1.5 Adolescent Health

1.5.1 Introduction

Adolescents (10-19 years) in India represent almost one-third of the population. A large number of them are out of school, get married early, work in vulnerable situations, are sexually active, and are exposed to peer pressure. These factors have serious social, economic and public health implications. Adolescents are not a homogenous group. Their situation varies by age, sex, marital status, class, region and cultural context. This calls for interventions that are flexible and responsive to their disparate needs.

It is important to influence the health-seeking behavior of adolescents as their situation will be central in determining India's health, mortality and morbidity; and the population growth scenario.

Some of the public health challenges for adolescents include pregnancy, excess risk of maternal and infant mortality, sexually transmitted infections and reproductive tract infections in adolescence, and the rapidly rising incidence of HIV in this age group. In context of the RCH program goals, with special reference to reduction in IMR, MMR and TFR, addressing adolescents in the program framework will yield dividends in terms of delaying the age at marriage, reducing the incidence of teenage pregnancy, the prevention and management of obstetric complications including access to early and safe abortion services and the reduction of unsafe sexual behavior.

The use of services by adolescents is limited. Poor knowledge and a lack of awareness are the main underlying factors. Pregnancy is associated with significantly higher obstetric risks in adolescent girls and yet they are no more likely than older women to obtain antenatal care or experienced institutional or skilled attendance at delivery. Few understand the importance of prompt pregnancy related care.

Studies show that pregnancy in the early teens, before 16 years, is associated with an adverse effect on maternal nutrition, birth weight and survival of the offspring. Many adolescents suffer from malnutrition and anemia. Many may not have received tetanus immunization. Anemia during adolescence can get worse during an ensuing pregnancy. Thus, ill health during adolescence has profound implications for maternal, perinatal, neonatal and infant mortality.

Service provisions for adolescents are influenced by many factors. For example, at the level of the health system, a lack of adequate privacy and confidentiality, and the judgmental attitudes of service providers, who often lack counseling skills, are barriers that limit access to services.

1.5.2 Strategy for addressing Adolescent Reproductive and Sexual Health (ARSH) in RCH Phase II

A two-pronged strategy will be supported. Strategy One falls within the overall scale and coverage of the RCH Phase II program. The DoH&FW will incorporate adolescent issues in all the RCH training programs and all RCH materials developed for communication and behavior change. This will entail that interventions

for addressing unmet need for contraception and pregnancy care, prevention of STIs including HIV/AIDS will have specific activities to reach out to adolescents. Strategy Two will be implemented in select districts. This strategy will require the DoH&FW to undertake special efforts to reorganize services at the PHCs on dedicated days and dedicated timings for adolescents. This will depend on local capacities to deliver, staff availability and orientation.

1.5.3 Policy and institutional framework

Both the National Population Policy 2000 and the Tenth Five Year Plan highlight the need for catering to the reproductive and sexual health needs of the underserved population group such as adolescents. This policy framework will guide the implementation of the operational plan for ASRH service delivery through the existing public health system.

Policy level actions would need to be considered by the DoH&FW to facilitate implementation of the operational plan. These relate to, for example, administrative guidelines for providing contraceptives to unmarried adolescents, consistency and clarity with regard to contraceptive delivery and access to services, the identification of a core package of services for adolescents at all levels of health care. The DFW will need to steer policy dialogue and partnerships with other departments for inter-sectoral activities.

At the district level, the district RCH Society will be responsible for the overall implementation and regular monitoring. The district RCH Officer will be the focal point. Medical and health care needs will be met through the existing network of CHCs, PHCs and sub-centers.

Depending on the presence of the private sector especially in rural areas, private providers can be engaged in the provision of ASRH services. The possibility of engaging private providers for organizing teen clinics on dedicated days/time can be explored. Pediatricians and general practitioners could be engaged through their respective associations for providing free counseling services once a week for the adolescents. Partnerships will also be attempted with members of FOGSI, local chapters of the Indian Academy of Pediatrics, NGOs and other departments and stakeholder groups. Synergy with other health initiatives, in particular, the National AIDS Control Organization, will need to be promoted, especially with school health programs.

