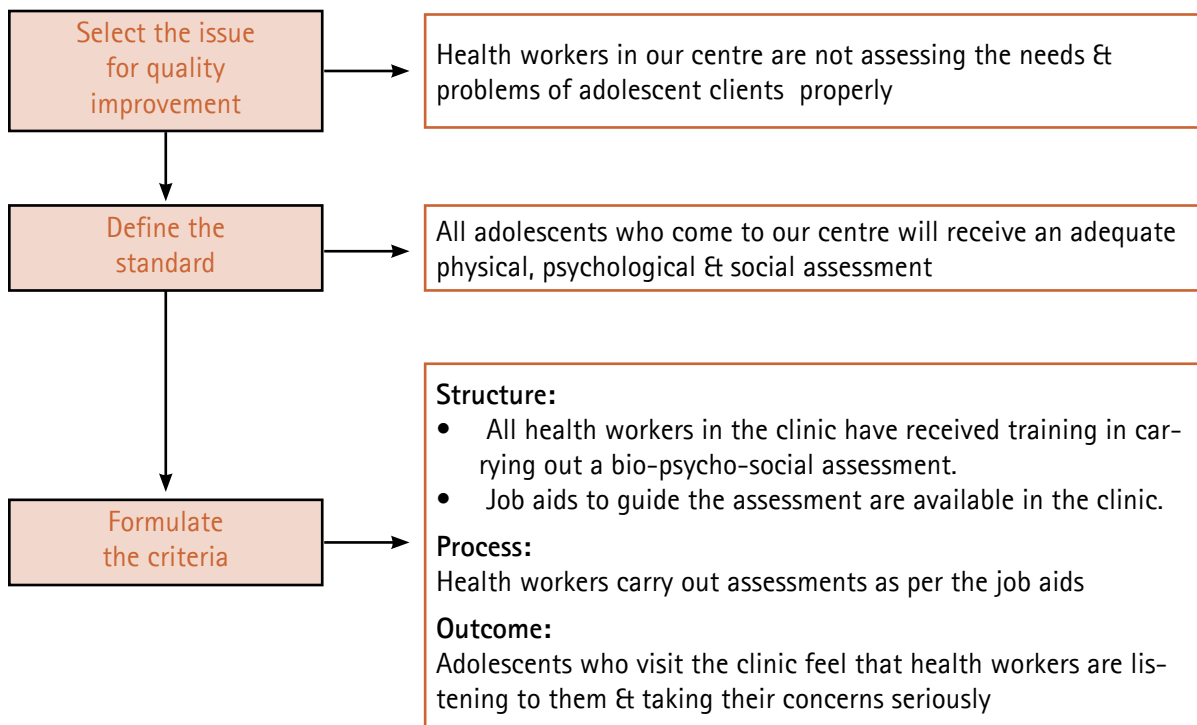
Participants were divided into groups for working in-depth on different components of the operational guidelines, which were followed by group presentations and plenary discussions. Day 2 was devoted to the issues pertaining to 'standards', facilitated by Dr. Chandramouli (WHO) and Dr. Farah Usmani (UNFPA). The Consultation also included poster presentations on tertiary level AFHC experiences.

To facilitate discussions two presentations were made by Dr. Chandramouli.

The first one raised pertinent questions like 'What are the health outcomes we are aiming for?', 'Which population segments/groups of adolescents do we want to address (& why)?' 'What is the package of health services to be provided to achieve the health outcomes we are aiming for?' 'By whom and where should these health services be provided?' 'What are the factors that make adolescents unwilling to seek health services?' 'Why is it difficult for adolescents to obtain the health services they need?' Raising these questions triggered discussions on standards and the rationale for identifying them. In addition the presentation also allowed the groups a direction by suggesting a framework for discussion. For example, with reference to a package of health services, the following diagram allowed the participants to venture into discussions.



The second presentation was on 'quality' of adolescent-friendly health services. It touched upon various dimensions of quality health services: Efficient, from the health system's perspective; Accessible, Acceptable and Equitable from the users' point of view; and Appropriate, Effective and Comprehensive from the provider's point of view. The presentation emphasized how standards made explicit the definition of quality required for a product or service and how standards provided a clear basis against which performance could be assessed or compared. Thus a good standard should in the least be technically sound, achievable, in line with national laws and policies, and socially and culturally sensitive. The presentation also highlighted draft standards from the workshop on 'ensuring youth-friendly services' held in Bangladesh. The presentation was valuable in giving a definite direction to the group work on developing standards.



Discussion Highlights:

There was general consensus about adolescents' demand to include reproductive and sexual health education in their curriculum and need for sensitization and training among schoolteachers to handle these subjects. Some of the participants felt that peer educators could be trained to talk about problems related to menstruation, sexuality and contraceptives. The main comments focused on the following issues and aspects of adolescent-friendly services.

- Only those standards should be specified that make an important contribution to the service. For example, one such standard would be that providers at the point of delivery should have proper attitude. The issue is not to specify minor details such as providers have to wear a suit and tie. Standards should contribute to improvements in quality. For this it was important to coin standards that are critical to the quality of the service. At the same time they need to be achievable. They also have to be in line with national laws and policies. If good standards are developed then services can be assessed uniformly across all centres from anywhere.
- When there is a gap between required and actual performance there is a problem. South Africa put in place the Going for Gold accreditation system and then implemented over the entire country with a well developed work plan. Tanzania and Bangladesh have also developed draft standards through the same process. In a conservative society there were different forces that had to be dealt with when drafting such standards. The most important was that gatekeepers promote the use of service. Thus Bangladesh spent the first year focusing on trying to win the support of gatekeepers to ensure the successful implementation of the programme.
- The need is to move to action. It is important to understand what goes beyond the standard and to explain what needs to be done to achieve the standard. For example a problem has been identified that adolescents are not aware of existing services, both health and counselling services in the community. The standard is that in five year's time all adolescents are given information on health services available and where they can be accessed, or that in five year's time 40 percent of adolescents become aware. Once the standards have been defined, then approaches can be identified to achieve them. For example, to increase awareness among adolescents, notice boards, leaflets, peer education programme, etc should be used. Another example is that health workers in clinics are not assessing

the needs and problems of patients properly. The standard could be defined as 'all adolescents who come to the clinic will receive an adequate physical, social and psychological assessment'. Then what is needed for providing the required services may be ascertained. These could be training, job aid, etc. It is important to be clear about the essential elements at points of delivery. For this, an exercise about standards in the context of points of service delivery was also conducted in the morning session.

Group Work

The task for the groups was to identify barriers, identify five aspects they wanted to see at the points of delivery, come up with a list, and define the actions. Finally, they also had to form a descriptive statement about the five attributes explaining why they chose these attributes. These attributes would also be derived from State PIP. For example, an orientation programme to build competencies for management skills and inter-personal communication (IPC). Preventive, promotive and curative health services were also prioritized.



Group Response to Presentations

The groups agreed on the following:

1. To ensure that adolescents are comfortable with surrounding and procedures and the services provided, it is important to ensure that the services are easily accessible; providers are available and are competent and motivated.
2. The RCH ARSH IEC strategy should reach all the community members and stakeholders.
3. Supervision and monitoring guidelines have to be in place.
4. Infrastructure - The environment should be welcoming with assured availability of specific supplies, literature, information material, contraceptives, etc. The ambience should make the patients feel comfortable and at ease. The available infrastructure is adequate to provide AFHS as per guidelines - room, physical facilities, equipment, etc. Basic facilities are available. There should be a functional and clean toilet, privacy and reasonable space. There should be no green curtain. Fixed day and time should be adhered to. There should be easy access and the clinic should be close to the community. The aspect of social access should also be looked into.

5. Services – comprehensive package should be provided as per national guidelines.
6. Referral services should be in place.
7. There should be availability of staff with adequate capacity and competencies as well as communication skills. Providers should be sensitive to adolescent needs, have the appropriate technical skills and competencies
8. Positioning of AFHS should be considered while developing standards. It is important to separate what is exclusively needed for AFHS.
9. Supplies are available on a continuous basis.
10. Outreach activities are undertaken with key stakeholder to increase awareness of AFHS.

Comments on Group Work

1. All ideas relating to large-scale public sector programmes must be finally looked at from the point of view of feasibility of upscaling.
2. It is important to look at missing indicators in PIPs, identify the gaps and establish a link with NACP III.
3. It is important that the government engages other sectors in finalizing standards that are developed in this Consultation.
4. Examine and address the need to build standards for creating an enabling environment, especially when communities and families are not supportive.
5. Tanzania and Bangladesh identified gatekeepers as support structure for provision of services. There is need to understand the problems and needs of adolescents and explore different approaches to reach different people.
6. For certain activities it is essential to engage the health sector. For example, in Uganda the Islamic Medical Association was roped in by the national programme to work with Muslim religious leaders. Thus, at times it is important to engage a partner who can undertake and do a better job.
7. The state representative from Tamil Nadu shared the example of accreditation of emergency obstetric care in the state. Standards and criteria were set and medical colleges were taken on board to visit, certify and conduct a periodic follow up. A similar process can be considered for accreditation of the health facilities providing adolescent reproductive and sexual health services.
8. In Brazil, medical colleges are being developed as centres of excellence.
9. In Tanzania, the government has engaged Marie Stopes to take over the role of supportive supervision.
10. Accountability is a critical element.
11. The ideas and suggestions coming out of this Consultation would be presented to MoHFW, the final decision maker.

