Summer Training at
NRHM, Gujarat
(April 3 to June 2, 2017)

Study of Adolescent Friendly Health Clinics in Tribal and Non-Tribal Areas of Valsad District

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INSTITUTE OF HEALTH
MANAGEMENT RESEARCH
(WHO Collaborating Centre for District Health System Based on Primary Health Care)

IIHMR UNIVERSITY

CERTIFICATE

This is to certify that **Dr. Devashish Singh** has undergone summer training in **NRHM, GUJARAT** from 3rd April to 2nd June 2017.

The candidate himself completed the project assigned to him during summer training. His approach to the project was sincere and proactive. This summer training is in partial fulfillment of the course requirement recommended for the award of MBA in Hospital and Health Management.

I wish him success in all his future endeavors.

Col. (Dr.) Ashok Kaushik

Dean (Academic & Student Affair)

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Ref.no.DP/DHS/DPMU/Summer Trainnee/ 2017/03/dt.3/04/2017 Date- 3 /06/2017

To Whomsoever It May Be Concern

Herewith certify that Dr. Devashish Singh a student of the IIHMR University have worked as summer trainee on project RMNCH+A under district programme management unit, Health Department, district panchayat, Valsad from 6th April 2017 to 3rd June 2017. During his working period he was found to be sincere and hardworking.

Reproductive Child Health Officer,

Health Department,

District Panchayat, Valsad

Acknowledgement

First of all we would like to express our gratitude to the Almighty grace for embracing us throughout our journey. Summer training is a great experience for any student and without the support of Mentors , teachers, staff and friends this journey would never have been so successful. Our sincere gratitude to all the people who have guided us at every step in our summer training schedule.

We would embrace the opportunity to thank The IIHMR University for providing us with summer training program in our curriculum and The Commissioner of National Health Mission(NHM) of Gujarat for giving us the platform to learn about the organisation.

We would sincerely present out thanks to The Chief District Medical Officer (Dr.Ajay S. Sanghvi) and our Mentor i/c Reproductive Child Health Officer (Dr. Manoj Patel) for their support . The experience became enlightening by the support of District Program Coordinator (Dr. Hemangini P. Solanki) and i/c Additional District Health Officer (Dr. Sandeep) , District Programme Officer (Niteen Sir) , District Programme Officer (Nikita) who have guided us at every step and helped us at every obstacle.

Our special thanks to ANM Supervisor at DPMU office (Geeta ji) ,all Medical officers, ANMs, ASHAs, MPHWs, Peer Educators and every individual that helped us learn more and more.

Our report would be incomplete without presenting respect to our Mentors at institution Dr. S.D. Gupta and Dr. Nutan P. Jain for all their guidance and encouragement throughout the summer training.

Lastly we would thank our Parents for being my source of motivation for my work.

Dr. Devashish singh
Dr. Kirti dhamija

Table of contents:

