



strategy handbook



Rashtriya Kishor
Swasthya Karyakram
राष्ट्रीय किशोर स्वास्थ्य कार्यक्रम



Strategy Handbook

Rashtriya Kishor Swasthya Karyakram राष्ट्रीय किशोर स्वास्थ्य कार्यक्रम



Government of India
Ministry of Health and Family Welfare
Nirman Bhavan, New Delhi



Acknowledgements

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Ghulam Nabi Azad

Minister of Health and Family Welfare



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Message

India is home to 243 million adolescents, who are the future of this country. It is important that we engage with them and match their expectations by addressing an entire gamut of evolving needs of an emerging generation of adolescents in the nation. We all know that adolescent health and development is the key to achieving improved health and development outcomes for the population as a whole.

The National Adolescent Health Strategy proposes a multi-level, multi-sectoral solution for diverse adolescent health needs. The strategy has been developed in consultation with various ministries, development partners, multi-laterals, civil society, academicians and the voices of those who matter the most - the adolescents. The shift from a clinical approach, to that of health promotion, is well demonstrated in the plan – clearly articulating the need for instilling positive behaviours and for supporting adolescents in making a healthy transition from childhood to adulthood.

I congratulate the team for developing this strategy and I am certain that this document will be used constructively at national, state, district and sub- district level for improving the lives of millions of young people.

The challenge before us now is to ensure the implementation of this initiative and I urge all stakeholders to come forward and transform this strategy into a successful programme. It is time to transcend words and steer on-ground action. It is time that India fulfils its promise to the youth of the nation.

GHULAM NABI AZAD

Hon'ble Union Minister for Health & Family Welfare,
Government of India



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Foreword

Adolescence represents a unique period in the life cycle, when young persons are no longer children but are not yet adults. Adolescents make significant choices about their health and develop attitudes and health practices that affect their current safety and well-being as well as influence their risk for future serious chronic disease. Adolescent persons in the age group of 10-19 years, constitute 22 percent of India's population. Investing in adolescent health and well-being is a huge opportunity that can transform the social and economic fortunes of the country. Promoting the health and safety of adolescents is of critical importance to the future of the nation. By investing in adolescent health today, we invest in the workforce, parents, and leaders of tomorrow and of course improve our maternal and child health outcomes, breaking the inter-generational cycle of poor health.

The Adolescent Health Strategy is the first step toward addressing the needs of adolescents comprehensively and reaching out to them in their own environment i.e. schools and communities. The strategy realigns existing approaches to focus on community based health promotion and prevention and identifies six priority areas of action: Reproductive and Sexual Health, Nutrition, Mental Health, Injuries and Violence including Domestic and Gender Based Violence, Substance Misuse, Non-Communicable Disease.

The approach proposed in the strategy is based on a continuum of care for adolescent health through provision of information, commodities and services at the community level and linking them to the public health system through referrals. Interventions are planned at distinct layers in the adolescent universe: individual, family, school, and community and aim at providing a comprehensive package of care and services.

I am certain that this strategy is the key to translating our vision for improving adolescent health and well-being into reality. The strategy provides a framework which will guide the states, programme managers and communities in establishing priorities, take collective action, and measure progress toward the shared goal of improving the health, safety, and well-being of their adolescents and young adults. I believe that this strategy will serve as an excellent starting point for new and evolving efforts that foster the healthy development of India's youth.

A handwritten signature in black ink, appearing to read 'K Desiraju', with a horizontal line extending to the right.

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Preface

India is on the cusp of a transition from an older world to a new one that is taking shape with different opportunities and possibilities. We are a young country; adolescents (age group of 10 -19 years) constitute 21% of the total population of India.

This demographic bulge can only be translated into a rich dividend if we, as policy drivers and programme managers, focus on health and well-being of this 243 million strong, very vulnerable population group.

Adolescence is commonly understood to be a healthy phase, relatively free from mortality and morbidity. However, adolescent health and nutrition status has an inter-generational effect; more than 33% of the disease burden and almost 60% of premature deaths among adults can be associated with behaviors or conditions that began or occurred during adolescence—for instance tobacco and alcohol use, poor eating habits, violence, sexual abuse, and risk taking behavior. It thus becomes essential for us to engage with adolescents to protect them from violence and poor health and to address their health and development needs in order to achieve improved health and development outcomes for the population as a whole.

It is in this context that Ministry of Health and Family Welfare has developed a new adolescent health strategy to strengthen and complement the adolescent component of India's Strategic Approach to Reproductive, Maternal, New-born, Child and Adolescent Health (RMNCH+A). This strategy is underpinned by evidence that it is during adolescence that minds can be influenced positively and attitudes and behaviour modified for better, making it the most important stage of the life cycle for health interventions. I firmly believe that if AH is addressed,

several RMNCH challenges can be obviated. For instance, anaemia can be tackled effectively if IFA supplementation is given to adolescents. Similarly, age at marriage, birth preparedness and appropriate spacing, teenage pregnancy and mortality and morbidity associated with it can be addressed only when we start to work with adolescents, both boys and girls and their caregivers.

The strategy acknowledges the importance of substantially broadening the content, taking it far beyond Sexual and Reproductive Health bringing in focus on life skills, nutrition, injuries and violence (including gender based violence), non-communicable diseases, mental health and substance misuse - all critical for holistic human development of a young adult. Key strength of this strategy is that it adopts a health promotion approach. It moves beyond the existing programming norms of facility based interventions and reaches out to adolescents in their own environment, such as schools and community and at the same time focuses on their influencers and caregivers. Programme drivers identified in this strategy are community based outreach through peer educators and counsellors, communication for information and behavior change and adolescent friendly health clinics

This document is designed to serve as a broad guide for Secretaries, Mission Directors and Programme Managers at National and State level giving an overview of situation of adolescents in India, priority areas of actions and a comprehensive approach to addressing adolescent health issues within the overarching framework of RMNCH +A and continuum of care. A series of operational guidelines and resource materials have been developed to support the rolling out of this strategy.

Convergence with departments of Education, Social Welfare/ Women and Child Development and Youth and Sports Affairs is the cornerstone for successful implementation of this strategy and it will ensure that we are not reinventing the wheel but utilizing existing, tried and tested platforms like schools, Anganwadi Centres, Sabla, Kishore- Kishori Samooh, Nehru Yuva Kendras etc. for providing services to this hard to reach population group.

The approach argued in this strategy is evidence based, practical and inclusive. I am certain that we, as Programme Managers, are ready to set new benchmarks and take up this challenge – building blocks for which are already there – we just need to think beyond the traditional approach of curing people to one that prevents people from being sick and remain healthy and productive.

I am certain that States will read this strategy as a call to action for adolescent health and translate it into vibrant and successful programme for a population that has remained largely underserved and at the periphery of the health system.

A handwritten signature in dark ink, appearing to read 'Anuradha Gupta', with a long horizontal flourish extending to the right.

ANURADHA GUPTA
Additional Secretary and Mission Director



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Message

In order to respond effectively to adolescent health, it is important to situate adolescence in a life-span perspective within dynamic sociological, cultural and economic realities. Further, diverse groups of adolescents are faced with different sets of opportunities and challenges. Certain core needs and concerns are universal, yet the concept of 'several adolescences' is an important consideration in adolescent friendly policies and programmes. This guiding document offers insights on operationalising services on-ground taking into account the diverse needs of this group.

The well-being of the adolescent population is a key driver for achieving health for all which can no longer be ignored. The success of the roll-out of this strategy lies in the collective ownership of the work-plan. Different stakeholders working on issues related to adolescent health and development have a lot to gain by building on each other's work both in terms of achieving programme objectives as well as improved indicators for adolescents. This document is both a nascent and a significant step towards achieving this.

The six thematic areas covered under adolescent health programming include Nutrition, Sexual and Reproductive Health, Injuries and Violence (including Gender-Based Violence), Non-Communicable Diseases, Substance Misuse and Mental Health. The six strategic priority (programme) areas have emerged from a situational analysis of adolescent health issues in India. It is envisaged that addressing these critical areas through convergence across ministries would help bring about holistic adolescent health care in the country. To deliver these interventions the health system will need to be strengthened

and effective communication, capacity building and monitoring and evaluation systems will need to be instituted.

The National Adolescent Health Strategy is a clear call to action to ministries as well as Programme Managers in the States to ensure health and development needs of adolescents. Indeed, no single entity can deliver complete health care solutions to adolescents. It is this synergy that can unleash transformative on-ground impact.

I am certain that the states and our partner Ministries will do their utmost for translating this strategy into a reality which will have a profound impact not only in improving health outcomes but also in improving quality of life of millions of young people. I pledge my unstinting support to this initiative.



DR RAKESH KUMAR
Joint Secretary



Dr. Babatunde Osotimehin

Executive Director

United Nations Population Fund

Under-Secretary-General of the United Nations



Message

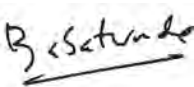
Of the many promises that we have made to the world's young citizens, there are some that we simply cannot afford not to keep. The promise to respect, protect, and fulfill young people's right to health is more than a promise; indeed it is our obligation. Today, every fifth person in India is an adolescent (10-19), and every third is a young person (10-24). In order for the country to fully benefit from this youth bulge, and for the sake of adolescents themselves, it is imperative that all those on the brink of adulthood enjoy good health and adequate opportunities. The aspirations of a fourteen year old girl in a remote, tribal village deserve as much chance of fruition as that of a fourteen year old boy in a metropolis.

Given the marked variations in the experiences of adolescents across age, gender, geography and socio-cultural background, programming for a diversity of adolescents is imperative. Further, the existing social, legal and policy environment must be aligned to promote adolescent health. Access to health, including sexual and reproductive health information and services, should not be the privilege of a few. For every young person whose right to health information and quality health care services remains compromised, a part of the nation is held back.

I am pleased to note that the Adolescent Health Strategy of India demonstrates a paradigm shift from a clinical stance to one of disease prevention and health promotion. The integrated Adolescent Health Care Package identifies and recommends a set of interventions across different levels of care. The Strategy also recognizes that the wide-ranging health needs of adolescents must be met with wide-ranging inputs delivered through innovative methodologies and successful partnerships. Indeed,

this is an ambitious strategy befitting an ambitious generation of Indian adolescents.

The United Nations Population Fund congratulates the Government of India on its reaffirmation of the rights of adolescents, especially girls and those from marginalised groups, so that they can grow up healthy and safe. As India gears up to offer a complete health package to its adolescents, the United Nations Population Fund commits its full support to this endeavor. We will continue to provide our international as well as national expertise, and facilitate opportunities for exchange between India and other countries. I am confident that with the roll-out of the national Adolescent Health Strategy, in the coming years, India will be globally upheld as a case study for others to emulate. The lives of adolescents are replete with possibilities, and their journeys have only begun. It is our collective responsibility to ensure that their voyage is an uninhibited and successful one.

A handwritten signature in black ink, reading "B. Osotimehin", with a horizontal line underneath.

DR. BABATUNDE OSOTIMEHIN
Executive Director
United Nations Population Fund
Under-Secretary-General of the United Nations

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Executive Summary

Adolescents (10–19 years) constitute about one-fifth of India's population and young people (10–24 years) about one-third of the population. This represents a huge opportunity that can transform the social and economic fortunes of the country. The large and increasing relative share and absolute numbers of adolescent and youth population in India make it necessary that the nation ensures they become a vibrant, constructive force that can contribute to sustainable and inclusive growth. The skills, knowledge, attitudes and behaviour of today's young people are essential to whether, and how well, the demographic dividend is successfully leveraged.

In order to enable adolescents to fulfil their potential, substantial investments must be made in education, health, development and other areas. Investments in adolescents will have an immediate, direct and positive impact on India's health goals and on the achievement of the Millennium Development Goals (MDGs), especially goals 1, 2, 3, 4, 5 and 6¹; at the same time, it will enhance economic productivity, effective social functioning and overall population development. However, a considerable number of adolescents face challenges to their healthy development due to a variety of factors, including structural poverty, social discrimination, negative social norms, inadequate education, and early marriage and child-bearing, especially in the *marginalised* and under-served sections of the population. In order to respond effectively to the needs of adolescent health and development, it is imperative to situate adolescence in a life-span perspective within dynamic sociological, cultural and economic realities.

¹ MDGs: 1. Eradicate extreme poverty and hunger 2. Achieve universal primary education 3. Promote gender equality and empower women 4. Reduce child mortality 5. Improve maternal health 6. Combat HIV/AIDS, malaria and other diseases

Taking cognisance of the need to respond to health and development requirements of adolescents in a holistic manner, the Ministry of Health and Family Welfare (MoHFW) has developed a comprehensive strategy, based on the principles of participation, rights, inclusion, gender equity and strategic partnerships. The strategy envisions that all adolescents in India are able to realise their full potential by making informed and responsible decisions related to their health and well-being. The implementation of this vision requires a concerted effort by all stakeholder ministries and institutions, including health, education, women and child development, and labour as well as the adolescents' own families and communities.

The strategy is a paradigm shift, and realigns the existing clinic-based curative approaches to focus on a more holistic model, which includes and focuses on community-based health promotion and preventive care along with a strengthening of preventive, diagnostic and curative services across levels of health facilities. The approach proposed in the strategy is based on a continuum of care for adolescent health and development needs, including the provision of information, commodities and services at the community level, with mapped out referral linkages through the three-tier public health system. Most importantly, it proposes a convergent model of service delivery that will engage adolescents and field service providers (for example, teachers, Accredited Social Health Activists—ASHAs, Auxiliary Nurse Midwives—ANMs, Anganwadi Workers—AWWs and Nehru Yuva Kendra Sangathan—NYKS—volunteers) actively, to secure and strengthen mechanisms for access and relevance. The strategy moves away from a 'one-size-fits-all' approach to more customised programmes and

service delivery specific to needs of adolescents, and aims at instituting an effective, appropriate, acceptable and accessible service package, addressing a range of adolescent health and development needs.

To implement this paradigm shift, the strategy identifies seven critical components (7Cs) that need to be ensured across all programme areas. These components are: coverage, content, communities, clinics (health facilities), counselling, communication and convergence. The six strategic priority (programme) areas that have emerged from a situational analysis of adolescent health and development in India are: nutrition, sexual and reproductive health (SRH), non-communicable diseases (NCDs), substance misuse, injuries and violence, including gender-based violence (GBV) and mental health. These interventions and approaches work at building protective factors that can help young people develop 'resilience', to resist negative behaviour and operate in four major areas: the individual, family, school and community by providing a comprehensive package of information, commodities and services.

To deliver these interventions, the health system will need to strengthen effective communication, capacity building and monitoring and evaluation systems. Also, several constituencies need to converge effectively and harness their collective strength to respond to adolescent health and development needs. The different stakeholders, working on issues related to adolescent health and development, have a lot to gain by building on each other's work both in terms of achieving programme objectives as well as in the improved indicators for adolescent health and development.



Background

Realising the enormous potential of adolescents depends on appreciating what shapes their present. It is a complex interplay of the adolescent life-stage, larger social determinants such as poverty and education, societal and familial pressures, the rural-urban differential, and how these impact health.

India is home to 358 million young people in the age group of 10–24 years. Of these, 243 million are in the age group of 10–19 years, accounting for 21.2 percent of the country's population. Adolescents represent a huge opportunity that can transform the social and economic fortunes of the country. However, this dividend has yet to be realised. Impeding this realisation are multiple factors such as disparities in access to resources, socio-economic status and others.

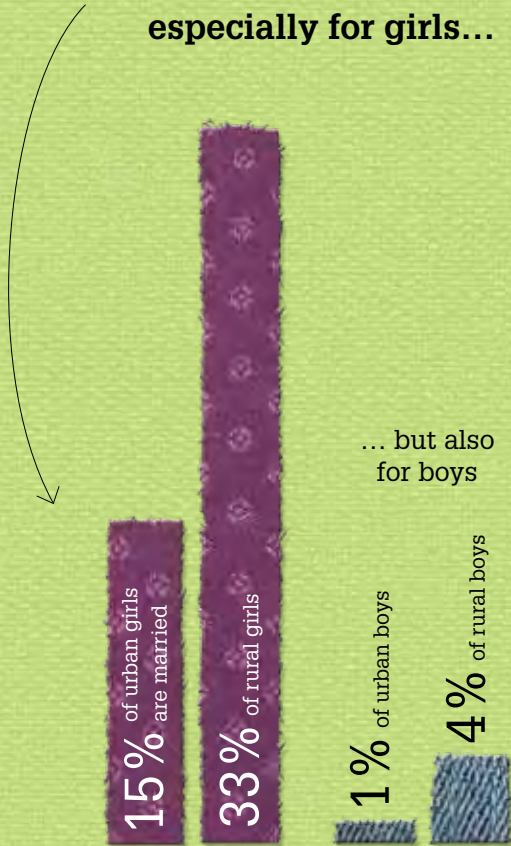
In order to enable adolescents fulfil their potential, substantive investments must be made in education, health, development and other areas.

In order to enable adolescents to fulfil their potential, substantive investments must be made in education, health, development and other areas. Investments in adolescents will have an immediate and direct impact on India's health goals and on the achievement of MDGs, especially goals 1, 2, 3, 4, 5 and 6², and at the same time contribute to enhanced economic productivity, effective social functioning and overall population development. This requires programmes and services, which recognise the special needs of adolescents and addresses these in a supporting and non-judgemental manner. This also requires a better understanding of their existing status within the prevailing socio-cultural settings and their vulnerabilities.

² Goal 1 Eradicate extreme poverty and hunger; Goal 2 Achieve universal primary education; Goal 3 Promote gender equality and empower women; Goal 4 Reduce child mortality; Goal 5 Improve maternal health and; Goal 6 Combat HIV/AIDS, malaria and other diseases

1

Early marriage is more likely in rural areas, especially for girls...



MARRIED ADOLESCENTS, 15-19 YEARS, NFHS 3

Social context

Adolescence is a transitional phase between childhood and adulthood, characterised by a number of cognitive, emotional, physical, intellectual and attitudinal changes as well as by changes in social roles, relationships and expectations. It means the quality of this passage from childhood to adulthood is crucial and much of a person's experience as an adult depends on its outcome.

Young people broadly continue to experience major constraints in making informed choices. Many adolescents, especially girls, face challenges to their healthy development into adulthood.