6

Day 3

Recapitulation of Day 2

The third day was mainly devoted to group work, in which the participants discussed the key statements of the draft standards and the contributing factors. The groups presented their comments in the plenary. After this, the groups were given specific issues in the areas that needed to be discussed. The five groups came up with presentations on issues such as services, service organization, capacity building, communication and management. The day began with the participants giving feedback about the previous days' sessions by writing down their feelings, thoughts, suggestions and critique on a card. All the cards were collected and the feedback was shared.

The highlights of the feedback are as follows:

- Moving from circle of concern to circle of influence is difficult.
- Sessions are productive, organized, participatory and focused.
- Group work needs more time.
- AFHS will be a reality five years hence.
- System's capacity to deliver needs to be taken into consideration.

Dr Chandramouli then summed up the previous days' proceedings. The other issues, which also came up, were the request from the Ministry to deliberate on the branding and marketing strategy for AFHS. While doing this it is important to bear in mind the system's ability to deliver.

The group was able to achieve a lot of progress on the draft standards. Dr Chandramouli reiterated that "standards are like goals that challenges us". They need to be concrete not utopian ideas.

The challenge for this group was to come up with standards that were achievable. The participatory approach of this Consultation was to be instrumental in making the states and experts share their views and experiences, agree on what is doable and try and capture that in the standards. He agreed that it was always a challenge to move from the circle of concern to the circle of influence.

While presenting the agenda for the day Dr Farah Usmani flagged that it was important to view the standards and guidelines from the perspective of the health department and the Medical Officer at the district level. It was very important to address that the District Programme Manager would not be able to implement the programme alone, but would need support in terms of developing linkages, organizing training, data collection and analysis.

Presentation on Draft Standards, Dr Chandramouli

Dr Chandramouli made a presentation on the key statements of the draft standards. These standards were derived from the outcomes of the group discussions held on the Day 2.

Each standard was explained with the contributing factors for achieving these standards.

These are draft statements that need to be modified/ revised based on experience and available literature. The standards cannot be prescriptive but need to be generic. They should provide people the tools necessary to make decisions. In developing effective standards, it was important to set clear goals for performance and set a clear basis for measuring the achievement of goals.



S.No.	Standard	Contributing Factor
1.	Service delivery points provide the specified package of health services for adolescents, effectively.	Health service providers are in place and have the required competencies in terms of clinical and inter- personal communication skills. In addition to this, it is necessary that evidence-based protocols and patient information materials are available; supplies, equipment and basic amenities are available and functional referral systems are in place.
2.	Service providers are sensitive to the needs of adolescents and are motivated to work with them.	The contributing factors are that written clinic policies and procedures on privacy and confidentiality are available and that service providers are aware of these policies and procedures.
3.	Adolescents are well informed about the availability of quality health services from the service-delivery points.	Outreach activities are in place to provide adolescents with information about the services available. During group work one group came up with suggestion of outreach.
4.	An enabling environment exists in the community for adolescents to seek the health services they need.	The contributing factors are 'linkages with other sectors such as NGOs, educational system, etc.'
5.	Service delivery points are accessible to adolescents.	Services are provided on specified days and at timings convenient to adolescents.
6.	Adolescents should feel at ease with the surroundings and the ambience of the service delivery points.	Availability of clean and functional toilets, drinking water, waiting area and appealing environment.
7.	Management systems are in place to sustain/and improve the quality of health services.	Systems are in place to collect, analyze and make use of data; provide staff members with the support they need to perform to the best of their abilities.

Group Work:

Feedback on Draft Standards

The participants were asked to split into groups of three-four each and reflect on the presentation, the standard statements and the contributing factors. They were asked to come up with one or two points; to take up some issues and explore them, capture the ideas and incorporate them into the standard; assess if there were any gaps and weaknesses that needed to be addressed and strengthened. While doing this, it was necessary to take into consideration the capacity of the system to deliver, think of the worst clinic in the country; then come up with a lowest common denominator that all clinics are expected to deliver. Clinics that are better performing or equipped could be asked to take on some more challenges during the pilots if they have the resources, the energy, and the enthusiasm.

Group Work Presentation in Plenary

The groups were asked to submit their points on the cards provided. The cards were collected. The moderator went from group to group, giving each an opportunity to present its views on a single point in the first round. If a previous group had already covered a point, the next group was asked not to mention it again. The key points raised in the different rounds by the groups are summed up below:

- Concern was expressed about how to ensure that service delivery points were providing confidentiality.
- Equity is a cross-cutting issue in all standards. However, equity should not be treated as a cross-cutting issue, else it would become like gender mainstreaming, which is everybody's work and ends up with no one taking responsibility for it.
- Package of services to be provided should be appropriate to the level of service delivery and in sync with the socio-cultural characteristics of the place.
- The scope should be enlarged to take advantage of the already existing structures such as Integrated Child Development Services (ICDS), Panchayati Raj Institutions (PRIs) and village-based Registered Medical Practitioners (RMPs).
- Protocols should be made available in regional languages for both providers and clients.
- Creation of an enabling environment in the community with regard to needs of adolescents and service delivery points can be done through mass media.
- Standards should be laid out for reaching and sensitizing parents and making them aware of the services for adolescent health.
- Standard six – 'adolescents at ease' is difficult to measure. From the client's point of view privacy is the most important criteria.
- Ethical and legal issues should be incorporated into standard no. 2.
- A rapid needs assessment and focus group discussions should be conducted before roll out to take into account the social and cultural differences.
- On standard no. 7, it was suggested that data collected should be shared with other stakeholders like schools, communities and others.
- On standard no. 3, the group felt that awareness generation should involve community-based organizations like Stree Shakti, women leaders and youth clubs in informing adolescents about AFHS.
- On standard no. 2, adolescent beneficiaries should also be informed of the privacy and confidentiality policies of the service delivery points.
- On standard no. 6, to make adolescents feel at ease, it was felt that there should be male providers for boys and female providers for girls.

- Exit interviews of a random sample could be used to capture client satisfaction with the services.
- If a parent or teacher comes to the centre to discuss the issues of their wards, they should be given attention and not sent away.
- Important to ensure sustainability and continuous availability of services.
- Centres could extend outreach wings in schools and market places to create demand for services.
- Para teachers should be involved in the monitoring of services.
- There should be flexibility in the package of services and they should be modified depending on feedback and should be open to the needs of adolescents.
- Required supplies should be updated and made available as per use.
- On standard no. 7, MIS for ARSH should be integrated with regular health MIS. There should not be a separate MIS for ARSH.
- Based on the MIS, feedback should be given to the point of generation of the data. This is usually missing. The popularity of the centre can also be assessed on the basis of revisit of patients.
- The standards should be broad in scope as there are huge differences across states. Also India has a very diverse and wide range in terms of capacities and resources. Kerala has made a lot of progress as it has been implementing AFHS over five years; Tamil Nadu has been working with different organizations such as patient societies and medical colleges. Some of the districts can be challenged to take on a larger role.
- Standards are like desired ideals, towards which the government is aspiring. When we are talking about adolescents, we should specify adolescent girls and boys in every standard. In the fifth standard on accessibility, there is a need to bring in the equity perspective. There is also the age criterion. Are we expecting adolescents in the age of 10-12 years to come to the service delivery point on their own? All standards have to be contextualized vis-a-vis the RCH II ARSH strategy the group should think when we talk about specified packages do we also say reproductive and sexual health services?
- A minimum standard has to be developed. When we look at the nutrition aspect, we have to consider the awareness, clinical and counselling aspects. The development of brain, biology and behaviour should go together.
- There can be levels of standards, starting with the minimum. The South African model that has different levels, such as bronze, silver and gold, was recalled. It is also important that an external assessment is conducted and an accreditation system like that for Emergency Obstetric Care is developed.

Synthesis of Group Recommendations

Following this a recap of the group recommendations was done by the rapporteurs. The presentations highlighted the following points from the previous day's discussions:

1. All adolescents are to be included; also include initiatives in communication and others to focus on vulnerable sub groups such as street children, unmarried girls and others
2. In terms of Health Services the issues related to ARSH included promotive activities IEC on normal growth and development on puberty; myths, misconceptions and concerns related to sexuality; preventive services like menstrual hygiene, personal and genital hygiene; and referral services which included menstrual disorders, early or delayed puberty, sexual problems, genital problems, and counselling.
3. The presentation also highlighted services like unintended pregnancy and safe abortions, pregnancy-related care, anaemia and other nutritional problems, STI/RTI, etc.
4. The groups had also discussed issues related to HIV/AIDS. In terms of promotive services, information education on transmission, including risk factors, violence and substance abuse, sexual abuse, and

safe sex had been mentioned. Condom access, emergency contraception, breast feeding advice, etc., are part of preventive services.