Acronyms/Abbreviations

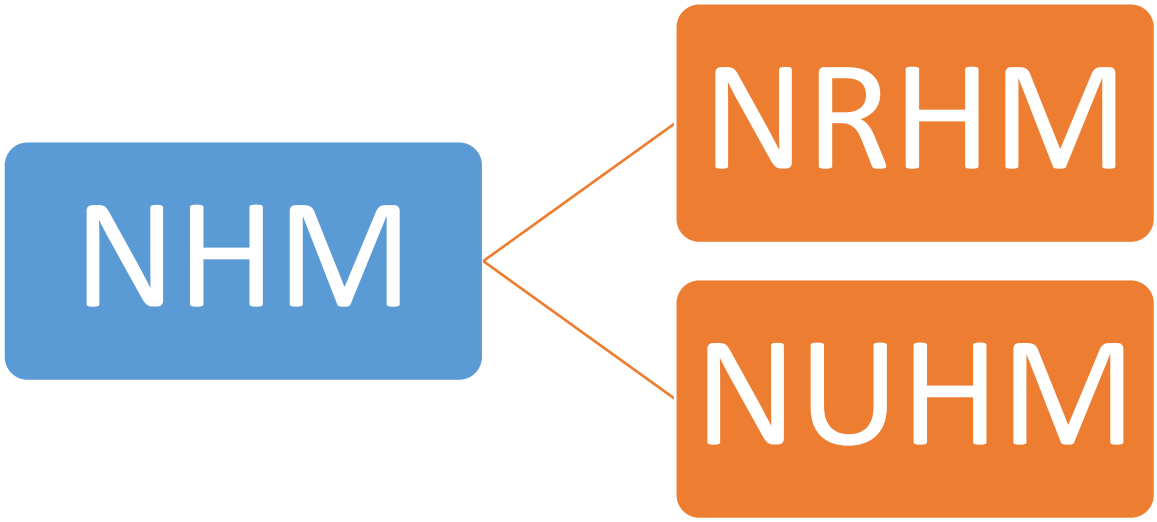
AFHC – adolescent friendly health clinic
AIDS- acquired immunodeficiency syndrome
ASHA- Accredited Social Health Activist
ARSH programme – adolescent reproductive and sexual health programme
AWC - anganwadi centre
AWW- anganwadi worker
AYUSH- Ayurvedic, Yoga, Unani,Siddha and Homeopath Systems of Health
BPL- below poverty line
CHC- Community Health Centre
CDHO- Chief district Health officer
DH- District Hospital
DPC- District program coordinator
Hb - haemoglobin
HCW- Health Care Worker
HIV- human immunodeficiency virus
IFA – iron folic acid tablet
IEC material- information, education and communication material
M.O.- Medical Officer
MPHW- multipurpose health worker
NA- Not Applicable
NDCP- national disease control programme
NHM- National Health Mission
NHRM- National Rural Health Mission
NUHM- National Urban Health Mission
PHC- Primary Health Centre
PIPs- programme implementation plans
PMCC- performance monitoring and control centre
PPP- public prvate partnership
PTKs- pregnancy test kit
RBSK- Rashtriya bal swasthya karyakaram
RCH- Reproductive & Child Health
RCHO- Reproductive child health officer
RI- Routine Immunization
RKSK- rastriya kishory swasthya karyakram
RMNCH+A- Reproductive, Maternal, Neonatal & Child & Adolescent Health
SC- Sub Centre
SIHFW- S-source for self development
I: innovation and inner transformation
H:human touch
F:fairness to all
W: way to excellence
SQIP- state quality improvement programme
THO- Taluka Health Office

CHAPTER 1

1. **Introduction**:

NHM i.e National Health Mission was launched in India on 12th April'05. It was initiated to provide healthcare in rural population , focussing the the disadvantaged groups including women and children- by improving access

- ❖ enabling community ownership
- ❖ demand for services
- ❖ strengthening public health systems for :
- efficient service delivery
- enhancing equity and accountability and
- promoting decentralisation.



- The national health mission has two sub-missions namely the national rural health mission and national urban health mission.
- The main constituents are - reproductive, maternal, neonatal, child and adolescent health (RMNCH+A). The aim is to achieve universal access to equitable, affordable and quality healthcare services that are accountable and responsive to people's needs.
- NHM in state regulates by State program implementation plans (PIPs) .
  The PIP's have following parts:

a) Part I: NHM RCH flexi pool
b) Part II: NUHM flexi pool
c) Part III: flexi pool for communicable diseases
d) Part IV: flexi pool for non- communicable diseases, injury and trauma
e) Part V: infrastructure maintenance

2. Vision of NHM-

According to website (ref) "Attainment of Universal Access to Equitable, Affordable and Quality health care services, accountable and responsive to people's needs, with effective inter-sectoral convergent action to address the wider social determinants of health".

- Safeguard the health of the poor, at risk and disadvantaged, and towards a right based approach through allocation and service guarantees.
- Strengthen public health systems as a basis for universal access and social protection against the rising costs of health care.
- Build environment of trust between people and providers of health services.
- Empower community to become active participants in the process of attainment of highest possible levels of health.
- Institutionalize transparency and accountability in all processes and mechanisms.
- Improve efficiency to optimize use of available resources.

3. NHM Gujarat:

National Health Mission , state health society Gujrat has created wide network of health and medical care facilities in the state to provide primary, secondary and tertiary care at doorstep of every citizen of Gujrat with main on BPL families , marginalized population and weaker sections in rural and urban areas.