Many adolescents, especially girls, face challenges to their healthy development into adulthood due to a variety of factors, including structural poverty, lack of information, negative social norms, inadequate education, lack of vocational training, early marriage and child-bearing, and social discrimination. Young people broadly continue to experience major constraints in making informed life choices; a significant number of young people experience risky or unwanted sexual activity, do not receive prompt or appropriate care and experience adverse health outcomes.

Marriage, before the legal age of 18 years, is an important factor that affects the health of girls in India. According to National Family Health Survey (NFHS)-3, 47 percent of the currently married women, aged 20–24, were married on or before 18 years of age. Of the respondent girls, who were 15–

Marriage before the legal age of 18 years, is an important factor that affects the health of girls in India. Increasing levels of education is strongly associated with improving health and fertility indicators.

19 years old at the time of the survey, 27 percent were married compared to less than 3 percent of the boys in the same age group. Figure ❶ shows the significant rural-urban difference in early marriage rates.

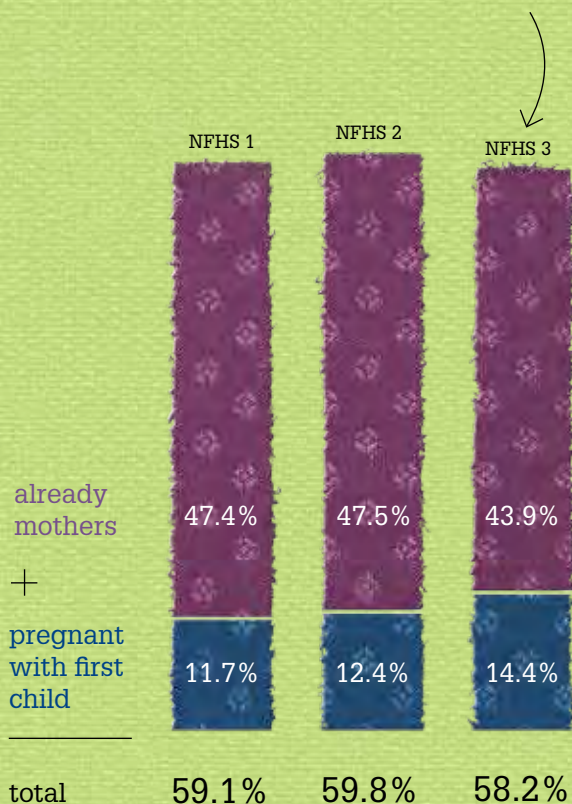
In India, teenage pregnancies are common owing to early marriages and the following familial and societal pressure on girls to prove their fertility. One in five young women aged 20–24 years had given birth at or before 18 years of age. Of the girls (married and unmarried) in their teenage years (15–19 years) at the time of the survey, 16 percent had already begun child-bearing. Of these, 12 percent were mothers and 4 percent were pregnant with their first child. As most child-bearing in India happens within the context of marriage, these rates were much higher among married adolescents, with 58 percent of them already mothers or pregnant with their first child at the time of survey. As seen in Figure ❷, this has not changed much since NFHS–1 in 1992–93. Like early marriages, early child-bearing is twice as common in rural areas compared to urban towns and cities.

Increasing levels of education is strongly associated with improving health and fertility indicators. Figure ❸ reveals that the median age at which girls get married for the first time steadily increases with improved education levels. This has resulted in a 4-year difference in the median age at marriage between women of 20–24 years with no education and women with at least 12 years of education.

Thirty-two million children enrol in Class I, but only eight million graduate from Class XII. Figure ❹ shows the declining net attendance ratio (as

2

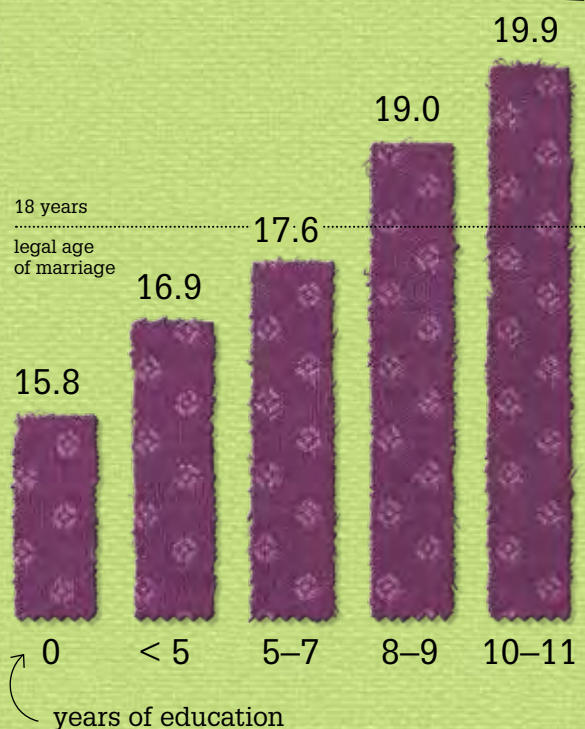
Early motherhood following early marriages: a sustained trend across three NFHS surveys



PREGNANCY AND CHILD-BEARING AMONG MARRIED
ADOLESCENTS, 15-19 AGE GROUP

3

Girls get married at a later age when they have more years of education



IMPACT OF EDUCATION ON MEDIAN AGE AT MARRIAGE, FOR 20-24 YEAR OLD WOMEN, NFHS 3

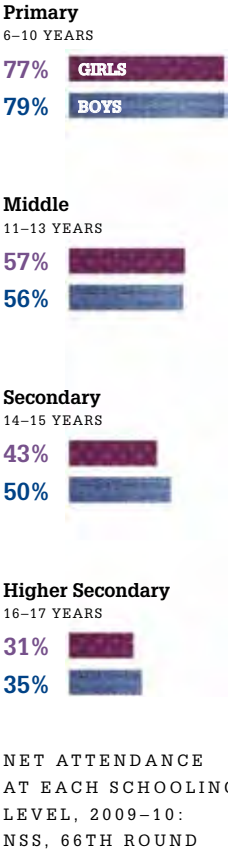
percentages of children in that age bracket) from one education level to another. There are marked inequalities in education among adolescents in India—access and completion being influenced by social class, caste, ethnicity and gender. The gender differential in school attendance increases at increasing education levels.

Under the patriarchal social norms prevalent in India, women and adolescent girls continue to face gender discrimination, evident in the declining sex ratio, early marriage, incidence of domestic violence, under-age pregnancy, unsafe motherhood, increasing incidence of sexual abuse, lower school enrolment and higher drop-out rates. Boys too face the pressure to comply with the prevailing norms of masculinity, which drives them to risky behaviours such as unsafe sex, violence and substance misuse.

These factors have a direct or indirect influence on the health and well-being of adolescents, and form an essential component of the background environment in which adolescent health issues should be understood. Programme interventions must, therefore, adopt a holistic approach and address these aspects in an integrated way, to leverage improvements in the health and well-being of adolescents.

4

The gender gap in school attendance increases at higher education levels



Health Context

Adolescent health is a construct of both biological and non-biological factors. Ranging from the social factors, as outlined above, to multiple layers of influence on adolescent environment (communities, schools, workplaces and peers), the health of adolescents is a confluence of a variety of factors (Figure 6). Understanding adolescent health, therefore, requires an examination of the impact of many factors.

Adolescence is ideally a healthy period. Nonetheless, more than 33 percent of the disease burden and almost 60 percent of premature deaths among adults can be associated with behaviour or conditions that began or occurred during adolescence, for example, tobacco and alcohol use, poor eating habits, sexual abuse, and risky sex (WHO 2002). Even within the age group of 10 to 19 years, the profile of the disease burden is significantly different for younger and older adolescents. Whereas injury and communicable diseases are the prominent causes for the loss of lives of younger adolescents from 10 to 14 years, the disease burden shifts to outcomes of sexual behaviour and mental health for older adolescents from 15 to 19 years (WHO 2011).

The priority needs of adolescents in India today span a range of health issues, including

malnutrition and anaemia, lack of knowledge on SRH (that may result in risky sexual behaviour, early and unwanted pregnancies, sexually transmitted infections—STIs—such as HIV/AIDS), substance abuse, communicable and non-communicable diseases, mental health concerns, and injuries and violence (including GBV)—all contributing to increased morbidity and mortality not only during adolescence but also later in their lives. Limited access to accurate information, and high levels of socio-economic and gender disparities generate differentials, in terms of disease burden and health issues affecting different sections of adolescents. Looking at some of the specific health issues helps in examining the situation more comprehensively.

More than 33 percent of the disease burden and almost 60 percent of premature deaths among adults can be associated with behaviour or conditions that began or occurred during adolescence.

MACRO/INSTITUTIONAL

Economic depression
Society in transition
Uneven access to resources
Implementation of youth policy
Inter-agency/Inter-organisational services

COMMUNITY

RISK PROTECTIVE

Violence | Poverty/Slums
Displacement | Corruption | Exploitation
Violent media | Lack of recreational facilities
Negative attitudes towards youth
Conflicting social messages | Harmful rites of passage

Supportive adults | Positive rites of passage | Availability & access to services | Communal Philosophy | Inter-generational dialogue | Opportunity for youth participation | Education and health/mental health

SCHOOL/WORK

RISK PROTECTIVE

Excessive discipline | Out of school | Unemployed | Physical and sexual abuse | Low expectations for girls
Lack of educational alternatives

Positive parent skills
Connectedness
High expectations
Family social capital

FAMILY

RISK PROTECTIVE

Overcrowding
Domestic violence
Lack of family planning
Single parent home
Mental illness, Hopelessness

Positive Parent skills
Connectedness
High expectations
Family social capital

PEERS

RISK PROTECTIVE

Negative peer culture
Deviant friends
Social isolation

Peer education
Youth participation
Youth organisations
Many friends

INDIVIDUAL

RISK PROTECTIVE

Depression/
Suicidability | Slum dweller | Gender disparity | Aggressive temperament | Mental retardation | Orphan
Ethnic discrimination
Disability | Violence
Homosexuality
Hopelessness

Self efficacy
Spirituality/
Religiosity | Being young | Agency

Spheres of Influence on Adolescent Health

HEALTH RISK BEHAVIOURS IN ADOLESCENCE

SUBSTANCE USE

Tobacco
Alcohol
Marijuana
Other

DIET AND EXERCISE

Inactivity
Unhealthy eating
Eating disorders
Overconsumption

INJURY AND VIOLENCE

Weapon carrying
Interpersonal violence
Helmet non-use
Drinking and driving
Sexual Assault

SEXUAL AND REPRODUCTIVE

Non-contraception
Condom avoidance
Early sexual debut
Multiple sexual partners

SOCIAL

School leaving
Arrest

POSITIVE YOUTH DEVELOPMENT

PHYSICAL

Injury free
Normotensive
Not overweight
Age appropriate Cholesterol, LDL
Appropriate Pubertal develop-
ment
Perception of self as healthy
No unwanted pregnancies
Physically Fit
Not STDs/HIVs

EMOTIONAL

Perception of self as happy
No clinical evidence of depression
No mental or emotional health
disorders
No history of suicide attempts

SOCIAL

Positive School Performance
Contributing to community
Positive family relationships

Nutrition

Anaemia and malnutrition affect large sections of the Indian population, including adolescents. Anaemia affects physical growth, cognitive development, performance in school and at work, and reproduction. Anaemic mothers are more prone to giving birth to low birth-weight children, increasing the morbidity and mortality rates for both mother and child. Findings from NFHS-3 indicate that as many as 56 percent of girls and 30 percent of boys in the 15–19 age group are anaemic. Of these, 17 percent of the adolescent girls and 14 percent of the boys suffer from moderate to severe anaemia. In fact, the prevalence of anaemia is more than 50 percent higher for boys aged 15–19 than for men aged 20–24. Married women in the age group 15–24 are more likely to be anaemic than their unmarried counterparts. The prevalence of anaemia (all age groups combined) is higher in rural than in urban areas, for both women and men. Also, marginalised groups, especially scheduled tribes, show higher levels of anaemia prevalence than the rest of the population.

Adolescents in India suffer from both under- and over-nutrition issues. In the age group 15–19, nearly half the girls (47 percent) and nearly three-fifths of the boys (58 percent) are thin³. At the same time, 2.4 percent of the girls and 1.7 percent of the boys in this age group are overweight⁴. As is to be expected, across age groups, the likelihood of being underweight generally declines with urban residence, increasing education and wealth levels whereas the chances of being overweight/obese increases under similar circumstances.

³ 'Thin' refers to a body mass index (BMI) of less than 18.5 kg/m²

⁴ 'Overweight' refers to a BMI of more than 25.0 kg/m²

The National Nutrition Monitoring Bureau (NNMB) report of 2006, shows that adolescent girls and boys consume only 32–45 percent of the recommended daily allowance of iron and only two-thirds of the recommended calories, which accounts in large part for the high prevalence of under-nutrition.

The unmet need for contraception in the age group 15–19 is 27 percent, which is the highest across all age groups.

Sexual and Reproductive Health

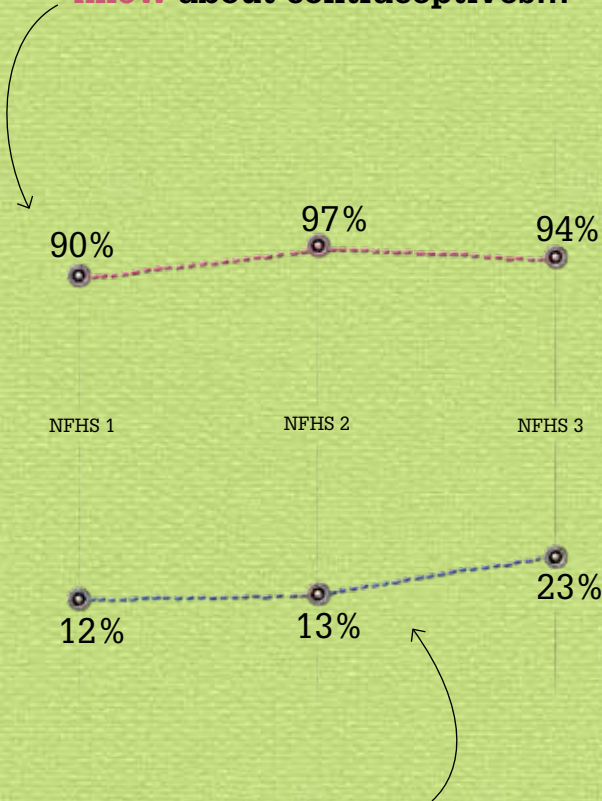
As mentioned earlier, child marriages leading to early child-bearing are common in India. Findings from NFHS–3 regarding age-specific fertility rates reveal that births in the age group of 15–19 years contribute to 17 percent of the total fertility rate. Of all the births in the five years preceding the survey (including current pregnancies) to women aged less than 20 years at the time of birth, 14 percent were unplanned. Comparison of data from the three rounds of NFHS does not suggest a substantive change in this indicator over time. The current contraceptive use among married teenagers (age 15–19) is as low as 13 percent compared to 33 percent in the age group of 20–24 years. The unmet need for contraception in the age group 15–19 is 27 percent, which is the highest across all age groups. These findings show that whereas on the one hand there is low demand⁵ (40 percent) for family planning in this age group compared to older women—often due to the strong social norms around child-bearing soon after marriage, on the other hand young married women are also not able to access contraceptive options when they want it.

Adolescent pregnancies pose a significantly higher risk to the life of the mother than pregnancies in the later reproductive age group. NFHS–3 shows

⁵ The total demand for family planning is the sum of unmet and met needs. Current contraceptive users are said to have a met need for contraception.

6

Nearly all married girls
know about contraceptives...



...but very few have **ever used** them
due to lack of accessibility or acceptability

MARRIED GIRLS, 15-19 YEARS

that approximately 4 out of 5 mothers less than 20 years of age had received antenatal care (ANC) for their most recent birth during the five years preceding the survey. Less than four visits were offered in most cases without the recommended basic services such as blood pressure measurement, abdominal examination and urine examination. Only 47 percent of adolescent deliveries were assisted by health personnel. Utilisation of all maternity care services (for women of all ages) is much higher in urban than rural areas, and increases sharply with wealth and education.

NFHS-3 shows that among adolescents between 15 and 19 years of age, 8 percent of the girls reported sexual debut before 15 years of age, compared to 2.7 percent of the boys. However, only 3 percent of the girls and 19 percent of the boys in this age group, who had had sex, reported using a condom the first time they had sexual intercourse. Whereas the data suggest that most sexual activity among adolescents happens in the context of marriage, the 2006-07 study about Youth in India reported that 3 percent of girls and 15 percent of men in the 15–24 age group had pre-marital sex. Even though 94 percent of the girls aged 15–19 knew of at least one modern method of contraception, only 23 percent of the married and 18 percent of the unmarried 15–19-year-old girls, who had ever had sex, reported ever using a contraceptive, compared to 46 percent and 30 percent of married and unmarried ever-users in the 20–24-years category. This gap between knowledge and actual use could reflect the difficulty in sourcing contraceptives along with the inability to negotiate contraceptive use with their sexual partners.

Sexually active adolescents are also vulnerable to STIs, including HIV/AIDS. In the age group of 15–19 years, among those who have ever had sexual intercourse, 10.5 percent of the girls and 10.8 percent of the boys reported having STI⁶ or symptoms of STI in the 12 months prior to NFHS 3. In addition, 0.07 percent of the girls and 0.01 percent of the boys in this age group were found to be HIV positive.

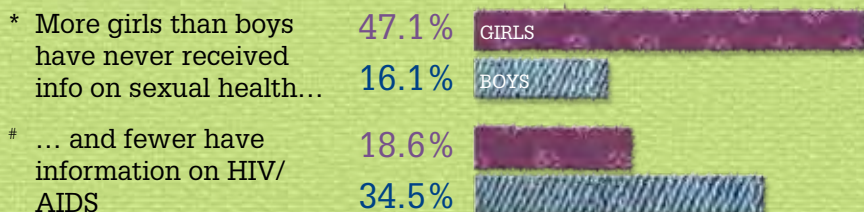
Knowledge is important to preventing STI and HIV infection. As with older age groups, knowledge regarding HIV/AIDS was much higher among the boys than the girls of the adolescent age group. Only 64 percent of the girls in this age group had heard of HIV/AIDS compared to 86 percent of the boys. Similarly, 19 percent of the girls and 35 percent of the boys had comprehensive knowledge about HIV/AIDS.