5. Following to be used as entry points for services to facilitate the proper utilization of ARSH: General health services, adolescent skin problems [such as acne], nutrition, etc.
6. Potential service delivery points included tertiary care hospitals, district hospitals, community health centres, PHCs, sub centres, schools, private clinics, NGOs, community outreach, health camps, depot holders, youth clubs, Nehru Yuva Kendras (NYKs), Rotaray clubs, Balikamandali, Village Health Centres (VHCs), etc.
7. Service providers could include male and female workers, Medical Officer, PHC, CHC, District Hospital, Block Education Worker, ASHA, school teachers, Counsellor at district level hospital, private practitioners, NGOs, etc.

Building Consensus on National Operational Guidelines:

Presentation on Terms of Reference for Group Work

Mandeep Janeja, UNFPA, made a presentation on the terms of reference for the five different groups. Over the first two days the Consultation had mapped out 'what' was to be done. The draft operational guidelines provided some pointer on 'how' to do it. The groups needed to further deliberate on the 'how' aspect and come up with suggestions that would help in concretizing the operational guidelines. The groups would keep in mind the RCH II ARSH strategy and the draft standards while identifying the essential, doable and practical functions by the Ministry of Health.

The five groups were to work on the following key areas:

- Services
- Service organization at service delivery point
- Capacity building
- Communication
- Management

The groups were given specific issues in their areas that needed to be discussed. The groups were also given two hours to discuss and come up with a presentation. Each group was asked to identify a chairperson and a rapporteur.

Group Work Presentations

The presentations were made by the rapporteurs of the five groups and moderated by Dr Farah Usmani.

Group A: Service Delivery

Dr Rashmi Asif made the presentation on service delivery on behalf of the first group. The group looked at the **existing** services at the different levels, from the sub centre level to the district hospital focusing on the service provider, target group, existing services, flow of service delivery and the newly added services.

At the **sub-centre level**, the group proposed the provision of a male health worker in addition to the existing female health worker. They suggested that a meeting be held once a month at the Anganwadi Centres (AWCs) which should also involve the Mahila Mandal. The additional services proposed by the group at this level were condom promotion, referrals when required, IFA and de-worming, emergency contraception, and awareness about sexual abuse. At the **Primary Health Centre** level the group proposed placement of both male and female medical officers, a male health assistant and trained counsellors in

addition to the existing staff. Teen clinics should be organized once a week, separately for boys and girls in addition to the routine services. The newly added services at this level were IEC for demand generation, counselling across all issues, condom promotion and distribution, anaemia management, IFA and deworming, emergency contraception, ANC, PNC and intranatal services, medical abortion, substance and sexual abuse and referral lab services for pregnancy and blood testing.

At the **Community Health Centre** level the group proposed the presence of both male and female medical officers, and service delivery through fixed teen clinic once a week separately for girls and boys. The newly added services, in addition to those at the PHC level were MTP, all medical problems, lab services and eye check up.

At the **district** level in addition to all staff and services at the CHC, the group proposed that a toll-free helpline be set up along with the provision of specialists including a mental health counsellor.

The group also identified **indicators** to measure availability of AFHS as follows:

- Proportion of vacancies of health service providers.
- Percentage of clinics conducted vis-a-vis those planned.
- Percentage of service providers who have received training.
- Fixed service day and public awareness about clinics.

Group B: Service Organization

The group specified the essential **supplies** that should be available at the sub centre level. Services should be provided at least once a month to all adolescents. The ANM should **develop links** with AWWs, PRIs, youth clubs, NYK, etc.

Timings can be decided by the medical officer on the basis of availability of staff, rooms, school timings, etc. The group also specified the layout of the AFHS in terms of registration area, waiting area, consultation area, examination room and other facilities like toilets and drinking water. The **confidentiality** policy should also be displayed prominently, in addition to posters and other literature and information material, such as referral slips, register, resource directory, etc.

Prominent signage with strong **branding** should be put up with direction boards. The group suggested some branding such as Yuva, Kishori, Sathi, Mitr, etc

The group also specified the **facilities** for CHC and district level facilities such as a counsellor or social worker. The group also proposed linkages with other facilities like VCTC, ARV, Prevention of Parent to Child transmission (PPTC) centres; with other stakeholder such as NGOs, State AIDS Control Societies (SACS) and schools. They also made some suggestions for tertiary care.

Comments on the presentation by group members

1. When planning services, AFHS also needs to take into consideration the huge coverage by private sector, quacks and RMPs who provide sexual health services and place emphasis on increasing outreach.
2. Each state could designate a fixed day as adolescent day.
3. One of the discussants shared that the confidentiality policy should be displayed prominently. There also needs to be a referral plan for cases of sexual violence
4. Another discussant wanted clarity on whether the supplies would be provided separately for ARSH or would be part of RCH II or ARSH . The second comment was that branding should be done at the state level in regional language and state level competitions could be organised for developing the logo and branding.
5. Coloured cards should be provided for measuring the weight and height of adolescents to determine the body mass index (BMI).

6. Some items were not in conformity with national programme guidelines such as injectible contraceptives. The group should re-look at the timings. Once a month at sub centre level was not enough as there should be optimal frequency also keeping in mind the ANM's schedule and the needs of adolescents. With regard to the issue of counsellors the discussant raised the issue of whether separate counsellors are needed for ARSH or can the counsellors of other programmes such as HIV take on the task. He shared that there was a need for further deliberations on the issue. He also felt that partnerships with the private sector were a good idea and public-private partnerships (PPP) in ARSH needed to be explored.
7. ARSH supplies should include pregnancy testing kits and blood grouping.

Group C: Capacity Building

The highlights of the presentation are as follows:

Capacity building is a continuous process that goes beyond **training**. The cascade-training model has a lot of failures and loopholes and the group wanted to explore institutional training. They also explored the possibility of training health workers to provide counselling.

They combined the standards into four groups for training and felt that the training should focus on adolescent-specific issues. The key areas were adolescent rights, laws and policies, communication skills and behaviour of the provider.

Another training approach is the **peer learning** methodology. The master level training materials are adequate.

The recommended five days **duration** for the training is sufficient but it should include at least 12 hours of field exposure at the PHC or village level. The selection of trainees should be based on self-motivation. The monitoring tools for training should include supportive supervision, checklist, problem solving and feedback at the level of input and output processes.

Post-training follow-up should include audit of service delivery, supervisory visits, supportive supervision and problems identified and solved.

Comments on presentation by group members

1. Though there is commitment and use of substantial resources, training is not as rewarding as per effort. This has been brought out by a number of publications. Capacity development has not happened due to flaws in training. It is important to consolidate the experiences and achieve success and then expand. There is a need for clearly defined standards as capacity building is ongoing and not a one-shot process.
2. The group member for Orissa expressed the view that post training, the outputs are below expectations. There is a need to improve the capacity of grassroot level functionaries and train master trainers at the national, state and district levels. Medical colleges can also be identified as training resources.
3. Another member shared that the key aspect is who should be trained and the basis of the selection criteria. A training needs assessment should be conducted. The training should have field level exposure. There is also a need for supportive supervision not policing, against output process and outcomes.
4. There should be capacity building at the community level to help address social taboos. The Block Extension Educator should also be involved in the training programme as he is responsible for communication activities. She also suggested that the training duration of five days be split into two sessions of three and two days respectively. This way the problems faced by trainees could be addressed more effectively.
5. The need for addressing attitude and motivation of service providers during training was expressed. Case studies and monitoring of training can be done. The output of training needs to be assessed, whether it should be only in terms of service utilization or some other means.

6. Quality of training needs to be improved. Also interpersonal communication skills need to be imparted to grassroot functionaries. The master trainers of the training institute need to be trained first. Also, the training material needs to be incorporated into the basic training curriculum of the ANM, LHV and other staff.
7. There is need to assess the effectiveness of the training programme over a couple of years.
8. There was need to critically examine other trainings such as MOs, other service providers, etc. It is important to measure the training outcomes. The assessment should not end with post evaluation but go beyond. There are several ways of measuring outcomes like understanding the behaviour of service provider post training, assessing the quality of services for improvement, etc. At the policy maker level, there is a lot of concern about the utility of training is it being done correctly or can it be done differently.
9. It was expressed that there had been very little innovation in the content of training proposals. There is a need to counter the training fatigue that sets in. National Institute of Health and Family Welfare (NIHFW), the key resource organization, is also burdened and the exposure is limited to traditional methods. It was for the group to suggest some innovations.

Group D: Communication

The group presented the conceptual ideas of communication and then went into the communication for ARSH.

In the context of adolescent health there is a need to create an **enabling environment** and improve **health seeking behaviour**. There is a fine line of difference between IEC and BCC. IEC is about raising awareness, motivation, and value addition. The presenter, Dr. Prasad, shared the example of the polio campaign three years ago, which featured Amitabh Bachchan. UNICEF supported the campaign which drew traditional people back into the fold and cleared misconceptions.