4. Programmes in NHM Gujarat :

a) **RMNCH +A**

Programmes under RMNCH+A include:

Maternal health	Rural health
Child health	Adolescent reproductive sexual health
Nutrition	Rashtriya bal swasthaya karyakram
Family planning	Training and capacity building / SIHFW
Safe abortions	Programme management
Urban RCH	Vulnerable groups

b) Immunization includes:

Vaccination

Monitoring the vaccination coverage
Surveillance of vaccine preventable diseases
Reporting adverse events following immunization
Training regarding immunization

c) NDCPs includes:

- In Communicable- NVBDCP, RNTCP, IDSP, NLEP
- In Non communicable- National programme for Health Care of Elderly people, NPPCD, NPCB, NPCDCS

5. Schemes by NHM Gujrat:

- Mukhyamantri Amarutum
- Rogi Kalyan Samiti
- Bal Sakha Yojna
- Janani Suraksha Yojna
- Various schemes for Immunization

6. **Initiatives** :

- SQIP
- E- Mamta
- Mission Balam Sukham
- Mamta Doli
- PMCC
- Sickel Cell Anaemia Control Programme
- ASHA Sammelan
- Arogya Setu
- Mamta divas

7. **Health and Demographic indicator of GUJRAT State and India** :

INDICATOR	GUJARAT	INDIA
Total population (in crore) (Census of India 2011)	6.04	121.01
IMR (SRS 2013)	38	42
MMR (SRS 2010-2012)	122	178
TFR (SRS 2012)	2.3	2.4
CBR (SRS 2013)	21.1	21.6
CDR (SRS 2013)	6.6	7.0
Sex ratio (Census of India 2011)	919	943
Child sex ratio (Census of India 2011)	890	919
Schedule caste population (in crore) (Census of India 2011)	0.40	20.1
Schedule tribe population (in crore) (Census of India 2011)	0.89	10.4
TLR(%) (Census of India 2011)	78.0	73.0

District profile

Valsad district is one of the 33 districts in Western Indian state of Gujarat . Valsad has total 6 talukas namely, Valsad, Pardi, Vapi, Umargaon as Normal Priority and Dharampur and Kaprada as High Priority due to presence of Tribal Areas. Total no. of districts in Valsad are 460.

According to Handbook of District Census 2011:

- Total Population: 1,705,678
- Total Area: 2,947 .49 sq. kms
- Total male population: 8,84,064
- Total female population: 8,19,004
- Total population in urban area: 6,34,074(37%)
- Total population in rural area: 10,68,993(63%)
- Schedule caste population :38,237(2.64%)
- Schedule tribal population: 9,02,794(57.75%)
- Population Density: 561
- Literacy rate: 80.94%
- Below poverty line population: 44%
- Sex ratio: 926

Various health facilities in Valsad are:

Name	Total number
District Hospital	1
Sub District Hospital	2
CHCs	10
PHCs	48
SCs	363

FINDINGS (UNIT WISE):

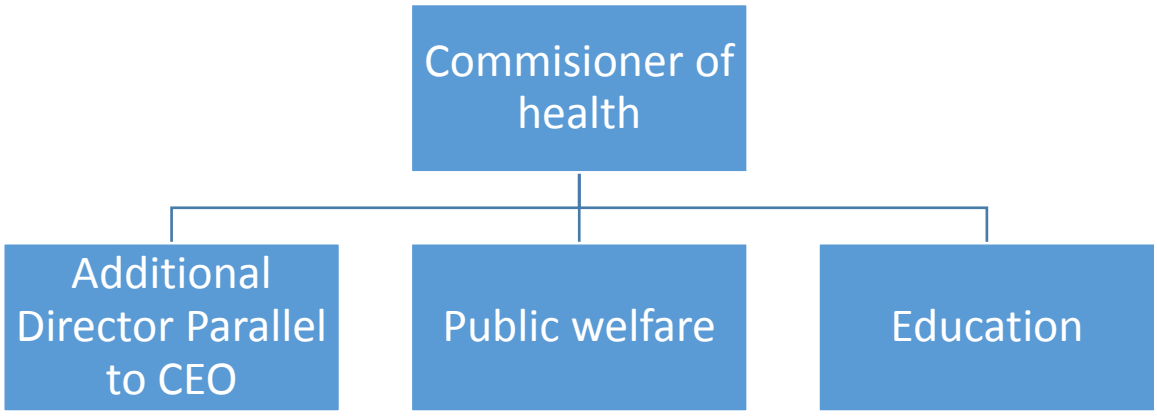
During our summer training programme we covered the health facilities in Valsad as per given schedule from the institute, we observed and learned the routine functioning, financing, logistics, programme implementation, sat com meetings , attended taluka level meetings in different units like district hospital, state hospital, DPMU, CHC, PHC, Sub-centre, Anganwadi and block offices. Some of our learning and findings are given below-