Global studies have shown that countries that offer age appropriate sexuality and reproductive health education along with provision of services for adolescents, including for family planning, have lower rates of teenage pregnancy, births and abortions. However, findings from the study about Youth in India (2006–07) suggest that adolescents and youth have limited awareness of majority of SRH matters. Only 15 percent young men and women in 15–24 age group reported that they had received family life or sex education in school or through special programmes sponsored by the government or NGOs although they expressed the need. Nearly half the young girls (15–24 years) and 16 percent of the boys said that they had never received any information on sexual matters from any source. This clearly highlights the need for programmes to respond to the sexual and reproductive needs of adolescents, irrespective of their marital status and sexual activity

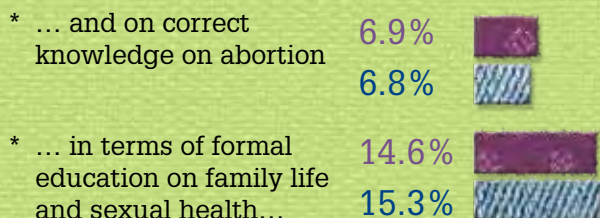
⁶ STI symptoms include abnormal, foul smelling genital discharge, genital sores or ulcers.

Adolescents are poorly informed on sexual health, with girls being worse off

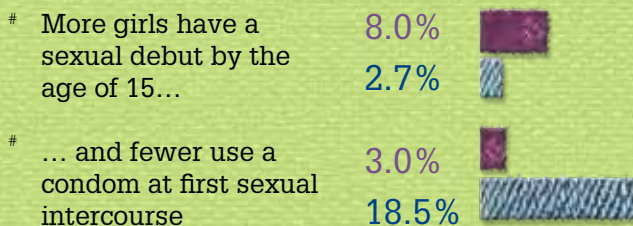
Girls are generally worse informed



Girls are as poorly informed as boys...



Girls also lag on practices



SRH KNOWLEDGE AND PRACTICES

* YOUTH STUDY (AMONG 15-24 YEAR OLDS) 2006-2007

NFHS 3 (AMONG 15-19 YEAR OLDS) 2005-2006

Injuries and Violence (including Gender-based Violence)

The top three causes of unintentional injury deaths in India are traffic accidents, by falls and drowning. Moreover, prevention of gender based violence remains a challenge in India.

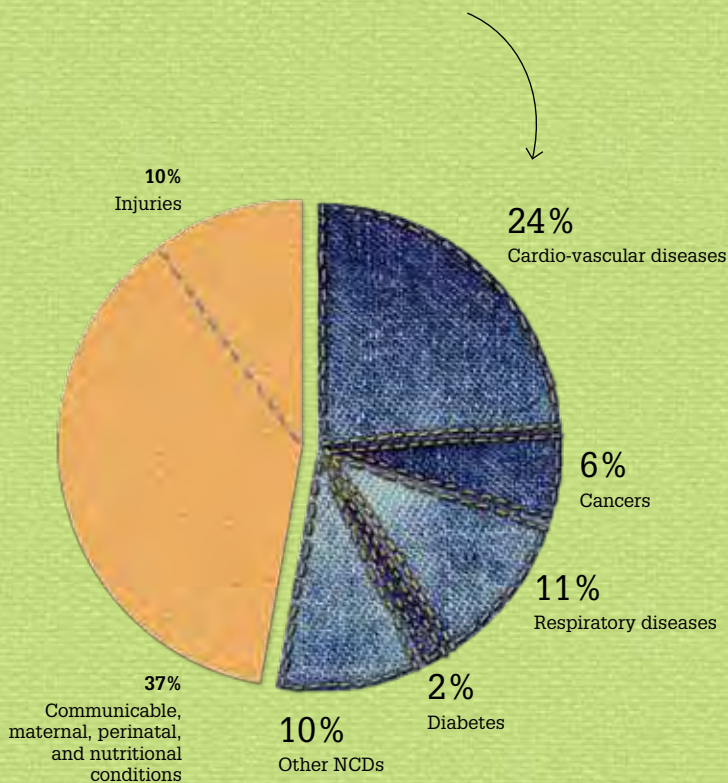
Unintentional injury deaths constitute nearly 20 percent of the total deaths in the 5–29 age group (Jagnoor et al. 2012) in India. The top three causes of unintentional injury deaths in India are traffic accidents, by falls and drowning. According to Global Burden of Disease 2004, road traffic accidents (RTA) are responsible for 3.35 lakhs deaths in India in the 15–29 age group, making RTA a leading cause of death in this age group.

Prevention of GBV remains a challenge. NFHS–3 revealed that 34 percent of ever-married adolescent girls (15–19) reported having experienced physical, emotional or sexual violence perpetrated by their spouses. In the case of sexual violence, the prevalence (ever experienced) declines from 13 percent in the age group 15–19 to 11 percent for the age group 20–24. There is wide variation among Indian states in the reported levels of spousal violence, with levels ranging from 7 percent in Himachal Pradesh, to 61 percent in Bihar. The incidence is higher in rural than in urban areas.

Non-Communicable Diseases

According to the WHO-NCD country profiles 2011, NCDs are estimated to account for 53 percent of all deaths in India across all age groups. NCDs also cause significant morbidity both in urban and rural populations, with considerable loss in potentially productive years of life.

Non-communicable diseases are estimated to account for 53% of all deaths



WHO-NCD COUNTRY PROFILES, 2011

Significant numbers of adolescents suffer from NCDs such as diabetes. Nearly 2 per 1,000 adolescent girls and 1 per 1,000 adolescent boys aged 15–19 suffer from diabetes.

More importantly, adolescence provides an opportune time for positive behaviour modification, to mitigate the emergence of risk factors of NCDs. Because the main preventable risk factors for NCDs such as tobacco and alcohol consumption, poor dietary habits, sedentary lifestyles and stress have their beginnings in this age group, it is imperative to initiate the promotion of a healthy lifestyle at a younger age. Data point to the need to educate adolescents, youth and parents on ways to prevent such lifestyle diseases as diabetes.

Substance Misuse

Tobacco, alcohol, cigarette/bidis, gutka and other intoxicants are commonly used by young people in rural and urban areas. Findings from NFHS–3 show that 11 percent of young men and 1 percent of young women in age group of 15–19 had consumed alcohol. Almost 3 percent of 15–19-year adolescent boys, who drink alcohol, consume it daily whereas another 18 percent consume it almost once a week. Almost 29 percent of the boys and 4 percent of the girls (15–19 years) use some kind of tobacco and more than 12 percent of the boys in this age group smoke cigarettes or bidis. The projected number of drug abusers in India is about three million, and most are in the age group 16–35 (UNODC 2003). Nearly 11 percent were introduced to cannabis before the age of 15 years and about 26 percent between the ages of 16 and 20 years (UNODC and Ministry of Social Justice and Empowerment 2004).

The use of alcohol and drugs among youth is associated with physical violence, risky sexual activity, depression and suicide as well as irregular school or work attendance and other negative outcomes. Tobacco use and alcohol abuse are also known risk factors for NCDs such as cardiovascular diseases and stroke in adult life.

Almost 14 percent of young men and women reported symptoms or behaviours indicative of mental health disorders.

Mental Health

A recent epidemiological study by the National Institute of Mental Health and Neuro Sciences (NIMHANS) reported that suicides have been increasing at the rate of 5–10 percent every year across the country. Psychological disorders such as depression and anxiety occur more often in girls than boys, with gender disparity becoming evident in early adolescence at the onset of puberty. Bullying (including cyber bullying) seems to be increasingly linked with adolescent suicide. Findings from a nationally representative survey conducted by the Registrar General of India (RGI) to determine the causes of death between 2001 and 2003 show that 13 percent of suicide deaths in the country occur in the age group of 15–29 years (Patel et al. 2012). According to the Youth in India study (2006-07), almost 14 percent of young men and women reported symptoms or behaviours indicative of mental health disorders

Government of India's Response to Adolescent Health Issues

Legal and policy framework

INTERNATIONAL COMMITMENTS

India has made several international commitments that recognise the right to health, and entitle all persons, in particular adolescents, to available, accessible, acceptable and quality health-care facilities and services. The Indian state has put in place a range of policy and programmatic provisions, directed towards meeting the health and development needs of adolescents and young people.

India is a signatory to the Programme of Action of the International Conference on Population and Development (ICPD), the Resolution of the 64th World Health Assembly and World Programme of Action for Youth (WPAY), United Nations Convention on the Rights of the Child (CRC), International Covenant on Economic, Social and Cultural Rights among others. India is committed, therefore, to provide the underlying conditions for health and to develop policies and plans, to address the main determinants of health that affect young people, including health-related behaviour and their impact on health at later stages of life.

Young people's health is included in the MDGs, to be achieved by 2015. Two of these are particularly relevant to young people's health.

- To achieve universal access to reproductive health (MDG Target 5.B), for which one of the indicators is the pregnancy rate among 15 to 19-year-old girls.
- To halt the spread of HIV/AIDS (MDG Target 6.A). It has indicators like a 25 percent reduction among young people, and also measures the proportion of 15 to 24-year-olds with comprehensive and correct knowledge of HIV/AIDS

At the national level a number of policies recognise the importance of paying adequate attention to adolescents and young people as a special and vulnerable group.

NATIONAL COMMITMENTS

At the national level, there are a number of policies that address the health and development needs of young people. Notable among the national policies addressing young people's health needs are:

- National Population Policy (NPP) 2000
- National AIDS Prevention and Control Policy 2002
- National Youth Policy 2003
- Draft of the updated National Youth Policy 2011

All these policies recognise the importance of paying adequate attention to adolescents and young people as a special and vulnerable group. The National Policy on Education 1986 (modified in 1992) and the National Skill Development Policy have reiterated the need to equip this group with adequate schooling and skills, for their development and well-being. The key programmes for adolescent health and development under MoHFW, Ministry of Human Resource Development (MHRD), Ministry of Women and Child Development (MCWD), Ministry of Youth Affairs and Sports (MoYAS) are listed as Annex 1.

2



Adolescent Health Strategy

Based on principles of adolescent leadership, human rights, equity and inclusion, gender equity, and strategic partnerships this strategy envisions, that all adolescents in India are able to realize their full potential by making informed and responsible decisions related to their health and well-being and by accessing the services and support they need to do so.

Guiding principles

The Adolescent Health Strategy adheres to the following key principles at all levels and stages of programme planning, implementation and monitoring.

ADOLESCENT PARTICIPATION AND LEADERSHIP

Health services and programmes should be participatory, with increasing scope for active engagement and expression by adolescents in related decision-making. Services and programmes should take into account adolescents' felt needs, issues and rights; help build self-esteem; and develop abilities to take on responsibility for self, relationships and (to an appropriate extent) society around them.

EQUITY AND INCLUSION

Adolescents are heterogeneous and diverse in terms of age, gender, urban/rural, caste, class, religion, region, cultural beliefs, disability, sexual orientation and so on. Adolescent health programmes should have inbuilt flexibility, respect diversity and ensure there is no discrimination in access to essential quality health services. Rigid, one-size-fits-all approaches are not appropriate.

Adolescent health and development is a cross cutting issue for several stakeholders, with the health sector playing a pivotal role. Synergistic action with other sectors and stakeholders is crucial.

GENDER EQUITY

Adolescent health programmes should recognise and address the needs of adolescents of different genders in an equitable, non-discriminatory manner because deep-rooted gender stereotyping and differentials result in health risks. Needs-based programme planning with gender equity as a central theme should be ensured.

STRATEGIC PARTNERSHIPS

Adolescent health and development is a cross cutting issue for several stakeholders, with the health sector playing a pivotal role. Synergistic action with other sectors and stakeholders such as education, social welfare and media is crucial, especially for (a) risk reduction (b) vulnerability reduction and (c) improved care-seeking. The health sector will lead and support the process for developing a multi-sectoral approach that addresses the determinants of adolescent health and development.

The Vision

The strategy envisions that all adolescents in India are able to realise their full potential by making informed and responsible decisions related to their health and well-being, and by accessing the services and support they need to do so. The implementation of this vision requires support from the government and other institutions, including the health, education and labour sectors as well as adolescents' own families and communities.

Building an agenda for adolescent health requires an escalation in the visibility of young people and an understanding of the challenges to their health and development.

Building an agenda for adolescent health requires an escalation in the visibility of young people and an understanding of the challenges to their health and development. It needs implementation of approaches that will ensure a successful transition to adulthood. This requires that the multi-dimensional health needs and special concerns of adolescents are understood and addressed in national policies and a range of programmes at different levels.

Health outcomes for adolescents need to be achieved as envisaged in ICPD, MDGs, Committee on the Elimination of Discrimination against Women (CEDAW), CRC, Resolution of the 45th UN Commission on Population and Development, NPP 2000, the 12th Five Year Plan, National Health Policy 2002, draft National Youth Policy 2011,

The adolescents' right to health is not only a question of what a health system does but also how it does it. Effective communication strategies will help adolescents make informed choices.

National Adolescent Reproductive and Sexual Health (ARSH) Strategy 2006, National Rural Health Mission (NRHM) and the National AIDS Prevention and Control Policy 2002. Programming should be differentiated, taking into account the differential needs of adolescents.

The adolescents' right to health is not only a question of what a health system does (for example, provide access to essential health services) but also how it does it. Importantly, adolescents should be provided reliable information about health rights, benefits and risks of particular behaviours, and protection of their right to privacy and confidentiality. For transparency and effective participation in decision-making on matters of health, information should be accessible, accurate and easily understandable. Effective communication strategies will help adolescents make informed choices.

Objectives

The life-course perspective emphasises that the health of adolescents is affected by early childhood development; the biological and social role changes that accompany puberty are shaped by social determinants of health that affect the uptake of health-related behaviours. The health choices that adolescents make or others make for them (for example, diet, lifestyle, substance misuse, sexual behaviour) also impact their health in the years to come.

In order to get a comprehensive picture of the health needs of young people, it is important to situate adolescence in a life-cycle perspective within dynamic sociological, cultural and economic realities. Further, diverse groups of adolescents are faced with different sets of opportunities and challenges. Certain core needs and concerns are universal; yet the concept of 'several adolescences' is an important consideration in adolescent-friendly policies and programmes. In this regard, giving special attention to the needs of very young adolescents, who are not in a position to make 'informed choices', is very important. This period, between 10 and 14 years, also represents a key opportunity for health promotion and prevention of unhealthy behaviour that increases the risk of diseases such as NCDs in the future.

In order to get a comprehensive picture of the health needs of young people, it is important to situate adolescence in a life-cycle perspective.

The Risk and Protective Framework (Blum 2005; see Figure 9) for adolescent health planning is the central tenet of this strategy. Interventions and approaches in the strategy work toward building protective factors that can help young people develop the ‘resiliency’ to resist negative behaviour and operate at four major levels: individual, family, school and community by providing a comprehensive package of information, commodities and services.

This programming framework takes cognisance of social determinants (illiteracy, child marriage, violence, gender, discrimination, poverty and others) that are associated with poor health outcomes and links relevant initiatives for the improved health of adolescents. In particular, the strategy aims at achieving the following.

1. Increase availability and access to information about adolescent health.
2. Increase accessibility and utilisation of quality counselling and health services for adolescents.
3. Forge multi-sectoral partnerships to create safe and supportive environments for adolescents.

To achieve these aims, the following strategic priorities with relevant objectives have been identified.

Improve nutrition

- Reduce the prevalence of malnutrition among adolescent girls and boys
- Reduce the prevalence of iron-deficiency anaemia (IDA) among adolescent girls and boys

Improve sexual and reproductive health

- Improve knowledge, attitudes and behaviour, in relation to SRH
- Reduce teenage pregnancies
- Improve birth preparedness, complication readiness and provide early parenting support for adolescent parents

Enhance mental health

- Address mental health concerns of adolescents

Prevent injuries and violence

- Promote favourable attitudes for preventing injuries and violence (including GBV) among adolescents

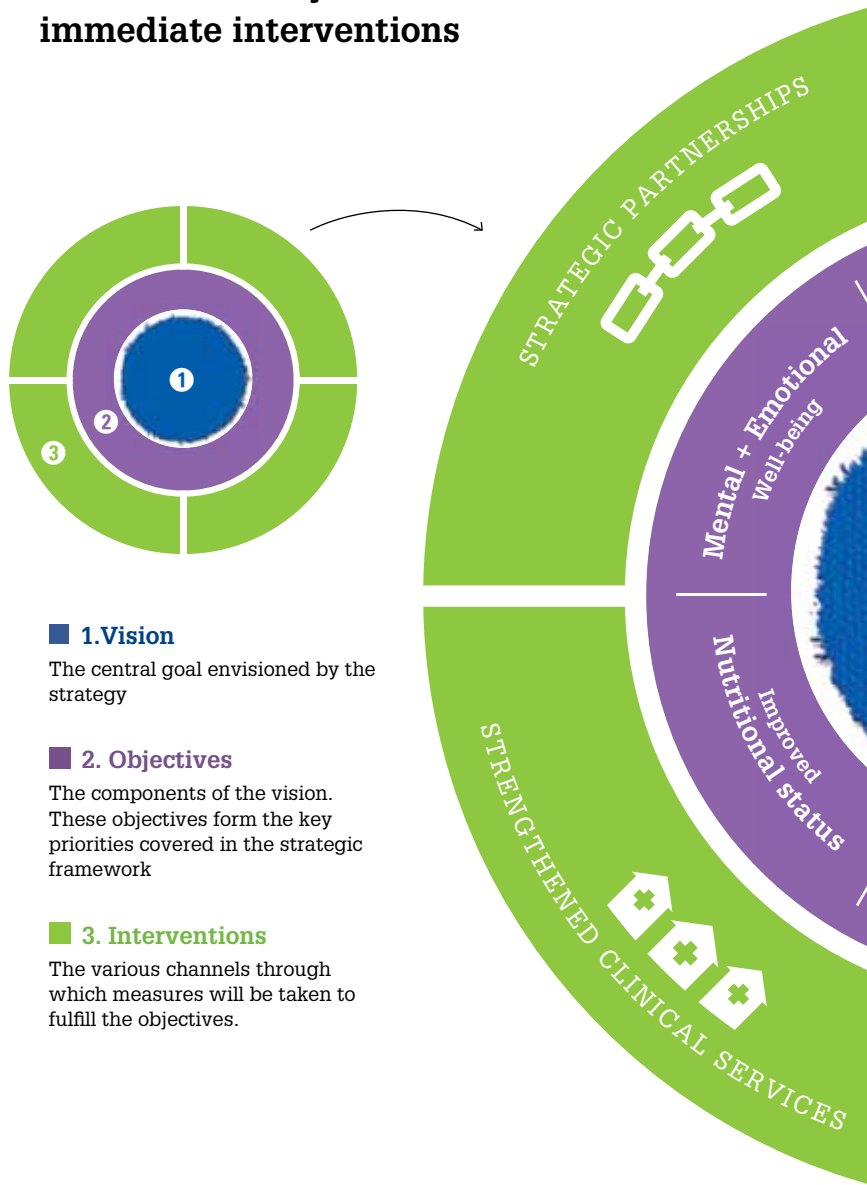
Prevent substance misuse

- Increase adolescents' awareness of the adverse effects and consequences of substance misuse

Address NCDs

- Promote behaviour change in adolescents to prevent NCDs such as hypertension, stroke, cardio-vascular diseases and diabetes

The National Adolescent Health Strategy is a matrix of end goals, intermediate objectives and immediate interventions



1. Vision

The central goal envisioned by the strategy

2. Objectives

The components of the vision. These objectives form the key priorities covered in the strategic framework

3. Interventions

The various channels through which measures will be taken to fulfill the objectives.