It was shared that the **communication package** of the ministry is usually dismissed but it is targeted at rural masses and produced keeping the clientele in mind. For the first time the Health Minister wrote a letter to the ANMs acknowledging them as the *kohinoors* of the PHC. The letter was highly appreciated by the ANMs and preserved. The communication is taken very seriously at the grass-root level. The communication is simple, direct and effective. The Tamil Nadu Health Department devised a snake and ladder game on vital health interventions that is being adopted in NRHM. At a meeting in Patna, Mr Prasad had a chance to interact with ANMs and ask them about their colour preferences. They told him they liked red as it gave them confidence. So the colour was incorporated into the NRHM logo.

It was expressed that communication needs to be in sync with the target audience. The strengths in the ministry were outlined – adequate financial resources, wide media channel reach, IEC and BCC material, state-specific coordination mechanisms, etc.

The objectives of communication activities were twofold – to create an enabling environment and to make adolescents aware of the scope of ARSH services.

The pre-requisites for creating an enabling environment are developing effective **communication tools** on ARSH and to address the stakeholders. The key actions that need to be taken involve the development of a national level BCC campaign on adolescent health that should anticipate the actual operationalization. The state and district level officials have a key role in organizing orientation programmes for stakeholders.

Inter-departmental and inter-sectoral coordination will play a key role in programme implementation. Existing mechanisms that would be used to facilitate are the NRHM steering committee, the Ministry of Youth Affairs and Sports (MoYAS), National Steering Committee on Youth, NACP III national youth and adolescent task force, HIV/AIDS inter ministerial group chaired by the MHRD. The existing state and district mechanisms would also be utilized and promoted.

To publicize ARSH, **branding** of the programme with appropriate logo and other innovations would be undertaken. The Ministry will also identify appropriate channels of publicity, mass media, folk media, print media (posters, banners, etc), outdoor such as health melas.

Health functionaries at different levels – medical officers, LHVs, ANMs will be asked to take on responsibilities such as disseminating information, periodic contacts in and out of schools, development and provision of IEC materials at all levels such as pamphlets and handbills.

A **feasibility** of the interventions will be assessed based on various factors – increase in service utilization, profiling the adolescents accessing services, seeking services, reach and appropriateness of communication tools, number of meetings and environment building activities undertaken in the community, change in knowledge and behaviour, existence and functioning of state inter-department convergence mechanisms as a consequence of communication.

Group E: Management

The terms for the group work were to review and suggest indicators and data sources, review systems of data flow and any other inputs. The group took into consideration the different types and levels of reports available – monthly, quarterly, outcome and **impact indicators** from periodic surveys.

The group was concerned about following impact indicators through periodic surveys since an extensive list of indicators was not available. There was awareness that the data generated in health system was not utilized so the group felt that the ARSH programme should not burden the system with additional data. The group reviewed the existing forms in the draft document and suggested one change. PHC should have adequate supply of emergency contraceptive pills. The group agreed on using IFA supplies as an indicator. The stock out of IFA tablets during the month can be used as an indicator of utilization of services. The group endorsed another indicator percentage of sub centres having communication material for adolescents.

The group also identified other process indicators:

- Total number of new pregnancies registered among teenage girls. There was a debate whether to have segregated data in terms of age and married/unmarried patients.
- Data on access of contraceptive services by method.
- Number of teenage pregnant girls who availed MTP services. There should be segregation between married/unmarried and age groups (early and late adolescents).
- Number of adolescents referred to CHC/district hospital, or tertiary facilities.
- Number of meetings held with partners like school authorities, ICDS staff.
- Number of adolescents who availed services from AFHS (new and follow up cases).
- Number of meetings held against planned.
- Number of adolescent girls and boys availed RTI/STI treatment.

The **management interventions** identified by the group were – monthly meetings at PHC/CHC. The district programme managers should review data generated at different level and provide feedback. Supervisory visits should include checklist for assessing adolescent friendliness of clinics. There should also be an assessment of quality of outreach services and linkages with SHG, NYK, PRI, etc. The group recommended a quarterly review at state level about utilization of services.

The group stressed **quality assurance** for each process through regular assessment of each criteria (input/ process/ output). The focus should be on outcome indicators rather than impact indicators. Adherence to protocol for delivery of AFHS should be monitored and quality improvements initiated based on these. The group stressed that the capacity of health system for quality assurance needs to be built. Quality checklist should be given to each provider and supervisor for self-administration to assess services provided.

Comments and inputs from participants on the communication and management presentations

1. Usually in government advocacy materials, there are large photographs of political leaders with the key messages confined to a corner.
2. The data that is collected through monthly and quarterly reports should be analyzed and used for further interventions. The objective is not to gather data but promote effective utilization of data for decision-making.
3. It was expressed that ARSH should have a brand ambassador. The youth can be polled as to their choice, either Abhishek Bachchan or Sania Mirza. The use of distance learning material such as CD ROMs, for self-learning, as they are cheap and effective, was also suggested.
4. It was agreed that it was a good idea to have a letter from the Health Minister to the ANMs. Moreover, it was agreed that often, even if materials were there, they are not used as the strategy, which was wrong. The method followed was that material was at first developed externally, and then the user is trained in using the material. On the other hand, there should be more understanding on how the communicators are going to package and use that information effectively. There are three essential elements, communication to publicize point of purchase, then build an enabling environment, and influence health-seeking behaviour. There is a distinction between the three and strategies required can be developed. Anticipating mass media is a good idea for sensitisation but not great for influencing health-seeking behaviour.
5. Clear audience segmentation needs to be done.
6. A note of caution was sounded on the use of impact indicators like teenage pregnancies and age of marriage. There is a danger in using such impact indicators where the interventions are not set up to bring change. There is a need to be careful in choice of impact indicators.
7. The programme should not be in a hurry to print and prepare IEC materials. What is required is a BCC strategy, as a starting point. The impact objective should be articulated clearly. BCC strategy is an important investment, which requires money, time and expertise.
8. There should be performance-based resource allocation and a carefully thought out monitoring and evaluation plan and strategy. Capacity development for monitoring and evaluation needs large investments on input, process and outcome indicators. Impact indicators are not very productive in the beginning of the programme but are useful later.
9. Communication should take into consideration the literacy level of health staff. The health department should take responsibility of using materials developed by other departments like Women and Child Development (WCD), SACS, etc. The department could also give a certificate to the ANM appreciating the work done by her.
10. Two examples of ineffective/ incomplete communication were shared. The WHO ORS advertisement on TV did not mention where the ORS was available. After the ad was broadcast a lot of phone calls came asking for the ORS as it was not available with chemists. In another example, adolescents were asked about the awareness of condom Nirodh. The response was that condom was used for prevention of HIV and Nirodh was for family planning. The perception stemmed from the terminology used by the family planning and the AIDS prevention programme respectively.
11. Key messages can be compiled into pictorial flip charts to be used by providers. Job aids such as aprons with a diagram of the reproductive health organs or a chart of the menstrual cycle, height and weight charts for adolescents can be developed. Self assessment checklists can be developed for providers and supervisors.
12. The block extension officer should also be included in the list. The communication skills of different levels of health care providers can be improved by adding communication skills to the basic training curriculum. Medical teachers also lack in communication skills and should be trained in improving the communication component of basic training.
13. As the government has a limited package of resources, it is important to do the percentage allocation for different components such as communication, training, etc.

14. It is very important to be clear on the target segmentation and address questions such as who is the target, what to communicate, by whom, where and when?

Response on the presentations

1. The services group was clear about the health problems to be addressed and the services to be provided at each level. The group had also put forth a clear and prescriptive list of activities for the states though there was room for innovation. So far there had not been much experience in the area of ARSH except in Kerala, which has been implementing the programme for over five years.
2. On sexual abuse there was a need to develop a module or find an existing module. The training package should be useful. Once the group decided on the health problems to be addressed and the services to be provided, it was important to assess the different functions of the providers and look at what the training materials had to address.
3. There was need to have clear strategic objectives. It was also important to ensure that services were in place before creating demand. It was clear from the polio campaign that it was important to go slowly, communicate in small groups rather than go big. In Kenya an international NGO launched a massive HIV/AIDS communication exercise with an aggressive message, 'the bible can save your soul but the condom will save your life'. They thought they were being provocative but in effect they managed to push the agenda back 10 steps. This is a very sensitive area.
4. At the state level it was important to set quality improvement at the heart of the issue. Use the energy to change the way things have been done.
5. Based on the outputs of the group work, the seven draft standards would be reworked and presented in the next day's session.

Group Summation

Dr Farah Usmani invited each group to respond to the comments and identify 3-4 issues and present the next steps that were needed to take the agenda forward.

Group A: Services

1. The ARSH clinic should be once a week at the PHC, twice a week at the CHC and daily at the district level. There was a need to debate and build consensus on this issue.
2. Accreditation was a key activity. There was need to work out a checklist. An external agency should be involved
3. There should be two trained counsellors at the district level, one male and one female.
4. There was need to review the terminology of 'teen clinic' as 10-12 year-olds were not teens.