- **Panchayat office/District programme management unit (DPMU):**
- observed the daily working of the DPMU employees (am pm)
- organogram of the organization
- Hierarchy in the district under Chief district health officer comes the Reproductive child health officer followed by District program coordinator .
- PIP budget plans.
- State language is the main language for official communication.
- Job role/responsibilities was not clear between employees

Organogram: a) Higher level at DPMU consists of

b) in case of financial concern :

- **District hospital**- It is tertiary Centre in health care delivery system.



- Under education comes: GMERS i.e. Government medical education and research society. It has both education and research in its functioning.

- Chief district health officer and Chief medical health officer play main role, where CDHO is head of Preventive care and CDMO is the head of curative care.
- ARSH Counsellor was not appointed at District Hospital.
- There is no schedule of Behavior change workshops.
- All specialty consultants were present.
- According to Hospital Administrator there was lack of supervision regarding programs like ARSH and lack of outsourcing.
- SATELLITE COM. meetings were a part of learning regarding malaria eradication.

- **Community Health Centre -**
- The CHC in tribal area did not have IEC suitable to beneficiaries as there is language gap in those areas.
- Male and female wards were together in tribal area.
- There was no separate room for pregnant mothers and newborn child.
- No counsellors were present both in tribal and non tribal areas.
- Lack of equipment and manpower
- Data entry was not done at the CHC we visited as it was mainly done at block level due to lack of resources.
- There was absence of residence for Medical officers in tribal areas.

- **Primary Health Centre -**
- Primarily we observed the routine of Medical officers and their supporting staff.
- 80% Infrastructure of health facilities was good.
- At about 70 % conveyance was available.
- Patient count was low i.e. they do not respond to government facilities.
- All Medical officers were newly appointed (mean experience was 1.2 years) and were not yet trained for various health programs.
- The supportive staff was trained but not skilled.
- Lack of supervision.

- **Sub-Centre -**
- We observed ANM's routine work and went on field visit along with them .We also observed the working in Mamta divas (on every Wednesday in gujarat for immunization and ANC) . Along with them we asked about responsibilities of MPHWs.
- ANMs who were graduates even with less experience were able to convey their knowledge but even with 30 yrs of experience some were unable to do so .
- Infrastructure was average, in 15% Sub-centers infrastructure was totally absent and were operating from Anganwadi centers.
- Resources were present at all AFHCs (except sanitary napkin) but some like Copper -T etc were not used at all.

- **Anganwadi Centre-**
- Routine of Anganwadi worker.

- Diet chart for kids
- Mamta divas programs
- They lack education and are unable to teach
- In case of ANC there is lack of privacy.

CHAPTER 2 :

Topic:

A STUDY OF ADOLESCENT FRIENDLY HEALTH CLINICS IN TRIBAL AND NON-TRIBAL AREAS OF VALSAD DISTRICT.

Introduction:

They are not homogenous group, there is variance in age, sex , marital status , class, regional and cultural context. Currently various programmes are running for adolescents under national and state government, though all programmes have their different objectives.it is important to raise awareness regarding health seeking behaviour of adolescents as their situation will be central and determining India's health , morbidity and mortality; and the population growth scenario.

With this under the RCH II programme and national health mission the adolescents reproductive and sexual health programme ARSH was introduced. This strategy has been made to facilitate adolescent care through public health systems. Large No. of adolescents suffer from malnutrition and anaemia which adversely effects their physical wellbeing.