A Paradigm Shift: The 7Cs

In response to a better understanding of the unique health needs of adolescents, the MoHFW has realigned its existing approach, to focus on community-based health promotion and prevention, and strengthening of clinics, to provide preventive, diagnostic and curative services across levels of care.

A combination of prevention, health promotion and healthy development strategies are proposed, offering a continuum of care for adolescent health and development needs. Interventions in the strategy are designed to provide information, commodities and services at the community level, and map referral linkages through the three-tier public health system. The strategy has a diversity of interventions that focus not only on adolescents but also on their social environment, including families, peers, schools and communities.

Most importantly, the strategy proposes a convergent model of service delivery, which will actively engage with adolescents through field service providers (mobile medical teams/Rashtriya Bal Swasthya Karyakram—RBSK, teachers, ASHAs, ANMs, AWWs, volunteers, etc.) and platforms within community spaces such as schools, teen clubs, Anganwadi Centres (AWCs) and Kishori Samooths, to secure and strengthen mechanisms

for access and relevance. The strategy moves away from a 'one-size-fits-all' approach to more customised programmes and service delivery, specific to needs of adolescents (both urban and rural), and aims at instituting effective, appropriate, acceptable and accessible service packages, addressing a range of adolescent health and development needs.

The strategy moves away from 'one-size-fits-all' approach to more customised programmes and service delivery, specific to needs of adolescents.

To implement this paradigm shift, seven critical components need to be leveraged, based on health promotion and preventive care approaches and encompassing elements beyond the clinical services. These are as follows.

who the strategy is aimed at

taking into account the needs of gender, age groups, education, socio-economic and marital status

1

Coverage

Dedicated programming for 10 to 19 year olds, including vulnerable and underserved sub-groups

the most important areas to work on

the very heart of the programme; what we actually need to do most to meet our goal of a healthy adolescent population

2

Content

Priorities based on 'at risk' analyses

- Nutrition
- Mental Health
- Violence
- Substance Misuse
- Sexual and Reproductive Health
- Non-Communicable Diseases

these are also the strategy's objectives (p 56) and the key priorities of the strategic framework (Chapter 3)

The 7Cs at a Glance

A useful way to remember and summarise the components that make up the strategy, described in detail in the following pages

how we reach adolescents

the places where service providers/ front line workers, community and adolescents can interact, including the media

3

Communities

Assured and consistent outreach in community based settings

4

Clinics

Dedicated spaces for adolescents in the existing health system

5

Counselling

Dedicated spaces for adolescents in the existing health system

6

Communication

Messaging on behalf of as well as for adolescents

coordinating the efforts of everyone

strategic partnerships to maximise impact and avoid duplication

7

Convergence

Between departments in MoHFW and other ministries/departments

1

Coverage

Girls

Boys

10–14

15–19 years

Unmarried

Married

In school

Out of school

Rural

Urban

All social groups,
including the
vulnerable

■ Coverage

Adolescence is a normal period in human development; nonetheless more than 33 percent of the disease burden and almost 60 percent of premature deaths among adults can be associated with behaviour or conditions that begin or occur during adolescence. Multiple social, cultural and other factors impact adolescent health and, within the age group of 10 to 19, the profile of disease burden is also significantly different for younger and older adolescents. In the 10–14 age group, injuries and communicable diseases are prominent. For the 15–19 age group, the disease burden shifts to outcomes of sexual behaviour and mental health (WHO, 2011). The new adolescent health and development strategy brings in dedicated programming for 10 to 19-year-olds, with universal coverage, that is, urban and rural; in school and out of school; married and unmarried, including the vulnerable and underserved subgroups.

2

Content

Nutrition

Malnutrition prevention and management

IDA prevention and management

Sexual and Reproductive Health

Knowledge, attitudes, behaviour, practice building

Prevention of teenage pregnancy

Improve birth preparedness and complication readiness in adolescents

Management of unwanted pregnancy

Prevention and management of Reproductive Tract Infections (RTIs) and STIs

Mental Health Promotion and Care

Address mental health concerns of adolescents

Substance Misuse Prevention

Increase awareness of the adverse effects and consequences of substance misuse

NCD Prevention

Promote behaviour change in adolescents

Injuries and Violence, Including Gender-based Violence

Promote favourable attitudes for preventing injuries and violence

■ Content

The diverse nature of adolescent health needs, issues and concerns call for a holistic multi-layered approach. The current policies and programmes are already directing efforts to address the SRH and nutrition needs of adolescents to a certain extent; however, the revised strategy identifies six strategic priorities based on 'at risk' analyses. The enhanced scope of the programme will now incorporate the following areas: Nutrition, SRH, Mental Health, Preventing Injuries and Violence (including GBV), Substance Misuse and NCDs. It will address a gamut of issues under each strategic priority. Life-skills education is identified as a key intervention.

3

Communities

Focus

Promotion

Prevention

Appropriate referrals

In Educational and Training Institutions

PEOPLE

Peer educators

Teachers

Instructors

Hostel wardens

Principals

District Education Officers
(DEOs)

SPACES

Schools including Residential,

Vocational Education and
Training (VET) Institutions

DIETs, District Resource
Centres, Block Resource Centres

Media

Community-based Institutions

PEOPLE

Parents

Peer educators

ASHA/ANMs

AWWs

NYKS volunteers

VHNSC members

Panchayati Raj
Institution (PRI) members

SPACES

Homes

AWCs

Adolescent girls (Sabla) and
boys (SAKSHAM, NYKS teen
clubs) groups

Recreation spaces

Workplaces

Self-help Groups/Women's
groups

Media

■ Communities

The strategy envisages a 'beyond health facility-based' service provision, to include innovations for assured and consistent outreach to different sub-groups, cognisant of their realities, in spaces where adolescents naturally congregate (such as schools, vocational education and training (VET) institutions, work places and recreation spaces) The mainstay of this approach will be peer educators (both girls and boys), selected, trained and supported by the teachers in the institutional setting, and by ASHAs and ANMs in community-based settings. To encourage and mobilise the peer educators, their work may be recognised through a certificate of excellence and incentives. Provisions will be made for segmented peer education, to reach out to all groups, sexes and ages of adolescents.

The mainstay of this approach will be peer educators (both boys and girls) selected, trained and supported by the teachers in the institutional setting, and by ASHAs and ANMs in community based settings.

Field-level functionaries will be providers of information, services and commodities at the community level and make appropriate referrals to adolescent clinics/adolescent friendly health clinics (AFHCs) as and when required. They will serve as the first point of contact for reaching out to adolescents in their spaces. These service providers will be instrumental in creating an enabling environment at the community level for adolescent health and development activities through existing platforms such as AWCs, Sabla Kishori-Samooch, Teen Clubs and Village Health, Nutrition and Sanitation Committees (VHNSCs), and creating new platforms for service delivery such as organising Adolescent Health Days (AHDs) every quarter. Community-based workers and volunteers will engage with parents and families of adolescents to increase awareness about the unique needs of this dynamic group.

4

Clinics

A Sub Centres (Walk-in clinics)

Screening for BMI and anaemia

Ante-natal services

Depot holders for pregnancy testing kits, sanitary napkins, de-worming tablets, non-clinical contraceptives

Counselling and referrals

B PHC (Adolescent Clinics)

As in A, additionally

Management of IDA and malnutrition, as per protocol

Provision of clinical contraceptives

Management of adverse events, following use of contraceptives

Management of RTIs/STIs

Screening for diabetes

C AFHCs at the level of CHCs daily clinic with a dedicated counsellor

As in A+B except skilled attendance at birth

Management of menstrual disorders

HIV testing and counselling

Medical abortion and referrals

Management of mental health problems

Management of physical violence and sexual abuse as per protocol

Management of diabetes

Linkages with de-addiction centres and referrals

D AFHCs at the level of district hospitals

As in A+B+C

Specialty clinics twice a week for gynaecology and paediatrics

E AFHCs at medical colleges

As in A+B+C+D, including CHC and DH.

Clinic five days of the week, with a different specialty on each day, namely, gynaecology, paediatrics, dermatology, psychiatry and surgery.

■ Clinics (Health Facilities)

The strategy envisages a dual focus: on developing community-based interventions and on strengthening AFHCs, which are dedicated spaces for adolescents in the existing health system.

Whereas community-based interventions will serve as windows for information and commodities such as sanitary napkins, Iron and Folic Acid (IFA) tablets and non-clinical contraception, and facility-based services will ensure availability of counselling, medical and para-medical specialised services to adolescents, with emphasis on privacy and confidentiality.

HUMAN RESOURCES FOR CLINICS

Sensitised and trained staff will be made available from the existing health systems. There will be walk-in services at the Sub-centre level and a dedicated weekly Adolescent Clinic at the Primary Health Centre (PHC). At the Community Health Centre (CHC), District Hospital (DH)/Sub District/Taluka Hospital and Medical College, there will be AFHCs. A dedicated counsellor will be available from the Block/CHC onwards. Specialty clinics are planned in the districts and at medical colleges. This will also work as an in-system referral chain.

CAPACITY BUILDING

The Adolescent Health Strategy is broadly defined in terms of a set of services to be delivered at different levels of a health system or allied systems by engaging health functionaries and staff from other departments such as Education, Women and Child Development (WCD), Tribal Welfare, and Youth and Sports. In the view of the enhanced scope of the programme, capacity building is

For implementation of various interventions contained in the strategy, the knowledge, skills and attitudes required will vary for different levels of functionaries and stakeholders.

planned to equip the relevant service providers across levels and departments with the necessary skills to deliver the proposed interventions. It will be provided in the following modes.

- Pre-service training
- Continuing education, including refresher courses, based upon needs assessment (includes e-learning, distance learning approaches)

Key cadres will be trained using specifically designed content, including the material used for ARSH trainings, and Adolescence Education Programme (AEP) trainings (under MHRD). For implementation of various interventions contained in the strategy, the knowledge, skills and attitudes required will vary for different levels of functionaries and stakeholders. Appropriate training, in both pre-service and continuing education on adolescent health will be an essential component of training for functionaries and stakeholders.

For quality training, inter-sectoral convergence is imperative. For other departments that MoHFW collaborates with, it may be most efficient to integrate components of adolescent health in existing training programmes rather than create parallel training mechanisms. For example, adolescent health issues can be easily integrated in the existing continuing education programmes for teachers. The strategy also proposes to include adolescent health-specific additions/modifications in the curriculum of undergraduate and post-graduate medical and nursing courses.

Similarly, specific components of adolescent health will be added/strengthened in the induction training of health-care providers and other functionaries.

LINKAGES WITH RBSK

RBSK (child health screening and early intervention services under NRHM) screens children from birth to 18 years of age for four Ds: Defects at birth, Diseases, Deficiencies and Developmental delays, including disabilities. This initiative involves the engagement of mobile health teams that visit government schools, aided schools and AWCs for the health check-up of children. RBSK will cover in phases about 27 crore children in the country, through more than 12,000 mobile medical teams.

- RBSK will be the first point of contact of the health system with adolescent population and will ensure that adolescents enrolled in government and government-aided schools are screened for diseases and deficiencies.
- It will also provide appropriate referrals to AFHCs and District Early Intervention Centres (DEICs).
- RBSK will also be the medium for providing key health promoting messages through the Community Health Mobiliser attached to the block level mobile health teams.

5

Counselling

In Education and Training Institutions

Peer educators, teachers, instructors, hostel wardens as para counsellors

Professional counsellors

Helpline

Health Facility-based

Staff nurse as para counsellors at PHCs

Professional counsellors at AFHCs

In and Out of School Settings

AWW, ANM

Helplines

Counsellors at designated NGOs

Counsellors at workplaces

■ Counselling

The provision of correct knowledge and information is a key strategy in health promotion approach. The strategy aims to create windows to enable adolescents to develop self-understanding and to make positive changes in their lives through provision of counselling services at every level of the adolescent universe, for instance, peers, nodal/school teachers, ground-level health service providers such as ASHA, AWW, multipurpose health worker (male), ANM, staff nurses and Medical Officers (MOs), in addition to professional Adolescent Health counsellors. Tools have been developed to equip counsellors with the necessary skills to reach out to adolescents and support them in resolving issues of varied nature.

This service is aimed not only at the adolescents but also influencers, care-givers and families, who act as gatekeepers. Interaction opportunities during Village Health Nutrition Days (VHNDs), Kishori Diwas, health melas and AHDs will be put to optimum use for this purpose.

6

Communication

Mass Media

TV, radio, newspapers, magazines

Ideal for wide coverage

Viewership/Listenership / Readership profiles used to maximise target-audience, specific reach

Other A/V media

Video vans, mobile miking, community radio, video walls, CCTV

Help reach a large number of audiences at a single location.

Dependent on availability of technology

Outdoor mass media

Hoardings, wall paintings, wall writings, banners, posters, bus panels

Helps reach audiences in difficult terrains

Events

Exhibitions and road shows, plays and street theatre, haats and fair stalls, puppet shows

Ideal to weave in local flavour and use local talent

Internet-based platforms

Social media networks, customised websites, e-counselling, e-mailers

Low-cost options, ideal to reach the net-savvy adolescent population

Printed material

Flip books, flash cards, comics, story books, book labels/covers, leaflets

Ideal for IPC material and mass distribution material for schools, anganwadi kendras, youth clubs, etc.

Telecom-based platforms

Telephone hotlines, VSAT networks, SMS gateway

Wide reach and deeper penetration due to large mobile user-base

Two-way communication helps take expert information/ counselling to the doorsteps of clients and frontline workers

■ Communication

Effective communication is an integral part of this strategy and will be a catalyst in the successful implementation of the strategy. It proposes communication intervention at every level, viz., interpersonal communication (IPC), mid-media and mass media in all possible spaces that reach out to adolescents and their influencers. Communication strategies have been designed so that there is messaging on behalf of the adolescents as well as for the adolescent. The strategy proposes that health professionals should act as advocates on behalf of young people and as providers to young people and their care-givers/parents of most relevant and up-to-date, evidence-based information; they should use methods and language deemed appropriate by the adolescents themselves.

7

Convergence

MHRD

Sarva Shiksha Abhiyan (SSA)
and Rashtriya Madhyamik
Shiksha Abhiyan (RMSA)

AEP (Including National
Institute of Open Schooling—
NIOS)

Department of Education (DoE)
and Higher Education

MWCD

Sabla

ICDS

MoYAS

NYKS teen clubs

MoHFW

ARSH

RBSK

Menstrual hygiene scheme

Anaemia control

Mental health

AEP-NACO

Others

LABOUR AND EMPLOYMENT

ITIs, Apprenticeships
programme

SOCIAL JUSTICE

Destitute and juvenile homes

Drug rehabilitation centres

Disability homes

POLICE

Child Welfare Committees

RURAL AND URBAN DEVELOPMENT

NATIONAL AND STATE COMMISSION FOR PROTECTION OF CHILD RIGHTS

NGOS, PUBLIC-PRIVATE PARTNERSHIP (PPP)

■ Convergence


The Adolescent Health Strategy envisages intra-ministry convergence, with existing programmes of the MoHFW, for instance:

- RBSK
- Family Planning
- Child Health
- Maternal Health
- National AIDS Control Programme
- National Tobacco Control Programme
- National Mental Health Programme
- National Programme for Non-Communicable Diseases

This strategy also envisages inter-ministerial convergence with:

- Ministry of Youth Affairs and Sports (MoYAS)
- Ministry of Human Resource Development (MHRD)
- Ministry of Women and Child Development (MWCD)
- Ministry of Labour and Employment (MoLE)
- Ministry of Social Justice and Empowerment (MSJE)

Strategic partnerships with other allied ministries, departments and key stakeholders will strengthen existing linkages and create new opportunities for partnerships and prevent duplication. This will help maximise effort, resources, impact and help establish comprehensive review mechanisms. The key strategies for convergence include cross-training of service providers, inclusion of the adolescent health module in the training curriculum, and the use of existing platforms for generating demand and service provision.



3

Strategic Framework

The strategic framework is a roadmap for providing a comprehensive health care package for adolescents, using a continuum of care approach within the overall ambit of RMNCH+ A. Health promotion is the central precept of this framework and interventions are designed to foster positive health behaviours in adolescents. This framework is based on an understanding of the vision for adolescents in India and is a strategic response to their varying needs and concerns.

The Strategic Framework proposes an integrated adolescent health care package that comprises health promotion, preventive and curative interventions, as well as diagnostic and referral components across levels of care.

It defines the essential package of services and the focus of the intervention for the relevant subgroup, that is, early adolescent (10–14 years) and late adolescent (15–19 years). The interventions proposed are designed to promote positive health behaviour as well as strategic responses to the health-care needs of this age group, at various levels of care and service provision.

To respond to health needs of adolescents in a holistic manner, this strategy is realigning its approaches to focus on health promotion and prevention models rather than provision of clinic based curative services only. The strategy aims to institute an affordable, acceptable and accessible service package addressing a range of adolescent health and development needs through provision of information, commodities and services with mapped out referral linkages through the multi-tier public health system.

How the strategic framework is organised

Themes

The 6 themes are the content of the programme, and are the broad action areas of strategic framework.

STRATEGIC PRIORITY

Each theme prioritises one or more goals, addressed by **STRATEGIES** and **INTERVENTIONS**, and measured by **INDICATORS**.