Group B: Service Organization

1. The national programme guidelines on RTI /STI were not in sync with what had been proposed in the group presentation.

Group C: Capacity Building

1. Agree to the suggestion that NGOs should be involved at the community level.
2. There should be integration of different capacity building measures under RCH II.
3. There is a need for constant upgradation and introducing new approaches to capacity building as no single method is foolproof.

Group D: Communication

1. Need to examine monitoring more carefully and have well-defined parameters.

2. Leave room for flexibility as states are at different levels of preparedness in terms of human resources and infrastructure.
3. It is not possible to bring in a new cadre of counsellors. Attention should be given to using the existing VCTC counsellors, social workers, etc.
4. It is not easy to do away with photos of politicians as there are official compulsions at times. The other side of the coin is that in rural India, noted and popular politicians are very well accepted and increase the effectiveness of the material.
5. There is a need to limit the performance of state IEC bureaus to performance indicators. Earlier campaigns were based on mathematical computation of the cost. Under RCH II it is issue based as specified in the PIP. The campaign will be assessed based on the response after three months and then the next phase planned.
6. Agree that the weakness in M & E is the non-availability of tools. Partners have extended help in raising the technical capacity of the division. There is also lack of understanding of M & E. Even at the state level downwards there are several vacancies and gaps that have to be taken up in earnest.
7. It is important to have a technically sound BCC strategy with impact indicators.
8. Linkages have to be put in place at the national, state and district levels.

Group E: Management

1. Lot of work is needed on M & E especially with regard to process indicators.
2. An analysis plan must be devised to analyze and act on the data.
3. Quality of the data is a key issue.

The rapporteurs presented their thoughts

1. The RCH II national PIP and state PIP have a specific mention of 50 percent PHC to provide essential package of reproductive healthcare. There are many PHCs where the infrastructure and personnel are not in place. This presents a clear opportunity to include AFHS within this 50 percent. The RCH II focuses on primary reproductive care strategy; it does not delve into the tertiary level. There is need to involve medical colleges.
2. Accreditation is being done by the public health system for the first time. Tamil Nadu has done it for emergency obstetric care, which was limited to only 3-4 facilities in a district. Here we are talking of 30-40 facilities in a district, which will be put under accreditation.
3. Networking with professional bodies like the FOGSI and the IMA is a good idea. Under RCH II there is clear reference to the private-public partnership. If the district CMOs feel there are good providers at the sub district level and taluka level they can be engaged and extend services.
4. As per the drug act the ANM cannot prescribe RTI/STI medication.
5. Self-selecting trainees – Trainees are usually selected by the district programme managers who have little choice and are guided largely by which facilities have to be provided for the intervention and what is available. If we go as per the PIP at the state/district level we will have to pull out the MO for almost 60 days in a year for different training and thus seriously disrupting the services. Use of other techniques should also be encouraged and the capacity of training institutions increased.
6. Management – There is an integrated MIS for RCH II. Some indicators have been included and integrated with the MIS of RCH II. The indicator for teenage pregnancy rates can be collected additionally for these clinics in a very simple format. Three to four key issues can be generated and analyzed at monthly meetings and feedback given. The larger surveys which are conducted every two years capture information on age, sex, and can have clear information for the district so that it is possible to assess the change in adolescent health status. One cannot make a mid course correction in the district household surveys. NFHS III also gathers data for 15 to 19-year-old persons, which

can serve as a baseline. The data collection starts this month. For the 10-19-year-age group, another survey or the BSS could be mounted.

The session was summed up by Dr Farah Usmani, who said that the next step was to reflect and come up with suggestions and innovations. She said that they needed leaders at the state level to take on the programme and then scale it up. It was also important to try out innovations and then scale up based on lessons learnt.

Day 4

The first session on the last day was chaired by Mr Prasad. An important objective of this Consultation was to develop a list of criteria for selection of 75 pilot districts to be involved in the initiative. Dr Chandramouli traced the progress of the Consultation from the plenary, moving towards the development of draft standards and operation guidelines. The capacity building and communication groups were to consolidate their group work. Another group was to work on Mr Prasad's request for developing budget lines.

State representatives made presentations on the ground realities in their respective states. Each state was given 5-7 minutes to make their presentation.

Session on Ground realities in the States

Rajasthan

Dr Minocha presented a demographic and geographical profile of Rajasthan and the structure of the health department. The Rajasthan Health Development project is implementing ARSH in district hospitals. There is a need to decide whether medicine distribution by ANM would be more efficient as the patients at the community level can relate to her.

Tamil Nadu

Dr Padmanabhan presented the demographic profile of Tamil Nadu, the key indicators, and detailed the health initiatives undertaken by the State. He presented the adolescent health initiative under which two adolescent girls have been identified in each health sub centre and trained to act as link persons in the community. They promote antenatal care services and are in charge of five ANC and five post-natal mothers. They are trained to identify danger signs, referring them to the referral intuitions. The pilot was initiated in two districts and was now being scaled up to the entire state under RCH II.

Another innovation is the *Adolescent Radio Programme* started with Danida support, which is also being scaled up to the entire state. A listeners' club is created in each village with 10 adolescent boys and girls. There is also a school health programme. Every Thursday is school health day in the State. A team of doctor and paramedic go to the school and do a complete examination of the students. There is a need to further strengthen adolescent health services.

Orissa

Orissa has an AFHS clinic in Cuttack which opened in April, 2005. The state provides maternal and child health services, family welfare services and sex and sexuality education through the State AIDS Control Society. There are family awareness clinics in all districts. Other awareness generation activities include seminars and meetings. In Khurda district, an NGO supported by CDMO and State NGO Coordinator organises sensitization activities. A strategy has been developed to cover adolescent health with a budget which has been included in the SCOVA and the approved PIP. STD clinics are operating in the former 13 districts with a venereal disease (VD) specialist. There are plans to improve and make them more effective.

Balika mandals, or adolescent girl groups, have been formed by the WCD Department under the Kishori Shakti Yojana. IFA tablets and deworming services are provided to all adolescents. Outreach services are organized through mobile health units where doctors provide clinical and preventive services to adolescents at the village level. Some AWWs have been trained on communication activities. School principals, the NSS volunteers and peer educators have also been trained on adolescent issues and Kishori

and Health Melas are being organized. The interface of government facilities with adolescent services is being improved.

Uttar Pradesh

Though adolescent health is covered under RCH II, the priority is family planning, immunization, reduction in IMR, MMR, newborn care, and adolescents. The state government is trying to link adolescent health with other ongoing programmes and not work in isolation. There is linkage with family planning, immunization, etc. and an effort to link adolescent services with other departments such as ICDS, sanitation and safe drinking water. There is presently a pilot project in Kakori in Lucknow and Prof. Uday Mohan has established an AFHS clinic at Kakori. There is knowledge and understanding of the problem and an effort to establish linkage with other programmes rather than work in isolation. It would be useful if a set of good standards and guidelines was available.

Gujarat

The presentation was in two parts – what has been done so far and what is planned.

The State government has been implementing the IPD project for the last eight years. In 2003, the specific component of adolescent health education was incorporated. The programme is being implemented in five districts where adolescent health education and service activities have already begun. Various activities under the programme include education camps in schools and colleges, training of school and college teachers, RTI and STI service provision in the districts. PHC doctors and lab technicians have been given training for RTI/ STI investigation and treatment. GSACS and NCERT have also been involved. An anaemia control programme for girls is also being implemented in all 25 districts of the state. Around 10 lakh girls are given IFA tablets each week under supervision. CEDPA has been involved in giving training to 10 MOs and 25 field level workers for initiating the adolescent health service in the district. An evaluation will be conducted shortly to assess the first phase. There are plans to start training and service activity in two blocks in each district within the next year. So far Rs 2 crore have been allotted by the state for adolescent-related health service activities.

Group Exercise on Criteria for Selection of Pilot Districts

The next session was devoted to group work on developing criteria for selection of the 75 pilot districts. As India is a large and diverse country, the challenge was to come up with generic guidelines.

The tasks before the Consultation were refinement and finalization of the draft standards and operational guidelines. Another task was identification of 75 pilot districts. The objective was to select 75 districts for the implementation of ARSH services intervention in the public systems. The participants were asked to offer suggestions and ideas for the selection of the pilot districts. The suggestions included:

- Random basis, i.e. list the districts and pick up randomly,
- Purposive,
- Geographical representation
- Based on an objective criteria
- Number of districts per state

The groups were asked to think through together what possible objective criteria could be used and recommended in the national guidelines for states to make their selections.

The methodology for the group work was to work in groups of two or three persons. Each group was asked to think of ideas and write down their suggestions on two cards, one idea per card. The groups were given five minutes for the exercise. The cards were then collected and categorized.