- Adolescent population is 22% (census 2001) of total population. There is a need to observe the adolescents regarding mental, social and physical problems.
- It is important to generate health seeking behaviour in adolescent as their situation is central in determining various indicators of health.
- According to SRS 2011-13 the MMR of India is 167 per 1 lakh and it is 112 per lakh for Gujarat.
- Acc. To NFHS-4 survey in Gujarat women age 15-19 years who were already pregnant at the time of survey was 27%(including rural and urban area) which contributes to major attention towards adolescent programmes like ARSH .
- Presence of traditional or tribal customs majorly affect the adolescent health.
- Nearly 20% of 1.5 million girls are married under age of 15 and are already mothers.
- Age specific fertility rate in the age group of 15-19 years contribute 19% of total fertility.
- 70% girls in age group 10 to 19 years suffers from severe moderate anaemia (DLHS-RCH 2004).over 35% of all reported HIV infections in India occur among people in the age group 15 to 24 years indicating that young people are highly vulnerable
- In 2013 GoI included Adolescent as an additional part to RCH program and was introduced as RMNCH+A.
- Total population of adolescents in district of Valsad is:

- ❖ in non tribal area 135616
- ❖ tribal area 78764

What is AFHC:

- Location of facility should be away from the OPD or any other crowded place.
- Dedicated space should be present.
- Privacy should be insured.
- Number of days an AFHC is functional in a week (in Gujrat Monday and Tuesday 2 to 4 pm)
- Equipment and commodities present in clinic – height measurement instruments, weighing machine, BMI charts, contraceptives, injection TT, IFA tablets, Albendazole tablets, sanitary napkins, PTKs.
- Availability of IEC material regarding ARSH promotion.
- Human Resource Required: Trained Medical officer ANM/LHV Counsellor (AH counsellor, ICTC counsellor, RMNCH+ A counsellor) in adolescent health

Need of AFHCs:

The pervasiveness of discrimination, lower nutritional status, early marriage, complications during pregnancy and child birth among adolescents contribute to female mortality.Adolescent mothers are at a higher risk of miscarriages, maternal mortality and give birth to still born and underweight babies.

Review of Literature:

- "In 2017,According to Grishma T. Dixit, Shikha Jain, Farzana Mansuri, Arjun Jakasania in their study topic. Adolescent friendly health services: where are we actually standing carried a cross sectional study on 10 Urban Health Centres of Ahmedabad Municipal Corporation where the respondents were between the age of 10-19 years. The result of their study was : Relative score for confidentiality, privacy, equitability, accessibility and knowledge gap in adolescent is 58.3%. Relative score for health care providers competencies to work with adolescents and to provide them with required services is 42.6%. Relative score for Observation tool used for facility inventory is 45.6%. Overall relative score is 47.3% of maximum possible score."

- "In 2012 according to Mona gupta, K. V. Ramani, Werner soors in their study adolescent health in India: still at crossroads concludes that adolescent health in India is still in an infant stage, and at risk of infanticide. if we want to deliver a comprehensive services package to our adolescents, then we have first to overcome a range of obstacles: traditional society, cultural restriction especially for girls and political-religious context , only government action can put these

hindrances aside. But government actors are far from steering in the same direction. Improved coordination should be a first step. coordination of policy processes amongst different departments and different ministries—especially the need to identify a lead agency which has the mandate and power to coordinate—is the key to any government policy. in arsh, shattered by many and buried in complexity, coordination and steering becomes imperative. however, this can only be a first step. from 'health for the adolescents' to 'health with adolescents', there is still a long way to go .In 2008 nath anita; garg suneela conducted a study on topic " Adolescent friendly health services in India: A need of the hour" states . In a conservative society where reproductive and sexual health related issues are taboo for discussion, young people are hindered from actively seeking counsel for their needs. Even though programs and policies directed towards improvement of adolescent reproductive health exist, there is a paucity of Adolescent Friendly Health Services (AFHS), the expansion of which is still in the nascent stage. Moreover, very few programs have been able to differentiate between the special reproductive health needs of married and unmarried adolescents. In addition, there is less focus on adolescent boys by these programs and policies. The significant features of an Adolescent Friendly Health Center/Clinic (AFHC) encompass provision of reproductive health services, nutritional counseling, sex education and life skills education. It is a kind of 'one-stop' shopping approach which means that the different needs of adolescents can be met under one roof, by a team of professionals who understand their needs and are trained to address them effectively. Adolescents continue to remain at risk, thus calling for development and strengthening of need based interventions."