The 6 themes and 10 priorities in the framework

Nutrition

- To reduce the prevalence of malnutrition among adolescent girls and boys
- To reduce prevalence of IDA among adolescents girls and boys

Sexual and Reproductive Health

- To improve knowledge, attitudes and behaviour in relation to SRH
- To promote healthy menstrual hygiene practices among adolescent girls
- To improve birth preparedness and complication readiness among adolescents
- To reduce teenage pregnancies

Mental Health

- To address mental health concerns of adolescents

STRATEGIES

Strategies to Prevent, Promote and Manage health problems

INTERVENTIONS

Activities in communities, educational institutions and health facilities

INDICATORS

Percentages, numbers, and observations that measure progress

Preventing Injuries and Violence

(Including Gender-based Violence)

To promote favourable attitudes against injuries and violence, including GBV among adolescents

Substance Misuse

To raise awareness on adverse effects and consequences of substance misuse

Non-Communicable Diseases

To promote behaviour change for prevention of NCDs, hypertension, stroke, cardio-vascular diseases and diabetes

Nutrition

STRATEGIC PRIORITY

To reduce the prevalence of malnutrition among adolescent girls and boys

STRATEGIES

Promotion

Promotion of consumption of a balanced diet with emphasis on locally available nutritious foods

Promotion of healthy dietary habits, personal hygiene and food sanitation

Imparting of knowledge about inter-generational effects of under-nutrition

Sensitisation of the community on gender bias in food distribution in households

Prevention

Provision of supplementary food

Food fortification

Counselling services to emphasise nutritional needs of pregnant and lactating adolescents

Management

Management of nutritional deficiencies

INTERVENTIONS

Community

Communication on consumption of balanced diet and nutritious food, and inter-generational effects of malnutrition

Nutrition education sessions at community levels, using platforms such as VHNDs, RBSK/Schools, Kishori Diwas, AWCs, VET institutions and NYKS

Nutritional counselling during the dedicated quarterly AHD in villages (in Sabla districts, this day will coincide with Kishori Diwas)

Inclusion of nutrition education in school curriculum—linkages with Sakshar Bharat

Community-based Institutions

Screening for BMI, and referrals

Linkage with RBSK, Sabla, mid-day meal (MDM) for screening, supplementary nutrition, fortificatsuch as condoms, oral contraceptive pills (OCPs) through home visits by ASHAs and male health workers

Availability of non-clinical contraceptives through social marketing

Health Facility Based

Counselling at AFHCs

Management of low BMI, as per protocol, and referrals

INDICATORS

Percentage of peer educators trained in the nutrition module

Percentage of adolescents with correct knowledge on balanced diet and nutritional deficiencies

Percentage of adolescents reported receiving any supplementary food for at least 20 days in a month in previous quarter (in-school and in-community; age and sex disaggregated).

Percentage of adolescents with BMI cards/ Kishori cards.

Nutrition

STRATEGIC PRIORITY

To reduce prevalence of
IDA among adolescents
girls and boys

STRATEGIES

Promotion

Promotion of consumption of a balanced diet
with emphasis on locally available iron rich
food

Creation of awareness on importance of
footwear, to prevent worm infestations (for
adolescents, influencers and care-givers)

Prevention

Iron supplementation: Weekly Iron and Folic
Acid Supplementation (WIFS)

Food fortification

Supplementary nutrition

Screening for anaemia

Management

Management (diagnosis and treatment)
of Iron Deficiency Anaemia and worm
infestations, as per protocol

INTERVENTIONS

Community

Communication to increase awareness about anaemia and its prevention, including healthy dietary habits.

Nutrition education sessions at community levels, using platforms such as VHNDs, Kishori Diwas, NYKS teen clubs and AWCs

Nutritional counselling during dedicated quarterly AHD in the villages (in Sabla districts this day will coincide with Kishori Diwas)

Social marketing of IFA tablets in private schools

Community-Based Institutions (Schools/Rbsk, Awcs, Nyks Teen Clubs, Vet Institutions, Etc.)

All of the above, and weekly IFA supplementation

Screening for anaemia

Bi-annual administration of Albendazole

Health Facility-based

Dietary counselling for cases of nutritional anaemia

Diagnosis of anaemia with Hb estimation

Treatment of IDA, as per standardised treatment protocol

Referral

Management of worm infestations

INDICATORS

Percentage of care-givers (AWWs, teachers) who have been trained on implementation of the Weekly Iron and Folic Acid Supplementation (WIFS)

Percentage of care-givers such as AWWs, teachers, peer educators and ASHAs, who have correct knowledge of iron-rich foods

Percentage of adolescents with correct knowledge of iron-rich foods

Coverage of WIFS: percentage of adolescents given 4 or 5 IFA tablets in the reporting month (disaggregated by sex)

Coverage of Albendazole: Percentage of adolescents given Albendazole tablets in the last six months (disaggregated by sex)

Percentage of adolescents with moderate/severe anaemia referred from schools/AWC

Percentage of adolescents with moderate/severe anaemia, managed as per protocol

Percentage of distribution points for WIFS reporting IFA stock-out

Sexual and Reproductive Health

STRATEGIC PRIORITY

To improve knowledge, attitudes, and behaviour in relation to SRH

STRATEGIES

Promotion

Information about changes during adolescence, process of growing up (with focus on the 10–14 age group), safe sex and reproduction.

Genital health and hygiene

Counselling on concerns related to growing up, sexuality, relationships, body image and identity (with focus on the 10–14 age group)

Promotion of responsible sexual behaviour

Information on management of unwanted pregnancy, legality of abortion and consequences of unsafe abortion

Information on causation, transmission and prevention of RTIs/ STIs and HIV

Prevention

Counselling on concerns related to nocturnal emission and menstrual problems

Access to non-clinical contraceptives such as condoms, OCPs and emergency contraceptives.

Screening for RTIs and STIs.

Access to Integrated and Counselling and Testing Centre (ICTC).

Management

Management of menstrual disorders

Management of RTIs/STIs

Safe abortion services

INTERVENTIONS

Community-based Institutions

IN EDUCATIONAL INSTITUTIONS

Life skills focused AEPs through schools, including residential schools, through linkages with RMSA and NACO and the School Health Programme (SHP)

Linkages with RBSK

Sanitary napkins provision and proper disposal through schools

Education in other institutions such as VETs, ITIs

OUT OF SCHOOL

Sanitary napkins provision and disposal through community workers such as ASHAs

AHD in partnership with Integrated Child Development Services (ICDS), NYKS, Department of Adult Education; PRIs and others, as relevant

Information provision through Kishori Samoo under Sabla of the Department of WCD, teen clubs of NYKS and others, as relevant

Information sharing through helplines

INTERVENTIONS

Community

Education on SRH issues (gender disaggregated if preferred by the community) on AHD

Health facility-based

Depot holders for sanitary napkins

Provision of contraceptive services

Management of menstrual disorders including counselling

Treatment of RTIs/ STIs

HIV testing and counselling

Comprehensive abortion care through linkages with MTP clinics

INDICATORS

Knowledge, attitude and practice /behaviour of adolescents on select SRH issues

Use of condom in last sexual activity.

Percentage of care-givers such as AWWs, teachers, peer educators, ASHAs, who have correct knowledge of adolescent SRH management

Percentage of adolescents, who report receiving any life skills-focused education on SRH issues.

Percentage of adolescents accessing adolescent clinics for puberty-related problems, RTIs/STIs, mental health concerns, abortion care

Sexual and Reproductive Health

STRATEGIC PRIORITY

To promote healthy menstrual hygiene practices among adolescent girls

STRATEGIES

Promotion

Provide knowledge about menarche, healthy menstrual practices and associated health benefits (with focus on the 10–14 age group)

Promoting menstrual hygiene through access to menstrual aids such as sanitary pads and clean cloth

Prevention

Commodity provision

Information on management of common menstrual problems

INTERVENTIONS

Community-based Institutions

IN EDUCATIONAL INSTITUTIONS

Provision and proper disposal of sanitary napkins in convergence with education and water and sanitation departments

OUT OF SCHOOL

Sanitary napkins provision and disposal through community workers such as ASHAs

Health Facility-based

Depot holder for sanitary napkins

Management of common menstrual problems, including counselling

Facility-based care for more serious menstrual problems

INDICATORS

Percentage of adolescent girls using disposable sanitary napkins or washed and sun-dried cloth

Percentage of schools providing sanitary napkins to adolescent girls

Percentage of adolescent counselling and health centres providing sanitary napkins

Sexual and Reproductive Health

STRATEGIC PRIORITY

To reduce teenage pregnancies

STRATEGIES

Promotion

Information about risks of early conception and use of contraceptives

Address social pressure and concerns related to early marriage, conception and contraception

Prevention

Counselling for contraceptive use and method choices

Access to quality contraceptive services, including emergency contraception

Referral for clinical contraceptives such as Intra-uterine contraceptive devices (IUCDs), as per the protocol

Management

Management of adverse events, following use of contraceptive methods

INTERVENTIONS

Community

Communication with individuals, families and communities, including men, to create support and influence cultural norms to reduce early marriage (such as information on the legal status of early marriage) and pregnancy.

Counselling of newly married couples and influencers on the risks of early conception and the importance of spacing

Pregnancy testing and follow-up action as per protocol

Distribution of non-clinical contraceptives such as condoms, oral contraceptive pills (OCPs) through home visits by ASHAs and male health workers

Availability of non-clinical contraceptives through social marketing

Facility-based

Counselling

Provision of non-clinical and clinical contraceptives, and pregnancy testing kits

Management as per protocol of adverse events following use of contraceptive methods such as heavy bleeding and pain

INTERVENTIONS

Community-Based Institutions

IN-SCHOOL

Consequences of early marriage and pregnancy incorporated in life skills focused AEP in schools, including residential schools.

Consequences of early marriage and pregnancy incorporated in relevant curricula in other educational institutions such as VETs and ITIs.

OUT OF SCHOOL

Consequences of early marriage and pregnancy, contraceptive needs of young couples addressed during AHD.

Consequences of early marriage and pregnancy, contraceptive needs of young couples addressed in Kishori Samooch through Sabla of the Department of WCD, teen clubs of NYKS and others as relevant.

Counselling of newly married couples and influencers on the risks of early conception and the importance of spacing.

Distribution of non-clinical contraceptives such as condoms, OCPs, Emergency Contraceptive Pills (ECPs) through home visits by ASHAs, and social marketing.

Information sharing through helplines

INDICATORS

Percentage of adolescents with knowledge of risks of early pregnancy

Percentage of influencers (such as mothers-in-law, fathers-in-law) with knowledge of the risks of early pregnancy

Percentage of married adolescents reporting unmet need for contraceptives

Percentage of married adolescents reporting use of spacing methods of contraception

Percentage of distribution points for contraceptive methods reporting stock out in the last quarter

Age of marriage of adolescent girls and boys

Median age at birth

Sexual and Reproductive Health

STRATEGIC PRIORITY

To improve birth preparedness and complication readiness among adolescents

STRATEGIES

Promotion

Awareness of availability of services and programmes

Messaging for institutional delivery

Prevention

Early registration of pregnant adolescents and entry into the Maternal and Child Tracking System (MCTS) database

Skilled attendance at birth

Focused ANC

Standard post-partum care

Pre-conception folic acid tablets

Management

Management of obstetric and postpartum complications, including anaemia

INTERVENTIONS

Community

Education on importance of early registration, care during pregnancy, focused ANC, need for skilled attendance at birth and home-based post-partum care through ASHAs

Access to entitlements under various government schemes such as Janani Suraksha Yojana (JSY) and Janani Shishu Suraksha Karyakram (JSSK).

Folic Acid 400 mcg tablets daily in peri-conception period to be distributed by ASHA

Community-based Institutions

Access to ANC services on VHND

Post-partum care through ANMs and AWCs (nutritional)

Information sharing through helplines

Health facility-based

Ante-natal and post-natal services

Skilled attendance at birth and referrals as per protocol

Pre-pregnancy check-ups as a component of maternity care, with one pre-pregnancy visit for couples and persons planning pregnancy

Counselling to provide early parenting support and delay of repeat pregnancy

INDICATORS

Percentage adolescents reporting correct knowledge of care during pregnancy

Percentage of peer educators and care givers (such as partners, husbands and mothers-in-law) reporting correct knowledge of care during pregnancy

Percentage of service providers (such as ASHAs, ANMs and AWWs) trained in the correct knowledge of care during adolescent pregnancy

Mental Health

STRATEGIC PRIORITY

To address mental health concerns of adolescents

STRATEGIES

Promotion

Promotion of protective factors such as self-esteem, healthy relationships, low levels of conflict and social support

Prevention

Skills for dealing with stress and conflicts positively

Screening for anxiety, stress, depression, suicidal tendencies, as per the provisions of primary mental health care

Management

Linkages and referrals to existing mental health services

Treatment of mental health problems as per the protocol

INTERVENTIONS

Community

Adolescent clubs through AEP in schools, and through Sabla and NYKS teen clubs in out-of-school settings

Mental health concerns addressed during AHD

Health facility-based

Counselling

Referral and management of mental health disorders through linkage with the national mental health programme

INTERVENTIONS

Community-based Institutions

Awareness of common mental health concerns and early warning signals of common mental health problems among adolescents and their care-givers (such as parents, teachers, principals, hostel wardens and ANMs).

IN EDUCATIONAL INSTITUTIONS

Mental health concerns incorporated in life skills-focused AEP in schools

Adolescent mental health concerns incorporated in relevant curricula in other educational institutions

Screening through RBSK

OUT-OF-SCHOOL

Mental health concerns addressed in Kishori Samoohs through Sabla, Department of WCD, boys and girls groups in teen clubs of NYKS and others, as relevant

INDICATORS

Percentage of teachers and ANMs trained in managing common emotional concerns of adolescents

Percentage of peer educators trained in mental health module

Percentage of adolescents, who have correct knowledge of early warning signals of common mental health problems

Percentage of adolescents seeking counselling services for mental health concerns among those seeking services at health facilities.

Preventing Injuries and Violence

(Including Gender-Based Violence)

STRATEGIC PRIORITY

To promote favourable attitudes against injuries and violence, including GBV among adolescents

STRATEGIES

Promotion

Communication aimed at promoting understanding of causes of injury/violence, including GBV, and developing favourable attitudes against it

Education on protection of women from domestic violence and child protection from sexual abuse

Prevention

Empower adolescents to challenge gender stereotypes, discrimination and violence within peers/families, educational institutions, workplaces and public spaces

Raising awareness about the laws and penalties related to gender based violence

Screening, identification, support and referral for cases of injuries and sexual abuse as per the protocol

Management

Referral and management of injuries and sexual abuse as per protocol

INTERVENTIONS

Community-based Institutions

IN EDUCATIONAL INSTITUTIONS

Awareness and skills to challenge gender stereotypes, discrimination and injuries/violence incorporated in life skills-focused AEP in schools, including residential schools and other educational institutions such as VETs and ITIs.

OUT OF SCHOOL

Issues related to gender stereotypes, discrimination and injuries/violence taken up during AHD.

Issues related to gender stereotypes, discrimination and injuries/violence taken up in Kishori Samoochs through Sabla, Department of WCD, boys and girls groups in NYKS teen clubs and others, as relevant

Information sharing through helplines

Health facility-based

Management of injuries and sexual abuse as per protocol in AFHCs

INDICATORS

Percentage of adolescents (disaggregated by sex), who have favourable attitudes against injuries/violence, including GBV.

Percentage of adolescents seeking/accessing support for injury or sexual abuse among all those seeking such support

Percentage of peer educators and care givers (such as partners, husbands, mothers-in-law, teachers and service providers) reporting correct understanding of GBV]

Substance Misuse

STRATEGIC PRIORITY

To raise awareness on adverse effects and consequences of substance misuse

STRATEGIES

Promotion

Communication on promoting awareness on adverse effects and consequences of tobacco, alcohol and drugs

Prevention

Skills to counter pressures to experiment with tobacco, alcohol and drugs

Supportive environment in families and institutions such as schools, VET institutions, teen clubs to counter pressures to experiment with tobacco, alcohol and drugs

Management

Referrals and linkages with de-addiction centres

INTERVENTIONS

Community-based Institutions

IN EDUCATIONAL INSTITUTIONS

Awareness and skills building to counter pressures to experiment with tobacco, alcohol and drugs in life skills-focused in schools, including residential schools.

Awareness and skills building to counter pressures to experiment with tobacco, alcohol and drugs incorporated in relevant curricula in other educational institutions such as VETs, and ITIs

OUT OF SCHOOL

Awareness of adverse effects and consequences of tobacco, alcohol and drugs taken up during AHD

Awareness of adverse effects and consequences of tobacco, alcohol and drugs taken up in Kishori Samoochs under Sabla, Department of WCD, boys and girls groups in NYKS teen clubs and others, as relevant

INDICATORS

Percentage of adolescents reporting correct knowledge of harmful effects and consequences of tobacco, alcohol and drugs use.

Percentage of teachers trained or oriented on substance misuse among adolescents

Percentage of peer educators trained on substance misuse model

Non-Communicable Diseases

STRATEGIC PRIORITY

To promote behaviour change for prevention of NCDs, hypertension, stroke, cardio-vascular diseases and diabetes

STRATEGIES

Promotion

Promotion of physical activity and healthy life styles, with focus on diet, and against tobacco and alcohol misuse

Prevention

Education and counselling on behaviour risk modification (avoidance of junk foods with high carbohydrates, sedentary lifestyles. tobacco, alcohol)

Screening for risk factors

Management

Referral and linkages to existing services for the NCD programme

INTERVENTIONS

Community

Awareness of healthy lifestyles taken up during AHD

Community-Based Institutions

IN EDUCATIONAL INSTITUTIONS

Incorporation of physical activity in schools.
Awareness of healthy lifestyles incorporated in life skills-focused AEP

Screening for diabetes in the SHP.

Awareness of healthy lifestyles incorporated in relevant curricula in other educational institutions

OUT OF SCHOOL

Awareness of healthy lifestyles taken up in Kishori Samooch through Sabla, Department of WCD, and teen clubs of NYKS and others, as relevant

Health facility-based

Screening and management of NCDs through relevant programmes

INDICATORS

Percentage of adolescents reporting 60 minutes physical activity/exercise daily

Percentage of schools with provision for daily physical exercise

Percentage of schools reporting annual screening for diabetes through the SHP

Percentage of diabetes cases referred post-detection

In order to operationalise the strategic priorities, the following need programmatic attention

Adolescent Health Day

Adolescent Health Day is proposed as a new platform for service delivery to adolescents. As of now, VHNDs are held each month at the village level, to provide services and information at the community level. AHDs can be held, using AWCs/ community spaces as venues, on a convenient day after this. The package of services will be based largely on promotion and prevention services.