Selection Criteria Categories Emerging from Group Work

The three main categories which emerged were as follows:

1. Socio-demographic indicators:
 - High prevalence of child marriages
 - High rate of adolescent pregnancies
 - Marginalized population
 - Declining sex ratio
2. Health programme performance:
 - Higher incidence of RTI/STI
 - Adolescent pregnancy
 - HIV/AIDS prevalence in youth
 - IMR, MMR, adolescent fertility
3. Health infrastructure:
 - Key posts not vacant
 - Good infrastructure available
 - High chances of success

Other criteria that emerged were as follows:

4. Performance of districts - Range districts from high to low on performance of health programmes.
5. Random selection on alphabetical order - List the districts alphabetically and pick up every 6th in a random selection.
6. Pressing problems such as rape, unwanted pregnancy, substance abuse.
7. State level stratification of districts based on performance and health indicators.
8. District level stratification based on motivation levels of health, PRI and ICDS functionaries, availability of enabling environment for collaboration with NGO, GO, inter-sectoral, high and low performance.
9. Strong linkages between HIV programme and ICDS.
10. ARSH innovations have already been initiated.
11. Strong support from state for AFHS.

This was followed by a discussion on how these indicators would be measured and what would be the sources of data. There was also a concern as to how many districts would be selected per state. Some suggested that at least a minimum of two districts should be selected per state.

The moderator then asked the participants to try and think whether so many indicators were needed or the most critical and useful ones for the purpose could be identified. Groups were asked to prioritize their ideas and shortlist 3-4 most critical ones. They were asked to rank the indicators on the basis of data availability, robustness, and choose the top 2-3 to come up with a manageable shortlist of criteria. The criteria were read out again and the groups were asked to rank the indicators under each head and remove the common ones.

Three indicators were finalized:

- Higher incidence of RIT, STI, HIV/AIDS prevalence
- Maternal mortality
- Adolescent pregnancy

The group recognized the fact that information on these indicators may not be available. However, proxy indicators could also be used. A word of caution was sounded on dismissing random selection. If a selection was made based on performance or high prevalence, the drawback is that the population would be already sensitised to health-seeking behaviour, health functionaries would be already sensitised to giving health education and advice. The results might also be skewed as the situation is already favourable for success of the programme. When the programme is scaled up the population will be more heterogenous and with limited resources and an unsensitized population similar results may not be obtained.

The first step in operationalization would be to set up clear channels for feedback on management issues. There is a need to focus on the learning and keep that in mind while expanding the programme.

In the next session, two groups – on capacity building and communication were given time to wrap up their group work recommendations and interact with state programme managers and think through indicative budget lines. Dr Mangal facilitated the discussion.

Closing Session

Mr Prasad introduced the chief guest for the closing session, Ms Ena Singh, Assistant Resident Representative, UNFPA. He shared that Ms. Ena Singh had inspired the programme and provided all the support, right from the stage of conception to the launch state. Over 55 participants from all walks of lives – professionals, state partners, donor agencies and other had come together for this important Consultation from all over the country. The meeting had set an example of how the government and development partners could work together on an equal basis with no imposition of the centre's perspective. All had collaborated in taking the agenda forward.

"Our Journey from 2nd to 5th September"

Ms. Mandeep Janeja and Dr Arvind Mathur presented a quick recap of the Consultation. The workshop had begun with the resource persons providing an orientation of the global, regional and national AFHS scenario. Well-planned sessions had helped develop a consensus on what needed to be done in implementing the ARSH RCH 2 strategy. A key focus area was the dimension of quality of health systems in terms of the patient, provider and the system. Group work and interactive sessions had been organized on developing the draft standard statements with a focus on the five key areas – service, service delivery, capacity building, communication and management. This was followed by discussion on 'moving from the circle of concern to the circle of influence'. A lot of innovative ideas had also been discussed and the key outputs were – developing of the draft standard statement, operational guidelines and selection criteria for the pilot districts.

Ms. Ena Singh expressed her pleasure to see the journey from thought to reality. A lot of good ideas and concepts had emerged during the Consultation. In realizing them, it was important to be cautious of excessive conceptualization and theoretization. The group had looked at the global concepts and experiences, writing and research and had tried to turn them into practical steps to be followed in the Indian context. This was a commendable exercise. The strategy and actions were based on what was doable rather than what needed to be done.

She said that everyone would be watching India closely as implementing ARSH on a public services scale was somewhat unprecedented, and for this RCH II and NRHM provided an excellent platform. The coming together of stakeholders from different sectors – education, health, HIV and civil society, provided the right ingredients for success as well as a significant management challenge. She also suggested that at the micro level, when one is looking at services to be provided – materials and supplies – it might be useful to consider HIV PEP kits, etc. Since the programme was being implemented through the public health system, both the capacity and maturity of health system were important. Further, it was important to ensure that mechanisms should be in place and the style of working had been scrutinized. The existing

health centers were generally not very friendly and inviting even to adults – and to make them invite and be friendly to young people, was like trying to do leapfrog. Elements that enabled flexibility, and not just develop approaches, standards, guidelines, training material and instructions and so on had to be brought out. Ms. Singh added that another significant aspect was that frontline workers had to understand why they were doing this. If the understanding was kept at a broad level, then the creativity and energy for local approaches, solutions and strategies come automatically. Though there were a number of challenges there were also some significant ingredients for success. Finally, she said that the time for ARSH had arrived in India.

Dr. Pratima added that she had been very impressed to hear about the progress that had been made during the conference and the mix of participants present. The meeting, she held, was a good example of collaboration between two UN agencies –WHO and UNFPA – both committed to supporting the government in working with adolescents. She reiterated that as a technical agency WHO stresses on the importance of having standards of quality for AFHS. Investing in adolescent health was not only an investment for now but also for the future. Moving from standards to operationalizing the guidelines was the next important step. Time was also right to look towards implementation of two major programmes – RCH II and NRHM and here there was also an opportunity to implement the AFHS. Finally, on behalf of the WHO, she expressed her pleasure in extending all assistance and offered her congratulations on the success of the conference.

Ms. Ena Singh complemented Mr. Chaitanya Prasad on providing able leadership without wavering and in seeing this strategy through its ups and downs.

Mr Prasad added that the first deliverable expected from the conference, even when it was being planned, was the adolescent module which was eventually rolled out effectively. He appreciated the support provided by WHO and UNFPA, Ms. Ena Singh's guidance, the work put in by Mandeep and Dr.Dinesh. He thanked the WHO team, Dr. Arvind Mathur, Neena, Bharti and Antigony. In the IEC Division he extended his felicitations to Mr. R.N. Singh, Mr. Sharma and Mr. Rawat in taking the programme forward. Mr. Prasad also extended his thanks to Dr Chandrmouli and Paul from WHO, Geneva.

He reiterated that the agenda would definitely be taken forward by finalizing the draft standards and the guidelines in the form of an implementation guide based on the suggestions coming from the Consultation. The government in the draft would issue these. The strategy would be rolled out in 75 districts. This was not the end of the process, as another National level Consultation was being planned in November and efforts were being made to invite the Health Minister and get the Ministry's acceptance.

Workshop evaluation

Finally, the participants were asked to write down what they felt about the workshop – both good and bad aspects on the two cards given. The cards were collected and the common feedback read out.

Outcomes of the Workshop

Global and regional experiences with AFHS and clinics at tertiary levels in India have pointed to a pressing need for policy guidelines for implementation of the RCH-II ARSH at the state and district level. The guidelines are tools to crystallize the policy rhetoric gradually into the programme, provision and service delivery. The guidelines also equip the MoHFW to refine the human stock in the health delivery system.

Crystallization of Operational Guidelines

The operational guidelines were deliberated upon and further detailed in terms of components of service delivery package; organization of services; capacity building; communication and monitoring. A minimum package of services for adolescents was zeroed down. This package includes promotive, preventive and curative services with a system of referrals. Reorganizing existing services through a combination of

routine and dedicated clinics at sub-centre, PHC and CHC levels in doable ways was discussed. In capacity building of service providers, stress is to be given on inter-personal skills, attitudes and motivation of service providers. For communication activities with adolescents and the community, a minimum set of activities by the health department was mapped (example, the ANM's participation in SHG and VHC meetings for discussion on adolescent issues; MO organizing half day meeting with district officials on adolescent issues). Suggested steps for piggybacking on the work of other departments and establishing inter-sectoral linkages in the field were outlined. Core monitoring indicators were worked out keeping in mind the existing load of the MIS and the proposed data flow system in RCH II

Following are the highlights of the operational guidelines suggested at the National Consultation. The guidelines focus on five aspects of the health interventions for adolescents:

- Core characteristics of services
- Package of services organized at PHC and CHC level
- Capacity building training of service providers
- Communication activities by the health department for demand generation strategy
- Monitoring and evaluation

The RCH-II ARSH strategy focuses on integration of adolescent issues in the communication and training material of the department, including organization of services for adolescents in the public health system. The strategy suggests a combination of routine-specific day services at the SC and PHC respectively, offering a range of adolescent-related services.

State PIPs also incorporate district hospital level services, as in the case of Orissa, which has decided to do this in a phased manner, Assam with special focus on demand generation by NGOs; and Gujarat's state-wide health strategy for adolescents.