- "In 2015 Latika Nath , R.K. Arya, G.K. Gupta, Narendra Singh In their studyChallenges in implementation of Adolescent health strategies of RMNCH+A in Ghaziabad states The adolescent services are sub-optimal in the district presently. Non consumption of IFA tablets needs to be addressed by better co-ordination between Education and Health department. Home based counselling should be strengthened in our socio-cultural milieu as per need. CONCLUSIONS The study is one of the first such in district Ghaziabad and was conducted in the rural areas using multi stage sampling technique. The coverage of adolescent health RMNCH+A services in the district are presently sub optimal. There is a need to improve the quality and quantity of interaction between community and front line workers Implementation support, mentoring and hands on support to field staff is needed based on gaps identified in this study. It is not a priority district but the benefits of a National programme should have equitable distribution. The adolescent services were not implemented as per guidelines and hence the services were not known to the beneficiaries. The adolescent care programmes like school health check -ups and WIFS were reported as being implemented by 64.5% and 24.5% of the respondents. Hence these were partially implemented and there was lack of coordination between the Education and Health department as compliance was poor."

- "In 2015 , Vijay Kumar Tiwari , L Lam Khan Piang , Sherin Raj T P , Kesavan Sreekantan Nair Correlates of Social, Demographic and Behavioural Factors affecting Adolescent Sexuality in a Traditional Society in India: Perspectives and Challenges" states "School background, leisure and entertainment practices, influence of taking alcohol, tobacco, drug, peer influence were found to be the major risk factor for indulgence in unsafe sex practices among adolescents. About 10% accepted involvement in premarital sex and majority of them (70%) of them had premarital sex between age group 15-19 years. The schools lacked in organizing awareness program and counselling activities on consequences of adolescent sex. The ARSH Program needs to synergize with school health program for desired results."

- "In 2014, Tiwari ; Sherin Raj ; Lam Khan Piang ; H Elizabeth; K S Nair Professor in their study . Does Reproductive and Sexual Health Knowledge and Risk Behavior among School Going Adolescents varies in High and Low Urbanized Cities? Evidences from a Hilly State of India resulted overall 94% were aware about HIV/AIDS but relatively less percentage of adolescents (83%) and approximately half of them (47%) knowing any of such symptoms of STDs. Nearly 23% respondents were aware about premarital pregnancy among friends and 7.5% were aware about complication due to unsafe abortion among them. The knowledge about emergency contraceptive pills was low (37%). About 70% disapproved premarital sex but opined that responsibility of safe sex with both the partners. About 10% accepted involvement in premarital sex and majority of them (70%) of them had premarital sex between age group 15-19 years and 54% never used condom. "and concluded" Risk of unsafe sex is almost same in both the places. Better awareness and counseling and supportive services to adolescents are needed through school health education."

- "In 2014, Vijay kumar Tiwari, Sherin raj and lam khan piang in their study "Does Knowledge and Awareness about Sexual and Reproductive Health Influence Sex Behaviour among School Going Adolescents? Myths and Realities" concluded Awareness about reproductive health facts have, in general, discouraging effect, but is not sufficient alone to prevent sex behaviour among adolescents. What is needed is increasing awareness about risk and serious psychological, physical and social consequences of sex during adolescence and to ensure supportive services in terms of counselling, contraception and abortion through better implementation of ARSH Programme. Study findings can be utilized effectively in working out strategies for adolescent friendly health clinics (AFHC), prioritizing community outreach programme by health workers, Does Knowledge and Awareness about Sexual and Reproductive Health 129 improving school health programmes for better counselling of adolescents and skilling them in negotiating peer pressure against indulging in sex."

Objectives:

- To review the guidelines on ARSH and related programmes.
- To study AFHCs in tribal and non-tribal areas of Valsad district.