Village Health, Nutrition and Sanitation Committee

The membership of this committee could be expanded by including a school teacher, preferably a lady teacher, and peer educator. The work plan of VHNSC could also include health promotion activities for adolescents, for example, adolescent health melas. Often, the 'gatekeepers' of the community block access of adolescents to services; these committees, therefore, can play a pivotal role in providing safe spaces for adolescents to seek services. Untied funds can also be utilised for conducting specific activities for adolescents.

Referral Linkages

Referral linkages are important in maintaining continuity and adequacy of care. Based on the needs of adolescents and scope of services at each level of care (broadly outlined in the 7Cs framework and detailed in the strategic framework), referrals will be needed from homes and community settings, to appropriate levels of health facilities. In situations in which there is stigma attached to seeking a particular service, for example, abortion care for unmarried girls or cases of GBV, adolescents may need more support and motivation to access the relevant service and the appropriate level of care.

In order to operationalise the strategic priorities adolescents need support and motivation to access relevant service and appropriate level of care.

In order for the referrals to be valued and used by the adolescents, the cases should be prioritised at higher levels of care, particularly at the AFHCs. Referral slips should be provided and group referrals encouraged, whenever possible, especially from settings such as schools so that a larger number of adolescents can travel together to access services.



Convergence

Several constituencies need to converge and harness collective strength to respond to needs related to adolescent health.

Government ministries and departments, civil society organizations, community-based organizations, development partners and others working on issues related to adolescent health and development have a lot to gain by building on each other's work both in terms of achieving programme objectives as well as attaining improved indicators for adolescents.

The priorities and interventions identified in the strategic framework in the previous chapter need to be translated into programmatic activities to ensure their delivery at the ground level. This strategy is encompassed within the overarching NRHM umbrella, which mandates decentralised programme management to ensure that programmes are responsive to the needs of the communities they intend to serve.

The inter-connected nature of the diverse needs of adolescents cannot be addressed by the health sector alone, providing a compelling argument for pooling of resources and strengths.

As with all NRHM activities, the interventions to implement this strategy to be undertaken at the state level will be articulated through the PIPs. Detailed guidance for the states and districts on rolling out this strategy will be provided through a separate document on the operational framework.

At the national level, the implementation of this strategy will be led by MoHFW as the convening ministry. However, the inter-connected nature of the diverse needs of adolescents cannot be addressed by the health sector alone, and there is a compelling argument for pooling resources and harnessing collective strengths across different constituencies, working towards improving the health and well-being of this population group.

Increasing investment in adolescent health and development underscores the need to establish partnerships between different stakeholders to effectively address adolescent concerns.

The Adolescent Health Strategy envisages intra-departmental and inter-ministerial convergence with the existing programmes of the MoHFW and other ministries. Currently, ministries of GoI address adolescent health and development concerns; prominent among them are:

- Ministries of Health and Family Welfare (MoHFW);
- Ministry of Youth Affairs and Sports (MoYAS);
- Ministry of Human Resource Development (MHRD);
- Ministry of Women and Child Development (MWCD);
- Ministry of Labour and Employment (MoLE)
- Ministry of Social Justice and Empowerment (MSJE).

Increasing investment in adolescent health and development underscores the need to establish partnerships between different stakeholders, to effectively address current and emerging adolescent concerns, reach more adolescents, and deliver relevant, accessible and quality health services. Effective collaborations can be brought about by building upon and strengthening existing programmes and platforms, using existing service providers, who already work with adolescents, as well as forging new links (See Annex 3 for a mapping of service providers).

Figure 9 presents a strategic, working framework for multi-sectoral convergence, to improve adolescent health and development. The components of the model include:

- The target group—adolescents. This component recognises that adolescents are a heterogeneous group, and specifies the various adolescent

groups that must be considered under health programmes.

- **Health issues:** This component specifies six key health issues considered in a multi-sectoral convergence framework, viz., SRH, nutrition, NCDs, mental health, tobacco use, substance misuse, and violence.
- **The stakeholders—GoI ministries:** This component is further broken down into the primary role of each ministry (that is, leadership, supportive role) and the resources they can offer (for example, demand generation, strategic inputs).
- **The key components of adolescent-focused health services:** Demand generation (outreach), health education and life skills education (implementation), health services (implementation), training and capacity building of service providers (strengthening and expanding service provision, monitoring).

POPULATION

ADOLESCENTS

Girls and boys (10–14 and 15–19 age groups)

Unmarried and married

In school and out of school adolescents

Rural and urban

All social groups, including the vulnerable

PURPOSE

HEALTH ISSUES

Nutrition

Sexual and Reproductive Health

Injuries and violence, including GBV

Non-communicable diseases

Substance misuse

Mental health

PROVIDERS

MOHFW

Leadership and Coordination

Information, commodities and services including counselling

Intra-ministerial convergence with RBSK NACO, Maternal health, Child health, Family Planning, Mental Health Programme, NCDs and Tobacco Control Programme

Capacity building

Health Management Information System (HMIS)/Monitoring and Supportive Supervision

MWCD

Supportive and Implementation

Demand generation

Information and service provision, including counselling using existing platforms/service providers

Capacity building

Successful convergence models

MHRD

Supportive and Implementation

Health education and life skills education

Information and service provision, including counselling using existing platforms/providers

Capacity building

MOYAS

Supportive and Implementation

Demand generation through youth groups

Information and service provision, including counselling using existing platforms/providers

OTHER MINISTRIES

MoLE

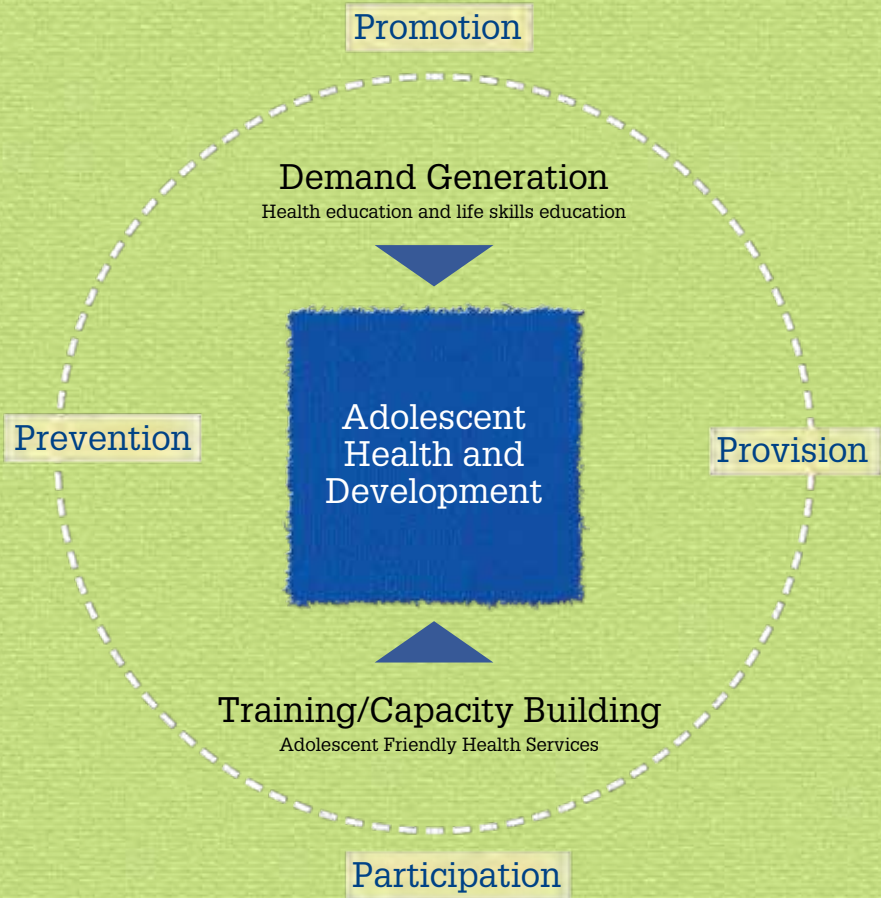
MSJE

Ministry of Rural Development (MoRD)

Supportive

Strategic inputs for Adolescent Health and Development

Framework for Multi-sectoral Convergence to Promote Adolescent Health



Structures for Convergence

This strategy envisages convergence across all areas of programming, to reach adolescents across diverse settings, such as rural, urban, in school, out of school or in health facility-based settings. The strategy proposes common orientation and training, including pre- and in-service training of service providers; use of common platforms and programmes for mobilisation; messaging and providing services; and monitoring and supportive supervision. For the strategy to be implemented successfully, it becomes imperative that convergence be effective on ground. Thus, establishing linkages, working relationships and consensus on the role of responsibilities become a pre-requisite to implementation.

National Level: Steering Committee for Adolescent Health and Development

An overarching Steering Committee for Adolescent Health and Development (SCAHD)—a national-level committee comprising representatives from all key ministries, namely, Health, Education, WCD, and Youth Affairs and Sports, representation from some states and other stakeholders is proposed to guide and steer policy and programme for Adolescent Health and Development. SCAHD

will be convened and chaired by the MoHFW, with MHRD and MWCD as co-chairs, and will meet biannually. SCAHD will be fed/supported by experience sharing workshops, in which the programming experiences of all concerned line ministries will be shared. Based on this, mid-course corrective action will be taken if and when required.

For this strategy to be implemented successfully, it becomes imperative that convergence be effective on ground.

State Level: State Committee for Adolescent Health

A similar state-level Committee for Adolescent Health (CAH) will be formed to oversee convergence efforts at the state level and resolve implementation issues. The Committee will meet biannually. CAH may be convened and chaired by the Chief Secretary/Principal Secretary Health, with representation from the departments of Education, Social Welfare, Tribal Welfare, and Water and Sanitation. The CAH will function as a sub group of the state health society. The state WIFS Advisory Committee will be subsumed in CAH.

District Level: District Committee for Adolescent Health (DCAH)

The scope of the existing district WIFS Advisory Committee will be expanded to encompass all adolescent health-related issues. The Committee will be chaired by the District Magistrate and will meet quarterly, to oversee convergence efforts, programme implementation and resolve bottlenecks. The Committee will have representation from all the concerned departments and will play an important part in planning convergent activities reflected in the annual work plan.

A dedicated programme officer for adolescent health has already been appointed at the state level. A similar programme officer for adolescent health may be appointed at the district level for effective coordination between departments, oversee programme implementation and undertake regular monitoring.

Village Health, Nutrition and Sanitation Committees

At the village level, VHNSCs are functional and are important forums to influence the local agenda of health and development. Currently, these committees have a very limited or no focus on adolescent health. In order to enable VHNSCs to respond to concerns of adolescents, it is proposed to expand the membership of these committees by including one adolescent girl and one boy. Furthermore, sensitisation programmes for VHNSC members could be undertaken on the need for adolescent health interventions and opportunities for programming for this population sub-group.

VHNSCs have an important role in ensuring accountability of community level workers (for example, ANM, AWW, teachers). VHNSC members should be encouraged to identify specific functions pertaining to adolescent health and well-being in the job descriptions of relevant community level workers so that these functions are better understood and executed effectively. Untied funds available with these committees can also be programmed for conducting health promotion activities for adolescents.

The MoHFW will play a pivotal role as a central agency for policy and programme design and implementation in scaling-up adolescent health programming in India.

Role of MoHFW

The MoHFW will play a pivotal role as a central agency for policy and programme design and implementation in scaling-up adolescent health in India. It will:

- Lead and coordinate policy on adolescent health and development
- Develop technical resource material (operational frameworks, guidelines, training material for capacity building) for all the six thematic areas identified in the strategy
- Facilitate training of service providers on Adolescent Health and Development issues of all participating ministries and use existing platforms wherever possible
- Enhance its focus on health education and health promotion at the community and facility levels, provision of commodities, and essential preventive and curative health services

MHRD, MWCD and MoYAS are key partners in adolescent health and development. Their programmes and platforms are integral to reaching out to adolescents

In addition to the above, joint monitoring and reporting mechanisms between participating ministries, especially MHRD and MWCD, will also be explored.

Role of MHRD, MWCD and MoYAS

MHRD, MWCD and MoYAS are key partners in adolescent health and development. Their programmes and platforms are integral to reaching out to adolescents, especially for health promotion, creating demand and establishing referral linkages. For instance, the inclusion of Adolescent Health and Development modules in the pre-service and in-service training of service providers such as teachers, AWW, and NYKS volunteers will address adolescent health concerns in various adolescent spaces (outreach).

Participatory approaches to capacity building and sensitisation will equip these service providers to act as first point of contact for guidance and information on commodities and services. For example, the use of AEP-trained teachers from CBSE, Kendriya Vidyalayas (KV), and Navodaya Vidyalaya Schools (NVS) in providing health education on SRH, HIV/AIDS and substance abuse. Teachers trained under AEP can be trained on adolescent health modules, to provide the first level of in-school counselling and facilitate referrals as needed. Working linkages with ICDS platforms are instrumental in reaching out-of-school adolescent girls on topics such as nutrition, SRH and life skills. Platforms such as NYKS teen clubs are existing spaces that can be utilised for adolescent-centric programmes, especially in expanding the outreach to adolescent boys in out-of-school settings.

Role of Other Stakeholders

Partnerships with other stakeholders such as MoLE, Ministry of Tribal Welfare, MoSJE need to be explored to reach adolescent spaces such as VET institutions and ITIs.



Programme Communication for Adolescent Health

Communication is considered effective when it succeeds in evoking a desired response from the other person. The strategy uses a multi-dimensional approach to programming and one of the key components of this strategy is to engage in effective communication with adolescents and on behalf of the adolescents. The strategy strongly advocates harnessing both traditional communication methods as well as new age tools.

Effective communication is an integral part of this strategy and will be a catalyst in successful implementation. Communication strategies will need to be designed so that there is messaging on behalf of the adolescents as well as for the adolescent.

It is important to ensure that adolescents play a lead role in steering communication processes related to their health.

In order to realise the adolescents' full potential as individuals, leaders and agents of progress, health services and programmes should facilitate and support meaningful engagement of young people. It is important to ensure that adolescents play a lead role in organising/steering communication processes related to their health. Such communication must take place in a non-threatening environment and ensure that adolescent perspectives should inform policy decisions.

The strategy proposes that health professionals act as advocates on behalf of young people and as providers to young people and their care-givers of most relevant and up-to-date, evidence-based information; they need to use methods and language deemed appropriate by the adolescents themselves.

Communication Planning Cycle

Communication is a process. It involves transforming the way a specific set of people think and behave regarding issues impacting them. To initiate this process, it is essential to know the starting point and the objectives for the purposes of communication. This process is, in fact, the basis of the communication planning process.



Strategic imperatives

Converse before you communicate

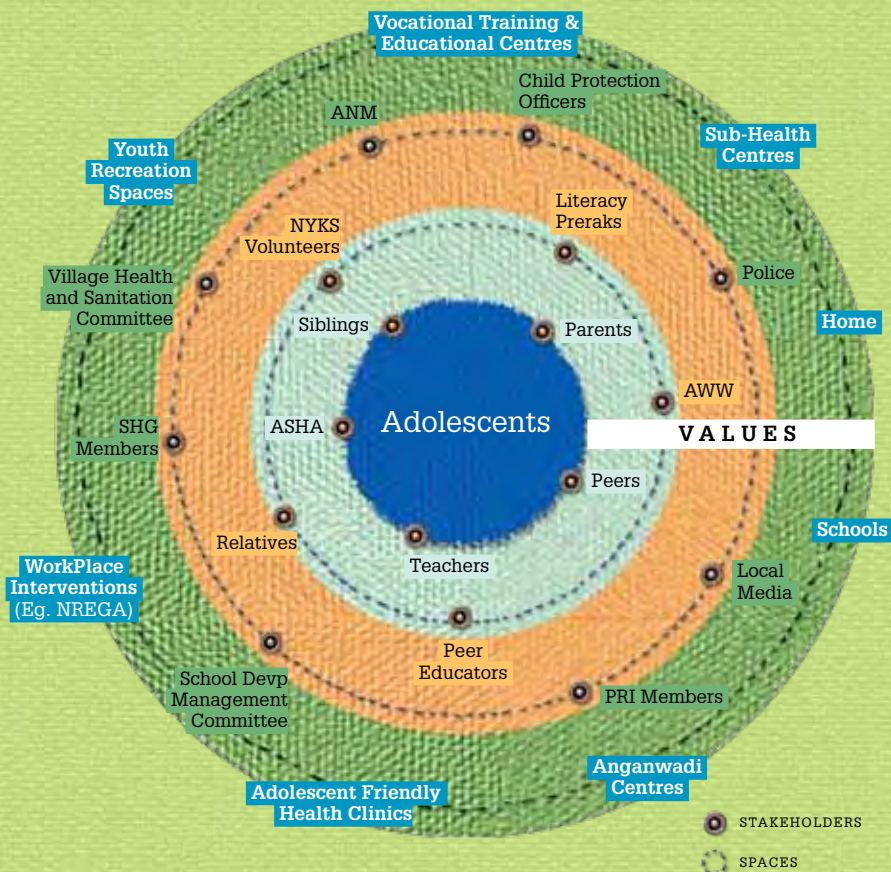
Before designing communication interventions, it is important to talk to the primary and secondary audiences. Such interaction should take place without any pre-conceived notions, with an aim to assess the blockages and opportunities. It is important to ensure that the setting of the conversation is not threatening or overwhelming for the people you interact with; otherwise, the information may be inaccurate or incomplete.

Before designing health communication pieces for diverse stakeholders, it is necessary to find the vital 'thread' that links all these pieces together for an integrated campaign.

Cross-cutting issues

As indicated in Figure 11, several individuals and institutions within a community influence the health of adolescents. They may represent different norms and cultures, and view the needs of adolescents from different perspectives. Before designing health-communication pieces for diverse stakeholders, it is necessary to find the vital 'thread' that links all these pieces together, and provide a 'community-wide' platform for an integrated campaign.

Several diverse stakeholders within a community influence adolescent health...