Core Characteristics

- Services are expected to be accessible, equitable and relevant to the needs and expectations of the adolescents. The MoHFW has brought married and unmarried boys and girls under the purview of its strategy, shading away the most discriminatory characterizations coming in the way of getting adequate medical attention in the form of referrals, for early and safe abortions, STI/RTI and HIV/AIDS prevention, etc.
- Implement these strategies at a legitimate pace.
- To ensure that these characteristics materialize, RCH-II provides policy support for equitable service provision and set procedures for M&E, and a comprehensive package of services with adequate referral links. The strategy also underlines subtle and otherwise understated or unconsidered areas like the need for competent and non-judgemental providers and involvement of adolescents as well as community support.

Organization of the clinics

- A separate space for adolescent clinic by available physical infrastructures or dedicated timing in an OPD of the MO can be organized. There cannot be uniform clinic timings. There is scope for variation and flexibility depending on the profile of adolescents, contract-labourers, school/college students, married adolescents, etc. Audio and visual privacy has to be ensured. RCH-II programme has made some budget available for innovations and renovations to make the services adolescent- friendly
- Clients need to be made mentally and physically comfortable in the setting. The clinic has to be convenient to approach so that clients feel free to visit, wait and ask questions
- Though AFHS needs only a small set of supplies these supplies like routine contraceptives, IFA tablets, gloves, STI/RTI drugs, antispasmodics, client information and take-away material should be regularly provided.

Capacity Building

- All technical strategies of RCH-II have capacity building as a major intervention. The training subgroup on ARSH has developed a training strategy, which is more focused on perspective building rather than knowledge building.
- The underlining approach is that the services need to be organized in a different manner. The final training package that has emerged from the exercise of developing of the service package in Gujarat, Rajasthan, and UP includes facilitator's guide for programme managers, the MOs, the ANM/LHVs and hand-outs for the programme managers.
- The training package that is designed for the programme managers (1 day), MOs (3 days) and ANM/LHVs (5 days) will roll out in the districts at the respective CHCs and PHCs. Since the profile of the trainers varies widely, precaution has been taken to ensure uniformity of messages being communicated. The module is also designed to induce feeling of ownership among the programme managers.
- Medical officers are sensitized on SRH concerns and HIV/AIDS prevention. Training modules and service packages hand-outs are produced in regional languages and sent to potential participants in advance.
- Residential training for trainers can be effective in guiding them through the modules and orienting them on how they could conduct training in their respective fields, like maternal health-care, emergency obstetric care, contraceptive updates, etc.
- Once services and capacities of the health care delivery system are in place, the next agenda for the health department is to undertake communication activities for encouraging the adolescents to come up to the service delivery points.
- A rational division of labour is proposed for this task, which essentially involves concurrent and continuous activities by the public sector, complemented by certain minimum activities initiated at the community level, so that an enabling environment is created for health-care interventions for the adolescents
- In the top-down chain of orientation, the NRHM and PRIs are expected to play a crucial role in the delivery of services. Ready reckoners and hand-outs can be used both by service providers for counselling and by the adolescents for their reference
- Linkages with other departments, some of them already having on-ground programmes for the adolescents for educating them on different aspects of SRH, HIV/AIDS, can ease the burden on the health department.

Monitoring and supervision

- Monitoring and supervision are based on positive input indicators (such as number of SCs and the PHCs having ready reckoners, communication and counselling material for access by adolescents, etc.) and process indicators (such as number of teenage pregnant women attending antenatal care, adolescents referred to CHC/DH).
- RCH-II MIS has already included ANC attendance as one of the key indicators. It is not possible to include all the input and process indicators in RCH-II MIS. Alternatively, service registers will help to capture the data on cumulative monthly basis for the two types of indicators.
- Output and outcome indicators, e.g., unmet need for contraceptives, prevalence of anaemia among pregnant women and teenage pregnancy rates can be captured through rapid annual household surveys and assessment studies. Training and communication activities also need to be monitored.
- One more format to be filled would add to the burden of programme managers and service providers. Earlier they routinely and mechanically collected data, which came to district/state/national level without any analysis or feedback. The key indicators in the presently suggested indicators need not flow to the national level. The data can be organized and analyzed monthly by the MO at the service centre and quarterly at the district level, to assess and improve service delivery.
- Field budgets also can be reviewed on monthly and quarterly basis.

Application of the guidelines mainly at the PHC level depends on the maturity of the health system, and how well the strategy has been adopted at the district and state level.

Selection of Priority Districts

There was brainstorming on criteria for selection of priority districts where the strategy could be implemented on a pilot basis (for example, prevalence of HIV/STI in the young population, low age at marriage, high teenage pregnancy rate). Additionally, a group exercise was conducted on working out some costing guidelines. It is expected that these suggestions would be further detailed out and incorporated as part of the Implementation Guide. There were some innovative suggestions from participants, which would be further incorporated in the Guide (for example, identifying adolescent girls as link workers for mobilizing pregnant women for the ANC, how the ASHAs could be involved, engaging block extension educators for communication activities, etc.).

Consensus on Standards Framework

The AFCs have taken all the care to improve their services. However, as in case of 14 centres initiated by SHAAN, absence of standards framework makes it difficult to assess what they have achieved.

The GoI along with MoHFW has been moving towards Indian public health standards for the PHCs and the CHCs. A standards framework will enable us to measure the gap between actual and required performance. England, Sweden, South Africa, Tanzania and recently, Bangladesh have developed a framework for public health facilities. While deciding on standards, the target group, services, the agency responsible for the delivery of services and accountable for maintaining standards need to be considered.

Seven Draft Standard Statements

1. Service delivery points (SPs) provide specified package of health services to all adolescents effectively: An agreement needs to be reached in this case and states need some scope to choose the package.
2. SPs motivated to work for adolescents: Counsellors and counselling skills are critically important.
3. Adolescents to be well informed about quality health services from the services delivery points: it is important to forge partnerships.
4. Enabling environment for adolescents to seek the health services they need: This is a broad statement and needs to be reconstructed: what are the elements of the enabling environment and who are the key players whom we want to engage in the initiative.
5. Service delivery points accessible to adolescents: This relates to physical accessibility to ensure that cost, distance and other issues are important.
6. Comfortable: Adolescents should feel comfortable with the ambience and surroundings and procedures of the service delivery points. Though the comfort levels are difficult to define, they are not impossible to define.
7. Management Information Systems to be in place to improve and sustain quality of health services.

These draft statements need to be developed further and tabled for more consensus building at a later stage.

The four-day Consultation has offered useful deliberations and ideas as to what needs to be done to contribute to each of these standards. Concrete actions are also identified to accomplish these standards. These standards will be further revised based on the feedback we get.

Next steps

1. Finalization of the Implementation Guide for State and District RCH II Programme Managers, based on expert inputs and deliberations of the Consultation. This Guide could be further adapted and modified at the state and district levels.

2. Finalization of the draft Capacity Building Package for Programme Managers, Medical Officers, and ANMs, which has been developed and pre-tested in three district settings. This could be further adapted and modified by states.
3. Upon completion of above-mentioned Steps 1 and 2, a National Consultation is to be organized with all State Government representatives for rolling out the implementation of the RCH II ARSH Strategy.

Other steps:

4. Publish and disseminate the Consultation Report.
5. Initiate national level BCC campaign on adolescent health issues (especially age at marriage and HIV prevention).

Annexure 1: Agenda

National Consultation on RCH-2 ASRH Strategy: Development of National Operational Guidelines and Criteria for Adolescent-Friendly Health Services 2-4 September 2005

Objectives of the workshop:		
	<ol style="list-style-type: none"> 1) To solicit inputs for operationalizing the RCH-2 ASRH Strategy of services for adolescents in a district setting 2) To build consensus on operational guidelines and criteria for services to adolescents in the context of Indian Public Health Standards 3) To share programming experiences and lessons learned on 'adolescent-friendly health services' 4) To strengthen inter-sectoral linkages and partnerships in particular NACP III in policy programming for services for adolescents <p><i>Expected Output</i> Agreed national operational guidelines and criteria for services for adolescents</p>	
Friday, 2 September 2005 DAY 1		
	Session I: Opening Session	
1000-1005	Welcome and Opening remarks	Mr. B.P. Sharma <i>Joint Secretary, MoHFW</i>
1005-1010	Opening remarks	Dr Salim J. Habayeb <i>WHO Representative</i>
1010-1015	Opening remarks	Mr Hendrik van der Pol <i>UNFPA Representative</i>
1015-1020	Context Setting and workshop objectives	Mr Chaitanya Prasad <i>Deputy Secretary, Ministry of Health and Family Welfare</i>
1020-1030	Keynote address	Mr P.K.Hota <i>Secretary Health & Family Welfare, Gol</i>
	Vote of Thanks	<i>Ministry of Health and Family Welfare</i>
1030-1100	Tea/ Coffee Break	
	Session II: Global Regional and National context and experiences	
1100-1130	Context Setting: RCH II ASRH Strategy	Mr Chaitanya Prasad, <i>MoHFW</i>
1130-1150	Global AFHS Overview: Background and context	Dr Chandramouli /Dr.Bruce Dick <i>WHO HQ Geneva</i>