Methodology:

- Area: This study was conducted in Valsad, Gujrat in 6 Talukas where 4 are non-tribal areas and 2 are tribal areas.
- Tribal talukas – Dharampur, Kaprada
- Non tribal talukas- Pardi, Umargaon, Valsad, Vapi.
- Schedule: Data collection at the AFHCs was done during April-May 2017 during 2-4 pm on Monday and Tuesday when AFHC run.
- AFHCs was not established in District hospital.
- 2 – CHCs, 11 – PHCs (could not contact 1 tribal PHC).
- Adolescent health clubs run in 21 Sub centres exclusively.
- Interviewed 15 MOs, 24 ANMs, ASHAs and 70 Peer educators .
- 15 out of Total 21 AFHCs have been covered and complete information was collected from 13 AFHCs since 2 were non – responsive .
- Out 24 ANMs and 24 ASHAs only 21 were responsive.
- 53 peer educators out of 70 were available.
- No Counsellor was present at any of the facilities.
- Questionnaire was prepared separately for Medical officers, ANMs, Peer educators, Counsellors, ASHAs. On the basis of this questionnaire the respondents were interviewed.
- A checklist was prepared taking support from the checklist provided by Government and was used for observation purpose.

Limitations of Study:

- We planned to include beneficiaries but it was difficult to include them during the time period of our visit as they were unavailable in schools.
- The non responsive people could not be covered twice as connectivity and conveyance was issue in tribal areas.
- Language was a certain barrier in tribal areas.

Data Analysis:

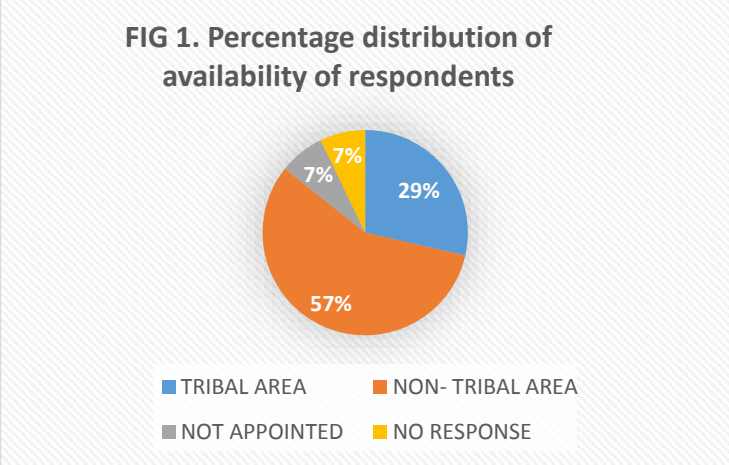
The data was exclusively collected, it was checked for completeness and consistency. Further it was compiled together in Ms excel software and further analysed.

Results:

Adolescent friendly health clinics

Medical officer (n=13)

- Availability of respondents: 15 out of Total 21 AFHCs have been covered and complete information was collected from 13 AFHCs. AFHCs was not established in District hospital:



Out of 15 AFHCs – 13 respondents were available, no Medical officer was appointed at District Hospital and one was unavailable in tribal area.

- Functional clinics in tribal and non tribal areas: All the functional AFHCs (46%) are in non tribal areas

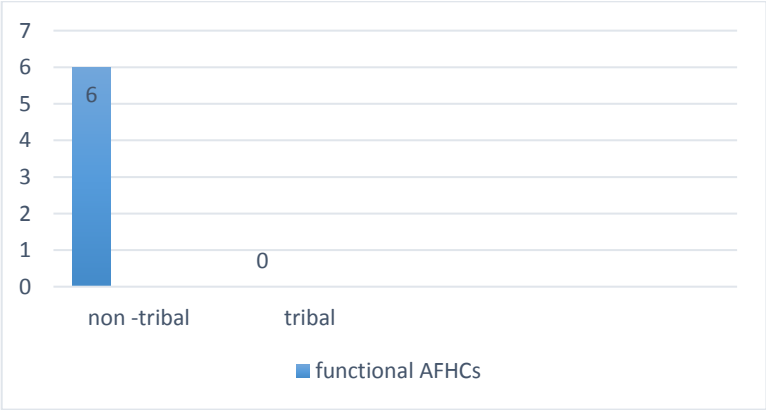
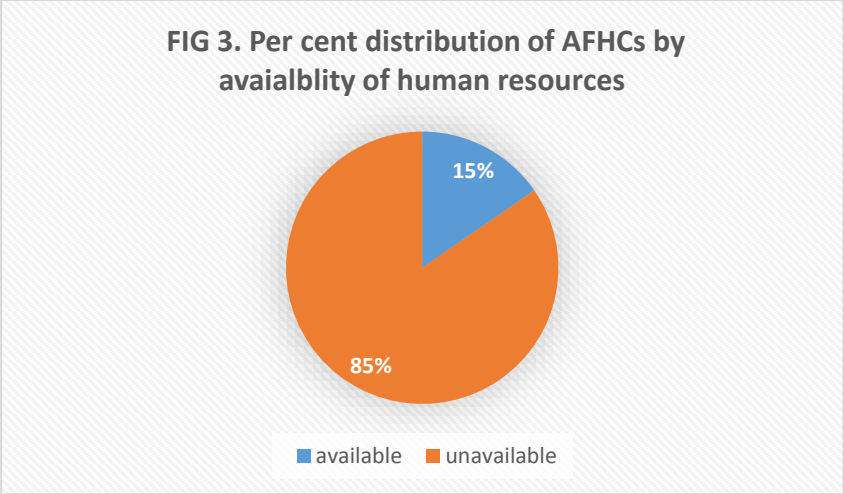