...but share a set of values that link them together

Identify the marginalised and the vulnerable

Identifying groups of adolescents, who are particularly marginalised and vulnerable, and identifying specific communication strategies to reach them is very important. The communication needs of out-of-school adolescents, those living in remote areas or facing other kinds of marginalisation should be factored in. Special programmes will need to be designed to communicate with very young adolescents and those disadvantaged because of physical or mental disabilities.

Special strategies will need to be designed to reach out to particularly marginalised and vulnerable groups of adolescents

New-age communication media

With mobile phones and the Internet penetrating deep into rural areas, and adolescents being the prime users of these emerging technologies, it is imperative to leverage emerging opportunities such as telephone helplines and e-counselling, social media, V-SAT, SMS and other ICTs. These technologies provide easy, wider and 24 x 7 reach for two-way information dissemination. For more information on these options, refer to the Communication Media Mix table in the Annex 5.

Target audiences

The messaging, media mix and expected outcomes of a communication-led intervention depend primarily on 'who we are talking to'. This defines the primary audience. Motivating and influencing adolescent health-seeking behaviour often requires the space or the freedom for them to take a positive decision and the engagement of secondary audiences. As mentioned earlier, it is important to pay special attention to marginalised and disadvantaged groups of adolescents.

AUDIENCE	DESCRIPTION
Primary Audience	Those whose behaviour is the focus of the strategic communication objectives.
Secondary Audience	Those who directly relate to the primary audience through frequent contact and can support/inhibit behaviour change in the primary audience.
Tertiary Audience (Gatekeeper)	Those with power/position to support/inhibit behaviour/social change, of which the primary audience is a part.
Agents/ Fieldworker	A natural agent of change, who can be brought on board for community programming, in terms of training, planning and implementation.

UNDERSTANDING WITH AN EXAMPLE

Consider the WIFS tablets that need to be given to schoolchildren between 10 and 19 years of age—the obvious primary audience are girls and boys going to school. Who will convince the students to have the tablets at school on a fixed day? Naturally, the teachers!

Many teachers may feel that distributing WIFS tablets is not a part of their task, and may skip days or students. Until the teachers are convinced that WIFS is indeed their responsibility, and they feel enthusiastic about this responsibility, not much success can be expected by providing information, education and communication (IEC) material to schools.

In such a case, adolescents as well as their teachers may need to be looked at as the primary audience, which needs positive behaviour change.

Similarly, when it comes to topics such as early marriage, early child-bearing and contraception, parents are often against such information being disseminated to their adolescent children. Here, parents are also the primary target audience because they need to be convinced of the value of providing such information and that it is indeed good for their children.

Thus, a particular segment may have multiple target audience labels. Or, as in the first case discussed, perhaps the teachers will move on the 'sliding scale of target audience' to gradually become the secondary or tertiary audience.

Communication for the Strategic Framework

The strategic framework provided in this document identifies six thematic areas, with various objectives under most of these areas. For the sake of effective programme communication, each objective listed here may need to be treated separately and differently in terms of target audiences, the key proposition articulated in the campaign messaging, media mix and the desired response.

Strategic Directions for Various Adolescent Health Strategy Priorities

Programmes requiring behaviour change are often met with resistance, based on social or cultural grounds. The intervention must, therefore, focus on the unfulfilled need of the primary target audience. Simply stating that a programme exists will not deliver desired results. The programme communication objective, therefore, packaged to appeal to an unfulfilled target audience need, must lead to the communication strategy and, thereafter, an interesting communication idea, that will help make the overall campaign messaging noticeable and memorable..

Whereas accurate communication strategies for each programme objective can be evolved only

after detailed analysis, creative planning and pre-testing, some examples of possible approaches for some of the objectives (based on the strategic framework provided in this document) can be found in Annex 4.

For effective dissemination, smart strategies involve a mix of various communication vehicles: mass media, community mobilisation and IPC.

Communication Media Mix

Rarely can a single communication channel suffice for a campaign. For effective dissemination, smart strategies involve a mix of various communication vehicles: mass media, community mobilisation and IPC. Within each stream, there are several options to mix and match. For instance, for community mobilisation among adolescents, peer influencers, teachers, celebrities and more can be used. That each media solution dovetails directly or indirectly into the others must be ensured, to enable the lowest possible cost per contact required for the desired level of impact. Some examples of popular options for media are listed in Annex 5.



6

Monitoring and Evaluation of the Adolescent Health Strategy

‘What gets measured gets done’. A robust system monitoring and evaluation systems is a key to successful programme implementation — not only for measuring the effectiveness of programme and extent of ground grained but also for making mid-course corrective action, build ownership and foster actability and transparency.

A monitoring and evaluation (M&E) system is an integral part of the adolescent health strategy. It assumes multiple functions and includes the measurement of performance on a regular basis at stipulated time intervals; identification of mid-course corrective actions needed to achieve programme objectives; assistance in judicious allocation of resources; and supporting advocacy for the benefit of other partners and organisations working in the area.

The M&E system will help evaluate the extent to which the strategy has desired impact on the lives of adolescents

M&E systems will facilitate implementation of the strategy in the following manner:

- Planning of interventions
- Making informed decisions regarding operations, management and service delivery to adolescents
- Judicious allocation of resources, ensuring their effective and efficient use
- Evaluating the extent to which the strategy has had the desired impact on the lives of adolescents

Monitoring and Supervising the Implementation of the Adolescent Health Strategy

The kind of health package proposed under this strategy requires that more indicators be added to HMIS.

NRHM has an established system of monitoring—HMIS, which, at present, covers maternal and child health (MCH), family planning and other relevant indicators. However, the data generated are not specified by age; measuring indicators related to adolescents, therefore, may not be possible through the existing system of reporting. Moreover, the kind of health package proposed under this strategy requires that more indicators be added to HMIS, and introducing these indicators in the existing platform may throw up various challenges such as revision of formats, integrating into the Web-based system and ensuring the quality of information.

The system needs to be tested and assessed for its efficacy in providing the needed information; if found suitable, necessary amendments in HMIS may be carried out at a later stage, to mainstream adolescent health provision monitoring in the overall monitoring system of the Ministry of Health and Family Welfare.

In the light of this, the evolving or developing of simple monitoring mechanisms has been proposed. To begin with, these can be in the form of reports that are submitted by different levels of the health system. The supervisory cadres, at different levels of the health system, will serve the twin purposes of ensuring the quality of information generated when implementing various interventions and of providing certain quantitative information, which could be useful feedback at each level of service delivery. Efforts should also be made to analyse data at each functional level for programmatic decision-making. The proposed monitoring system will monitor inputs, processes and outputs. The focus will be to monitor activities in the following areas:

1. Health promotion through awareness activities
2. Prevention
3. Treatment/Management

The quality parameters of the health package to the adolescents must be monitored; some of the crucial indicators reflecting quality of services, therefore, will also be part of the monitoring system. For each of these dimensions, suitable indicators will be evolved and the rationale provided, together with its linkages with the outputs and modalities of collection and compilation of information and feedback at each level of supervision.

The M&E of interventions will also need to focus on how these interventions are impacting marginalised groups, especially the most vulnerable, particularly those from disadvantaged social and economic backgrounds, including tribal, minority, rural/urban poor, out-of-school, migrant and working adolescents. In this regard,

Although there are several constituencies engaged in the implementation of the adolescent health strategy, there needs to be a single entity to monitor the programme.

data collected must be disaggregated on relevant grounds.

Although there are several constituencies engaged in the implementation of the adolescent health strategy, there needs to be a single entity to monitor the programme. As the strategy is being placed within the Ministry of Health and Family Welfare, the onus remains on the health sector to track how the health services are being delivered to adolescents amidst a variety of players engaged at various levels. Hence, the Health department will need to evolve a mechanism to oversee and report the delivery of services by stakeholders from other departments, to promote convergence.

Attempts will be made to generate indicators at the lowest levels of programme implementation because such geographical variations in performance and progress in areas with the tribals, minority population and urban slums can be monitored separately to bring in the equity focus. In this regard, it is important that the data collected be disaggregated on different grounds (for example, age, sex, rural/urban). Indicators for M&E are suggested in the Operational Framework. Further indicators will need to be developed for cross-cutting issues such as communications, convergence and participation. The monitoring system proposes to establish various review forums (at district and block levels), to review the performance and provide constructive feedback to lower levels of implementation and facilitate convergence among various participating departments and entities.

The on-going rapid assessments of the nutritional and health outcomes among adolescents, the periodic surveys and evaluation studies measuring

knowledge, attitudes and practices, the monthly reports of supervisors on activities related to adolescent health and nutrition, and the PHC/CHC monthly reports on services provided to adolescents can be valuable sources of data and verification.

Participatory monitoring mechanisms at the community level will be involved, in which adolescents will have a voice as well as stake in judging the progress of the programme.

Whereas there will be a system for a structured monitoring and feedback system of the adolescent health package, participatory monitoring mechanisms at the community level will also be evolved, in which adolescents will have a voice as well as stake in judging the progress of the programme.

Participatory monitoring differs from conventional approaches of monitoring in which it seeks to engage key stakeholders more actively in reflecting and assessing the progress of the intervention and, in particular, the achievement of results. Participatory monitoring is based on the following core principles:

- Considering primary stakeholders as active participants, not just sources of information
- Building the capacity of local people to analyse, reflect and take action
- Ensuring joint learning of stakeholders at various levels
- Catalysing commitment to taking corrective action

The new ways of assessing and learning from change are more inclusive and more responsive to the needs and aspirations of the primary stakeholders, and are geared towards not only measuring the effectiveness of a programme but also at building ownership and empowering adolescents, building accountability and

transparency, and taking corrective actions to improve performance and outcomes.

It is, therefore, important to define the monitoring, supervisory and evaluation systems by defining the indicators on which data will be collected at different levels of the health system as well as the analysis undertaken and the feedback provided. In case some data is already being collected by a different department, mechanisms to share the data inputs need to be established rather than creating parallel systems of data collection. In this manner, more resources can be made available for data analysis and timely feedback.

Accountability systems need to be strengthened, to ensure continuous improvement of health outcomes and to meet strategic objectives. This includes more support for and wider adoption of policies and programmes, which have a positive impact, and taking action to address what is not working, remedying problems, weak practices and any mismatch between objectives and results. It also includes learning from best practices and experience, to enhance the effectiveness of the efforts to improve adolescent health.

Recommendations

States may roll out interventions in districts where they have a strong adolescent health programme to build on ground gained or in 205 Sabla districts because convergence mechanisms have been established and programme linkages mapped out.

At the district level, it is desirable to have a designated focal point for adolescent health. This could be one of the existing district level officers. The designated adolescent health officer needs to convene a sub-group, which will have district-level representatives from other line departments and constituencies, working on adolescent health and development issues.

The sub-group needs to develop detailed work plans and budgets for an entire year, with clear timelines and resource requirements. This will form an integral component of the annual health plan. The same sub-group needs to take up periodic monitoring and review of progress on plans, including quality components of service delivery and community engagement, especially adolescents. Depending on the quantum of work, a dedicated person for coordination of the work at the district level (contractual) should be considered.

States may roll out interventions in districts where they have a strong adolescent health programme to build on ground gained or in the 205 Sabla districts because the convergence mechanisms have been established and programme linkages mapped out.

Participatory, process-oriented, teaching-learning approaches that enable providers to engage with adolescents rather than being prescriptive, stigmatising and fear-inducing should be utilised.

The Annual District Health Action Plan for adolescent health (detailed annual work plan and budget in the District Programme Implementation Plan—PIP) will have all relevant activities. This sub-plan will be comprehensive and will provide specifics, in terms of which department is responsible for undertaking an activity/activities.

The process for planning the adolescent health sub-plan will entail a rapid assessment of the status of adolescent health in the district. The sub-group is expected to conduct a desk review of different programmes (RBSK, AEP, ARSH, SHP, Sabla, WIFS, NYKS-supported teen clubs and others as relevant) and identify areas that need further strengthening. The sub-group will also identify decentralised coordination mechanisms at the block and village levels. Thus, the annual plan developed will define the roles of different stakeholders in delivering the interventions. For example, if a capacity building workshop of NYKS coordinators on SRH issues is to be organised, both the departments of Health and MoYAS will have a distinct role in conducting the training.

In addition to organising the service delivery systems, strengthening interventions specific for adolescent health such as capacity building, monitoring and supportive supervision and communication activities will be reflected in the annual plan. There is urgent need for sustained investment in enhancing capacities of relevant personnel in the domains of knowledge, attitude and skills. Participatory, process-oriented, teaching-learning approaches that enable providers to engage with adolescents rather than being prescriptive, stigmatising and fear-inducing should be utilised. Both induction training and

continuing education need to be given due attention.

Further, adolescents' views/perspectives need to be fully integrated in the programme planning and monitoring. In this context, districts need to organise at least one adolescents' conclave each year, inviting adolescents from different villages, social groups, married and unmarried, girls and boys. During the conclave, adolescents' inputs for improving their health and well-being will be gathered. Also, the opportunity must be used to share the physical progress made in programme performance in the district.

Abbreviations

A–B

AEP	Adolescence Education Programme
AHD	Adolescent Health Day
AIDS	Acquired Immuno-Deficiency Syndrome
AFHC	Adolescent Friendly Health Clinics
ANC	Ante Natal Care
ANM	Auxiliary Nurse Midwife
ARSH	Adolescent Reproductive and Sexual Health
ASHA	Accredited Social Health Activists
AWC	Anganwadi Centre
AWW	Anganwadi Worker
BMI	Body Mass Index

C–D

CEDAW	Committee on the Elimination of Discrimination against Women
CHC	Community Health Centre
CRC	Convention on the Rights of the Child
CSE	Comprehensive Sexuality Education
CSR	Corporate Social Responsibility
CWFC	Child and Woman Friendly Community
DALYs	Disability Adjusted Life Years
DHFW	Department of Health and Family Welfare
DHS	District Health Society
DLHS	District Level Household and Facility Survey
DoE	Department of Education
DWCD	Department of Women and Child Development

G–H

GBV	Gender Based Violence
GEMS	Gender Equity Movement in Schools
GER	Gross Enrolment Ratio
GOI	Government of India
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System

I–J

ICDS	Integrated Child Development Services
ICPD	International Conference on Population and Development
ICTC	Integrated Counselling and Testing Centre

IEC	Information, Education and Counselling
IFA	Iron and Folic Acid
IUD	Intra-Uterine Device
JSS	Jan Shikshan Sansthan
JSSK	Janani Shishu Suraksha Karyakram
JSY	Janani Suraksha Yojana

L–M

LHV	Lady Health Visitor
MCH	Maternal and Child Health
MCTS	Maternal and Child Health Tracking System
MDGs	Millennium Development Goals
MHRD	Ministry of Human Resource Development
MOHFW	Ministry of Health & Family Welfare
MOWCD	Ministry of Women and Child Development
MOYAS	Ministry of Youth Affairs & Sports
MSM	Men Who Have Sex With Men

N

NACO	National AIDS Control Organization
NCD	Non Communicable Disease
NCERT	National Council of Educational Research and Training
NCF	National Curriculum Framework
NCRB	National Crime Records Bureau
NFHS	National Family Health Survey
NGO	Non Governmental Organization
NIOS	National Institute of Open Schooling
NNAP	National Nutritional Anaemia Prophylaxis Programme
NPAG	Nutrition Programme for Adolescent Girls
NPEGEL	National Programme for Education of Girls at the Elementary Level
NPEP	National Population Education Project
NPP	National Population Policy
NPYAD	National Programme for Youth and Adolescent Development
NREGA	National Rural Employment Guarantee Act
NRHM	National Rural Health Mission
NYKS	Nehru Yuva Kendra Sangathan

P–R

PAHC	Primary Adolescent Health Care
PHC	Primary Health Centre
PIP	Programme Implementation Plan
PRI	Panchayati Raj Institution
PWDVA	Protection of Women from Domestic Violence Act
RBSK	Rashtriya Bal Swasthya Karyakram
RCH	Reproductive and Child Health
RMNCH +A	Reproductive Maternal Neonatal Child Health + Adolescents

S

SABLA	Rajiv Gandhi Scheme for Empowerment of Adolescent Girls
SACS	State AIDS Control Society
SATHI	Safe Adolescent Transition and Health Initiative
SCERT	State Council of Educational Research and Training
SC	Scheduled Cast
SDMC	School Development and Management Committee
SHG	Self Help Group
SM	Social Mobilisation
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health Rights
SSA	Sarva Shiksha Abhiyan
STI	Sexually Transmitted Infection
ST	Scheduled Tribe

U–V

UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
VET	Vocational Education and Training
VHND	Village Health Nutrition Day
VHSC	Village Health Sanitation Committee

W–Y

WCD	Women and Child Development
WIFS	Weekly Iron and Folic Acid Supplementation
WPAY	World Programme of Action for Youth
YFC	Youth Friendly Centres

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Annexures

Annexure 1 Key Programmes for Adolescent Health and Development under Various Ministries and Suggested Areas of Convergence

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Annexure 1

Key Programmes for Adolescent Health and Development

Programmes	Ground Level Linkages
HEALTH AND FAMILY WELFARE	
<ul style="list-style-type: none"> ▪ Family Planning ▪ Maternal Health ▪ Rashtriya Bal Swasthya Karyakram ▪ National AIDS Control Programme ▪ National Tobacco Control Programme ▪ National Mental Health Programme ▪ National Programme for NCDs 	<ul style="list-style-type: none"> ▪ Strengthen existing linkages with NACO, Family Planning and Maternal Health divisions for information, including existing programmes and schemes, counselling, services and commodities ▪ Family planning: Provision of contraceptives and pregnancy kits to adolescents; capacity building of health functionaries regarding varied contraceptive needs of adolescents; incentivisation of ASHAs for delaying first pregnancy in married adolescents. ▪ Maternal health-tracking of adolescent pregnancy for birth preparedness and complications prevention; capacity building of health functionaries to manage adolescent pregnancy and its complications.
YOUTH AFFAIRS AND SPORTS	
<ul style="list-style-type: none"> ▪ Adolescent Empowerment Scheme ▪ National Service Scheme ▪ NYKS Programmes ▪ NPYAD 	<ul style="list-style-type: none"> ▪ Adolescents, who have undergone the 45-day training on 'life skills education' can form a cadre of peer-educators ▪ Telephonic counselling under the National Programme for Youth and Adolescent Development (NPYAD) can be utilised to provide counselling services to adolescents