1150-1210	Youth Friendly Health Services for RH and HIV/AIDS: The South Asia Regional Context	Dr. Farah Usmani <i>UNFPA CST for South and West Asia, Kathmandu</i>
1210-1230	AFHS Experiences in India: A synthesis of public and NGO experiences	Dr Arvind Mathur <i>WHO India</i>
1230-1300	Participants' experiences and discussions	Mr. Chaitanya Prasad, <i>MOHFW</i>
1300-1400	Lunch	
	Session III: Moving towards an implementation framework in RCH-II ASRH component	
1400-1430	Making health services adolescent friendly using a Quality Improvement approach	Dr. Chandramouli, <i>WHO HQ</i>
1430-1530	Operationalizing health services for adolescents in the public health sector in the context of RCH II State Programme Implementation Plans [PIPs]	Dr Dinesh Agarwal Ms Mandeep Janeja <i>UNFPA India</i>
1530-1600	Tea/coffee break	
1600-1800	Session IV: Open Plenary- Participants' experiences and suggestions for operationalizing the ASRH Strategy	Chairperson: Chaitanya Prasad Facilitation/Panel: Ms. Sharareh Amikhalili (UNFPA), Dr Neena Raina, (WHO)
	Closing remarks from Chair	(WHO)
Saturday, 3 September 2005 DAY 2		
	Session V: Developing Criteria for Adolescent Friendly Health Services	
0930-0940	Reflections: Recap from Day 1	Dr Farah Usmani, <i>UNFPA</i>
0940-1000	Overview of the agenda for Day-2	Dr Chandramouli, <i>WHO</i>
1000-10.30	Barriers to young people's utilization of health services (Group Work followed by feedback in plenary)	Group Work Facilitators
1030-1100	Coffee/tea break	
1100-1130	Spill over session	
1130-1300	Making services PHCs adolescent friendly: What are the important elements? (Group work followed by feedback in plenary)	Group Work Facilitators
1300-1400	Lunch break	
1400-1530	Articulating the statement and the rationale for each criterion (Group work followed by feedback in plenary)	Group Work Facilitators
1530-16.00	Coffee/tea break	
1600-1730	Spill over time Experiences from other settings in developing and applying a Quality Improvement approach to AFHS.	
Sunday, 4 September 2005 DAY 3		
DAY 3	Session VI: Building Consensus on National Operational Guidelines	
0930-0940	Reflections: Recap from Day 2	Dr Chandramouli, <i>WHO</i>

Sunday, 4 September 2005 DAY 3 (contd...)		
0940-1010	Terms of Reference for Group Work- Outline of thematic areas for group work	Dr Dinesh Agarwal UNFPA Ms Mandeep Janeja UNFPA
1020-1030	Discussion /clarifications on TOR and group division in different thematic areas	Group Work Facilitators
	Session VII: Group Work on thematic areas for operationalization	
1030-1300	Group Work in different thematic areas for operationalization Group 1: Services [Appropriate, available and accessible services and counselling for adolescent for RH and HIV/AIDS and referral linkages and follow-up] Group2: Facility Organization [physical environment, Layout, timings, drugs and supplies, youth friendliness] Group 3: Capacity Building [Training plan, staff needs for training, category of staff to be trained, others] Group 4: Communication and Outreach [IEC initiatives, youth friendly RH/HIV IEC materials, how and who would provide information, involvement of young people] Group 5: Management [Data collection/Client records and follow-up, monitoring, quality assurance, supportive supervision]	Groups working in the 5 thematic areas to develop operational guidelines Each Group to select a group rapporteur to make a 15 min presentation on behalf of the group at the plenary Group facilitators to share the suggested presentation outline and TORs
1300-1400	Lunch	
1330-1400	Group rapporteurs to develop group presentation for the plenary using the suggested outline during lunch break	Working group rapporteurs
	Session VIII: Synthesis on Operational Guidelines	Facilitator Dr. Farah Usmani, UNFPA CST for South/West Asia
1400-1515	Group work plenary in the different thematic areas – 5 groups	Each group rapporteur to make a 15 minutes presentation on the suggested guidance on the thematic area.
1515-1545	Comments and clarifications on group presentations	
1545-1600	Synthesis	Dr. Farah Usmani
1600-1630	Tea Coffee Break	
	Session IX: Wrap Up and Next Steps	Chair: Mr Chaitanya Prasad, Gol
1630-1715	Challenges for Scaling-Up AFHS	Panel Discussion
1715-1730	Summary and Wrap-Up: Outline next steps including presentation of criteria for 75 pilot districts	UNFPA India and WHO India
1730-1800	Concluding remarks	Chair, MoHFW

Annexure 2: List of Participants

1. Mr A. K. Nanda, Population Foundation of India
2. Shril. Amarjit Singh, Secretary and Commissioner (H&FW), Department of Health and Family Welfare, Government of Gujarat
3. Ms. Antigony Koumpounis, WR India Office
4. Dr Arvind Mathur, National Professional Officer (FCH), WR India Office
5. Dr Bejayeeni Mohapatra, Professor and Head, Community Medicine Department SCB Medical College, Cuttack
6. Mr. Bhagwan Prakash, NACP III Team
7. Mrs Bharti Sharma, WR India Office
8. Dr Bruce Dick, WHO/HQ
9. Dr. Bulbul Sood, Country Director, CEDPA
10. Dr Chander Puri, Director, National Institute for Research in Reproductive Health
11. Dr Duru Shah, President Elect, Federation of Obstetric and Gynecological Societies of India
12. Ms Fedrica, European Commission Technical Assistance
13. Dr Geeta Sodhi, Director, Swaasthya
14. Dr G. N. V. Ramana, Senior Public Health Specialist, World Bank
15. Dr Hendrik Van der pol, UNFPA Representative to India, UNFPA
16. Ms Joanna Reid, Senior Advisor (Heath), Department For International Development
17. Mr Keshv Desiraju, Joint Secretary, Department of Secondary and Higher Education, Ministry of Human Resource Development, Government of India
18. Dr Krishna Bose, WHO/HQ
19. Mr Lester Coutinho, Country Programme Adviser, Packard Foundation
20. Ms. Loveleen Kakkar, Joint Secretary, Department of Women and Child Development, Ministry of Human Resource Development, Government of India
21. Dr Malbika Roy, Coordinator- RHN, Indian Council of Medical Research
22. Dr M. Wasta, President, Family Planning Association Of India
23. Ms Nandini Kapoor Dhingra, National Programem Officer, UNAIDS
24. Dr. Neena Raina AHD/SEARO
25. Dr N. K. Sethi, Director, National Institute of Health and Family Welfare
26. Dr P. Nayar, Bara Hindu Rao Hospital
27. Mr P. K. Mishra, Principal Secretary (Family Welfare), Government of Uttar Pradesh
28. Dr P.V. Kotecha, Professor and Head, Department of Community Medicine, Government Medical College, Vadodra
29. Dr Rajiv Tandon, USAID
30. Dr. Rashmi Asif, Consultant, CEDPA
31. Dr Rajesh Kumar, Professor and Head, IAPSM, Department of Community Medicine, Post Graduate Institute of Medical Education and Research, Chandigarh
32. Dr Rajesh Mehta, Professor, Department of Paediatrics, Safdarjang Hospital, New Delhi
33. Dr Revathi Narayan, National Coordinator, CHARCA

34. Dr Robert Clay, Director (Health Systems Division), USAID
35. Dr Sharda Jain, Indian Medical Association
36. Dr Sheena Chabra, Chief (Health Systems Division), Office of Population Health and Nutrition, USAID
37. Ms. Shiela Rani Chunkanth, Secretary (H&FW), Department of Tamil Nadu
38. Dr Shireen Jejeebhoy, Senior Programme Associate, Population Council
39. Dr Shivananda, Director, Indira Gandhi Institute of Child Health, South Hospital Complex, Dharmaram College Post, Bangalore
40. Mr Shivendu, Secretary (Health and Family Welfare), Department of Health and Family Welfare, Government of Jharkhand
41. Dr. Sukanta Chatterjee, Professor and Head, Department of Pediatrics, Kolkata Medical College.
42. Dr Sunil Mehra, Executive Director, MAMTA
43. Ms. Suzan Koshy, GTZ Office India
44. Dr Swati Bhawe, Indian Association of Paediatrics
45. Dr S. Y. Quraishi, Special Secretary and Director General, NACO
46. Dr. V. Chandramouli, Coordinator AHD/HQ
47. Ms Vandana Jena, Joint Secretary, Ministry of Sports and Youth Affairs, Government of India
48. Dr. Veena Parmar, Professor & Head, Department of Pediatrics, GMC&H, Chandigarh
49. Ms Vidya Ganesh, Chief (HIV/AIDS section), UNICEF
50. Dr Vijay Kumar, Director, Survival for Women and children Foundation (SWATCH), Haryana
51. Dr V. K. Srivastava, Professor, Post-Graduate Department of Social and Preventive Medicine, King George's Medical College, Lucknow
52. Dr Yasmin Zaveri Roy, Programme Manager Health and Education, Embassy of Sweden, Development Cooperation Section, SIDA