1.5.4 Coverage

Any operational model to provide ASRH services of necessity will have to take into cognizance the diversity of the program and maturity of health systems in the states. Hence, the specifics will need to be worked out, while developing state specific plans for RCH Phase II.

On a priority basis, it will be useful to pilot service delivery interventions in selected districts. One of the criteria for selection of districts could be the marriage age for girls and recent RHS data can be used to identify districts where more than 60 % girls marry below the age of 18. It is presumed that in these districts the incidence of teenage pregnancy shall also be high.

1.5.5 Operational framework for ASRH

1.5.5.1 ASRH service delivery through the public health system

A framework is proposed for operationalizing ASRH services within the context of public health systems. Actions are proposed at the levels of the sub-center, PHC, CHC and district hospital for delivering services to adolescents through routine OPDs, and a dedicated time (for example, once a month clinic for addressing the needs of unmarried and newly married adolescent girls).

The matrix below outlines service provision at each level of care.

Level of care	Service provider	Target group	Flow of service delivery activities	Services
Sub-center	HW(F)	Unmarried F Married F Unmarried M Married M	During routine sub-center clinics	▪ Enroll newly married couples ▪ Provision of spacing methods ▪ Routine ANC care and institutional delivery ▪ Referrals for early and safe abortion ▪ STIs/HIV/AIDs prevention education ▪ Nutrition counseling including anemia prevention
Primary Health Center/ Community Health Center	▪ Health Assistant (F)/LHV ▪ Medical Officer	Unmarried male and female	Once a week, teen clinic will be organized at PHC for 2 hrs	▪ Contraceptives ▪ Management of menstrual disorders ▪ RTI/STI preventive education and management ▪ Counseling and services for pregnancy termination ▪ Nutritional counseling ▪ Counseling for sexual problems

1.5.5.2 Key interventions for operationalizing ASRH

In order to facilitate provision for adolescents, the key interventions are explained below. These include - the orientation of service providers, environment building activities and MIS.

Orientation of service providers

Equipping service providers with knowledge and skills so as to enable them to cater to the reproductive and sexual health needs of adolescents is critical. The core content would include vulnerabilities of adolescents, need for services, and how to make existing services adolescent friendly. Based on the package of services chosen for implementation, these orientations could be modified. A self-learning module for peripheral service providers has been developed by DoH&FW and can be used in the orientation program for service providers.

These orientations would need to be integrated with other RCH Phase II skill development trainings. At the district level the RCH officer would be the nodal person responsible for organizing quality reproductive and sexual health services.

Environment Building Activities

Prevailing social barriers restrain adolescents from using the services. There is need to conduct some environment building activities so as to reach out to a broader range of gatekeepers with appropriate

messages. The key audiences could include district officials, panchayat members, women's groups and civil society.

The communication activities would essentially focus on the vulnerabilities of adolescents, the need for ASRH and a suggested package of services. For each group of stakeholders, communication material will have to be developed in the local language. It is proposed that the DHO/RCHO at the district level and the MO at the block level takes the lead in organizing such communication activities. In each district, the capacity of institutions and NGOs for conducting such communication programs can be assessed.

An intensive national campaign to generate awareness on key adolescent issues could provide an ideal backdrop for the launch of services in pilot districts.

MIS

Current health MIS does not analyze data in terms of adolescents as a separate client group. The revised MIS suggested in RCH Phase II will disaggregate information on key indicators to monitor the coverage of adolescents with preventive and promotive interventions. The main focus will be to monitor the teenage pregnancy rate, institutional delivery and the prevalence of STIs etc.

Evaluation and Operations Research

Adolescent health is a new component of the RCH program. In order to convert this initiative into a sustainable activity, it will be important to carefully monitor and evaluate its implementation. It is important that operational research studies are built into the program to develop new strategies.

1.5.6 Logical Framework

A logical framework for ASRH in RCH Phase II is presented on the next page. It spells out the outcome, outputs, activities and the key indicators and means of verification.