- **Rashtriya Bal Swasthya Karyakram:** Universal screening to include mental health problems such as depression, suicidal tendencies, risk of substance abuse and NCDs. Linkages between SHP and adolescent health clinics; peer educators to be involved in the implementation of universal screening.
- **National Mental Health programme:** Well-defined linkages with the District Mental Health Programme and the psychiatric wings of medical colleges for referral care.
- **National programme for prevention and control of cancer, diabetes, cardiovascular disease and stroke (NPCDCS)**—linkages with NCD clinics at CHC and DH levels; inclusion of health promotion on NCD prevention in training modules of MOs, ANMs, staff nurses, teachers and peer educators
- **National Tobacco Control Programme (NTCP):** Trigger behaviour change to eliminate tobacco use among adolescents through peer educators, role models and school-based activities of NTCP
- **Service providers/volunteers at schools, AWCs and teen clubs** to be trained in health promotion

- Trained District Youth Coordinators and Project Coordinators can be trained on adolescent health and development
- NYKS has linkages with local NGOs, the capacity of which can be built through training provided by skilled personnel from the Health Department

Annexure 1

Key Programmes for Adolescent Health and Development (continued)

Programmes	Ground Level Linkages
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WOMEN AND CHILD DEVELOPMENT

- | | |
|--|---|
| <ul style="list-style-type: none"> ▪ ICDS ▪ <i>Kishori Shakti Yojana</i> (KSY) ▪ <i>Balika Samriddhi Yojana</i> (BSY) ▪ Rajiv Gandhi Scheme for Empowerment of Adolescent Girls (<i>Sabla</i>) ▪ Swadhar Scheme | <ul style="list-style-type: none"> ▪ AWC to be the hub of activities for out of school girls (<i>Sabla</i> and KSY to serve as platforms) ▪ AWWs to be trained in health promotion for adolescent health programme areas, viz., nutrition and healthy lifestyles; SRH in order to inform mobilise/influence adolescents, care-givers and the community through regular contact and <i>Kishori Diwas</i> |
|--|---|

HUMAN RESOURCE DEVELOPMENT

- | | |
|--|--|
| <ul style="list-style-type: none"> ▪ AEP ▪ MDM scheme under the SSA ▪ RMSA ▪ <i>Sakshar Bharat</i> ▪ National Population Education Project (NPEP) | <ul style="list-style-type: none"> ▪ AEP to cover all the secondary and senior secondary schools of the country. AEP-trained teachers from CBSE, <i>Kendriya Vidyalayas</i> (KVs), and <i>Navodaya Vidyalaya</i> Schools (NVS) and State Board schools, to provide health education on SRH, HIV/AIDS, and substance abuse. ▪ Teachers to select, and mentor peer educators —incentive-based activity ▪ Teachers to be the first point of contact for guidance and counselling for Nutrition, SRH, substance abuse, mental health, NCD-related issues of adolescents |
|--|--|

- Linkages with BSY for community awareness on legal age at marriage
- AWWs to select and mentor peer educators under *Sabla* (use *Sakhi Saheli* when possible)
- AWWs and ASHAs to hold sessions on nutrition and SRH, including menstrual hygiene during dedicated quarterly AHDs in the villages (in *Sabla* district to coincide with *Kishori Diwas*).
- AWWs will also undertake screening for BMI and palmar pallor (pale palms) and the implementation of WIFS, and refer adolescents girls, as and when required, to the health service providers/facilities
- AWWs to ensure supplementary nutrition and early registration of pregnant adolescent girls
- Use of *Sabla* module to train ANMs

- Adolescent health development and promotion to be included in pre-service and in-service training of teachers so that every school has at least one trained teacher
- Linkages with MDM for provision of supplementary nutrition and implementation of WIFS
- Nodal teachers for WIFS to conduct Nutrition, Health and Education sessions in schools
- Linkages with *Sakshar Bharat* for information on nutrition
- Inclusion of topics related to mental health, substance abuse, NCDs, nutrition and violence in the curricula of secondary and senior secondary schools
- Peer educators enrolment from schools and provision of scholarships and certificates for peer educators
- Using the platform of schools to increase awareness about facility-based health services for adolescents at Adolescent Health Clinics
- Generating awareness about the importance of secondary education for girls on AHDs and peer-based Adolescent Clubs/*Samoochs*

Annexure 2

Adolescent Perspectives

Forty-three young people from twelve states across the country articulated the following critical needs for healthy development, at the National Youth Consultation jointly organised by the NGO, Pravah, and United Nations Population Fund (UNFPA) in November 2012 in New Delhi.

- **Support for acquiring life skills** comprises self-awareness, communication, ability to learn, decision-making, dealing with failure, inspiring and influencing others, negotiation, leadership, creating true relationships and support systems and conflict resolution skills.
- **Overall good health systems** include access to medical facilities, especially in remote villages, to get rid of eradicable diseases such as polio and tuberculosis.
- **Emotional and mental health** requires a healthy group of peers and friends, parents who understand the needs of their children, strong family ties for support, love, care and sense of belonging, employable skills leading to confidence and self-esteem, a peaceful environment, meditation, proper counselling, role models for moral support and inspiration.
- **Physical health** includes yoga and exercise as a means for achieving a healthy and happy life. A clean and green environment was perceived as a contributory factor for overall good health.
- **Social health, justice and personal safety/security** includes equality across caste, gender and colour, removal of all social ills, prejudice and biases, protection from sexual harassment, drug abuse and child labour.
- **Knowledge and support in SRH** includes access to accurate information and quality products, for example, sanitary napkins, and perspective and capacity building on issues such as early marriage, safe and consensual sex, contraception, safe pregnancy, safe abortion, access to a knowledgeable health practitioner, and support in changing

attitudes of family and community. Access to community-based worker for both girls and boys.

- **Safe youth spaces** for dialogue and engagement to enhance participation and leadership—a platform for open sharing with both fun and problem-solving elements.
- **Need for support groups** as well as knowledgeable and sensitive mentor/s—this is linked directly to emotional and mental well-being, and greater social adjustment.
- **Capacity to challenge discrimination and injustice** includes knowledge about processes and people to go to into cases of exploitation and discrimination (early marriage, rape, sexual harassment, sexual abuse, female infanticide, caste-based discrimination).
- **Need for free expression and choice**, for example, the right to pursue a career of choice, and freedom to engage in relationships, including outside one's community and gender.
- **Right to express and discuss about sexual urges and relationship experiences** so as to have peer counsel and mature counsel, to both enjoy and protect oneself.
- **A more caring attitude within the family, community and education settings**
- **Better education** that has real-world connect and guarantees jobs, opportunities for more diverse learning, free education to enable an expansion of paradigms and broadening of horizons
- **Career guidance, employable skills and support for entrepreneurship** includes awareness of opportunities available for earning livelihood.
- **Effective laws and citizen culture for social justice, and for a clean and green environment**
- **Adequate opportunities to learn more about the self and the world, and the chance to effectively apply this knowledge in society**

Annexure 3

Facility-based Service Providers for Adolescent Health (Optimum level)

Level	Counselling Session/Clinics	Services
Subcentre	Routine sub-centre clinics	Counselling on common concerns, and haemoglobin testing
Primary Health Centre	Weekly AFHCs from 2 to 4 p.m. by ANMs and MOs	Counselling
		Management of common health problems and referrals
Community Health Centre	Daily AFHCs from 9 a.m. to 4 p.m.	Counselling
	Two-hour daily clinic from 2 to 4 p.m. at the AFHCs by MOs, with support from staff nurses	Management of common health problems and referrals
District Hospital	Daily AFHCs from 9 a.m. to 4 p.m.	Counselling
	Two-hour daily clinic from 2 to 4 p.m. at the AFHCs by MOs, with support from ANMs	Management of common health problems and referrals
	Twice a week, Specialty AFHCs (S-AFHC) for Gynaecology and Paediatrics from 9 a.m. to 1 p.m.	Management of specialty problems and referrals
Medical College	Five days a week S-AFHC with different specialties from 9 a.m. to 1 p.m.	Specialty care

Functionaries	Training
ANMs /Multi-purpose workers (male)	Training on counsellor module to address concerns such as puberty, body image, nutrition and stress
ANMs	Training of ANMs in adolescent health modules
MOs	Training of MOs in adolescent health modules
Dedicated counsellors	Training in counsellor module
MOs and staff nurses	Training of staff nurses and MOs in adolescent health Modules
Dedicated Counsellors	Training in counsellor module
MOs and ANMs	Training of ANMs and MOs in adolescent health modules
Gynaecologists, Paediatricians	Sensitization on adolescent health schemes/programme
Gynaecologists, Dermatologists, Psychiatrists, Dieticians, Surgery	Sensitization on adolescent health schemes/programmes

Annexure 3

Indicative List of Information, Commodity and Service Delivery at Community Level

Nutrition

VILLAGE LEVEL		
Activities	Platform	Functionaries
Messages on balanced nutrition, iron rich food, importance of footwear, personal hygiene, inter-generational effect of malnutrition	VHND WIFS day AHD Teen clubs	Peer educators/PE Coordinator, ASHA, AWW
Iron supplementation, Screening for pallor and referrals, Biannual de-worming	WIFS day	Peer educators/PE Coordinator, ASHAs, AWWs
Nutritional assessment through BMI estimation, Supplementary nutrition	Kishori card under SABLA	AWW, ASHA

SCHOOL LEVEL		
Activities	Platform	Functionaries
Education on nutrition, anaemia, iron rich foods, personal hygiene	Incorporation in School curriculum	Teachers
Education on nutrition, anaemia, iron rich foods, personal hygiene	Incorporation in school curriculum	Teachers
Iron supplementation, Screening for pallor, Biannual de-worming	WIFS day	Teachers
Information sharing on nutrition and anaemia	Peer clubs	Peer educators
Supplementary nutrition with double fortified salt	Mid-day meal (MDM) scheme	Cook and helper under MDM

Annexure 3

Indicative List of Information, Commodity and Service Delivery at Community Level (continued)

Sexual Reproductive Health

VILLAGE LEVEL		
Activities	Platform	Functionaries
Information provisioning on the health risks of early pregnancy; contraceptives, safe abortion services, menstrual hygiene, birth preparedness, SRH	Monthly VHND Contact during doorstep contraceptive delivery by ASHA AHD Kishori Samooh	ASHA/PE coordinator Peer educators
Community-based distribution of non-clinical contraceptives	Delivery of contraceptives at the doorstep	ASHAs
Outreach activities for out-of-school adolescents	Monthly VHND	Peer educators
Sanitary napkins	Social marketing	ASHA
Encourage early detection of pregnancy	Linkage with sub-centres for pregnancy kits	ASHA for mobilisation and ANMs for commodity provision

SCHOOL LEVEL		
Activities	Platform	Functionaries
Inclusion of family life education and life skills	In school curriculum AEP	Teachers
Sharing of information and discussion on SRH concerns	Adolescent clubs	Peer educators
Screening of adolescents for clustering of health risks	Regular interaction with students Screening under SHP	Teachers Medical teams
Provision of sanitary napkins and proper disposal	Vending machine and incinerators through the SHGs/companies/ departments School as depot for sanitary napkins	Teachers as depot holder

Annexure 3

Indicative List of Information, Commodity and Service Delivery at Community Level (continued)

Mental Health, Substance Misuse, NCD Prevention, Preventing Injuries and Violence (Including Gender-Based Violence)

VILLAGE LEVEL		
Activities	Platform	Functionaries
Promotion of protective factors to prevent mental health problems, risk of substance misuse and NCDs	<ul style="list-style-type: none"> ▪ AHD ▪ Kishori Samooch ▪ Teen clubs 	<ul style="list-style-type: none"> ▪ Peer educators ▪ Mentors
Awareness generation among community members on mental health, substance misuse and NCDs	<ul style="list-style-type: none"> ▪ VHNDs ▪ Communication campaign 	<ul style="list-style-type: none"> ▪ ANMs ▪ ASHAs
Screening for mental health problems, substance misuse, NCDs	<ul style="list-style-type: none"> ▪ Routine sub-centre clinics ▪ Adolescent Information and counselling centre (AFHC) ▪ Opportunistic screening for NCDs 	<ul style="list-style-type: none"> ▪ ANMs ▪ MOs
Referrals for management of serious mental health concerns	<ul style="list-style-type: none"> ▪ Linkage between AFHC and District mental health programme ▪ Linkage between AFHC and NCD clinics 	<ul style="list-style-type: none"> ▪ MOs
Building favourable attitudes for preventing injuries and violence (including GBV)	<ul style="list-style-type: none"> ▪ AHD ▪ Kishori Samooch ▪ Teen clubs ▪ VHNDs 	<ul style="list-style-type: none"> ▪ Peer educators/ PE Coordinator ▪ ASHAs ▪ AWWs

SCHOOL LEVEL		
Activities	Platform	Functionaries
Influencing positive behaviour and skill building for dealing with stress and conflict; avoidance of substance misuse and behaviour change, to prevent NCDs	<ul style="list-style-type: none"> ▪ AEP ▪ Inclusion in curricula 	Teachers
Observing problems related to anxiety, stress, depression/ suicidal tendencies among adolescents	<ul style="list-style-type: none"> ▪ Regular interaction with students ▪ Screening under SHP 	<ul style="list-style-type: none"> ▪ Teachers ▪ Medical teams
Screening for NCDs	<ul style="list-style-type: none"> ▪ Screening under school health programme 	Medical teams
Skill building against GBV	<ul style="list-style-type: none"> ▪ AEP ▪ Inclusion in curricula 	Teachers

Annexure 4

Examples of Communication Strategies

Primary Audience	Felt Need of Primary Target Audience	Communication Objective
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IMPROVE NUTRITIONAL STATUS

Adolescent Boys and Girls	To look good and feel healthy	To prevent malnutrition through healthy diet
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DECREASE ANAEMIA PREVALENCE

Adolescent Girls and Boys	To win life's everyday challenges	To improve iron stores and ensure de-worming
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ADDRESS SUBSTANCE MISUSE AMONGST ADOLESCENTS

The Secondary Audience is the ideal change-maker in this case (Parents, teachers, siblings, peers)	To be respected as a true well wisher	To reverse the spread of substance abuse
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Communication Strategy	Communication Proposition	Proposed Media Mix
<ul style="list-style-type: none"> Communication Strategy Popularise BMI as a do-it-yourself health check The advantage of a healthy diet or the disadvantage of unhealthy diet is difficult to visualise for adolescents. Providing them a fun way to keep an eye on their own health status themselves can motivate them to eat healthy and be healthy. 	Know how healthy you are in two minutes!	Primary Media Printed material Support Media Events Optional Media TV
<ul style="list-style-type: none"> Position iron as a key to physical strength and mental agility Establish the importance of the IFA supplement, de-worming and healthy diet, to boost iron levels in the blood in order to be agile and alert. 	Be solid from within!	Primary Media TV, Radio, Printed material Support Media Outdoors Optional Media Other Audio Visual
<ul style="list-style-type: none"> Make screening tools easy to use Peer pressure and an urge to rebel are amongst the key reasons for more and more adolescents taking to drugs, alcohol and tobacco. The critical needs are: 1. Help the secondary audience recognise the common causes and symptoms, and 2. Appreciate that empathy works better than feeling sorry or reprimanding. 	Empathy works. Sympathy doesn't.	Primary Media TV, Radio, Printed material Support Media Helpline (For clients) Optional Media Events (Orientation)

Annexure 5

Examples of Communication Media Mix

Media	Strengths	Weaknesses
INTERNET BASED PLATFORMS		
Social network sites	<ul style="list-style-type: none"> ▪ Popular with young people ▪ 12.1 crore Internet users ▪ Over 4.5 crore Facebook users ▪ 2.7 crore smartphone users ▪ 4.5 crore rural Internet users 	<ul style="list-style-type: none"> ▪ Most popular sites are in English ▪ Slow Internet speeds in rural areas
TELECOM-BASED PLATFORMS		
Telephone hotlines	<ul style="list-style-type: none"> ▪ Overcomes access barriers arising from lack of mobility, cultural restrictions, inability to read/write, and expenses ▪ Enables client anonymity ▪ Crises hotlines work well ▪ Effective referral system 	<ul style="list-style-type: none"> ▪ For wide coverage, hotline personnel need to speak multiple languages/dialects ▪ Remote counselling/advice needs experts with special skills ▪ Whereas pre-recorded counselling is often used for non-working hours, this can be risky in volatile or crises cases
AUDIO MEDIA		
Community radio	<ul style="list-style-type: none"> ▪ Deep engagement with locals ▪ Low-cost dissemination ▪ Mobile phones used to listen ▪ Start with narrow-casting to build popularity and local engagement while waiting for radio station to be launched. ▪ Train local volunteers to set up and operate listeners' clubs, to generate community ownership and interest. 	<ul style="list-style-type: none"> ▪ Licenses take long to obtain ▪ Commercial advertisements not allowed ▪ Coverage radius maximum 10 km ▪ Licenses take long to obtain ▪ Commercial advertisements not allowed ▪ Coverage radius maximum 10 km

Simple Tips

- Micro-sites can be specially designed and/or existing apps can be used for sites such as Facebook, to customise Web interaction around specific subjects and target audience
- Apart from Facebook and Twitter, one can consider MySpace, Google+, LinkedIn, YouTube, and Pinterest
- Groups/blogs on such sites should be initiated only when there is long-term commitment and the resources to support it. Stopping midway leads to negative publicity, especially in cases where members may have invested sufficient time on the blog/group
- Sites such as Facebook offer options to include customised 'microsites' (usually not free), which allow use of target audience-specific, interactive tools, apps and more.
- Most leading sites such as Google Analytics provide special services, to track usage, visits, and other data that help gauge popularity of pages on social networking sites

- A small team of hotline personnel can cater to varied clients and issues, if different call-in numbers are connected to the same call-centre stations
- Doctors and counsellors make better hotline personnel, and an orientation on gender-sensitivity, cultural nuances and adolescent-friendly interaction proves invaluable
- Updated contact information (based on location, nature of query/problem, etc.) of referral services should be readily available with the hotline personnel, so that the same can be provided to clients who need it.
- An in-built system to track the call catchment area, repeat call-ins, etc., (without impacting confidentiality) helps strengthen the facility on an on-going basis.
- Special call-in numbers can be introduced for delivery of contraceptives, ASHAs/ ANMs-on-call, etc.

- Start with narrow-casting to build popularity and local engagement while waiting for radio station to be launched.
- Train local volunteers to set up and operate listeners' clubs, to generate community ownership and interest.



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