FIG 2.

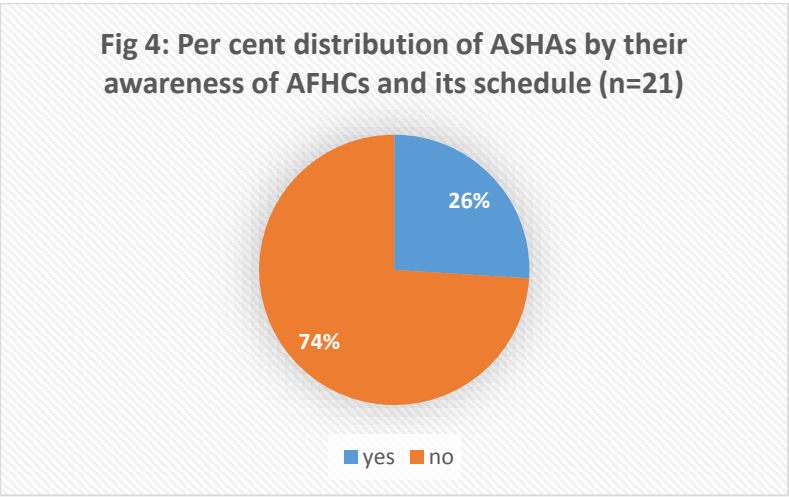
- Facilities with adequate resources:



Out of this 15% available one was in tribal areas and one was in non-tribal area. This resources includes infrastructure like absence of proper building in PHCs and SCs . implicating the level of difficulty in delivering health services.

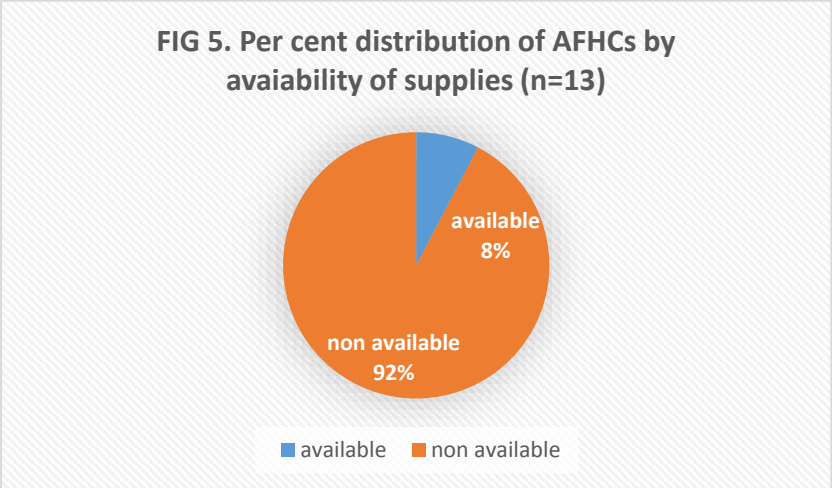
- No counsellor has been appointed at any AFHCs: No counsellor has been appointed till the day of visit

- Awareness amongst ASHAs related to this programme: 26% (3 non tribal and 2 tribal) ASHAs aware of the program and it's schedule

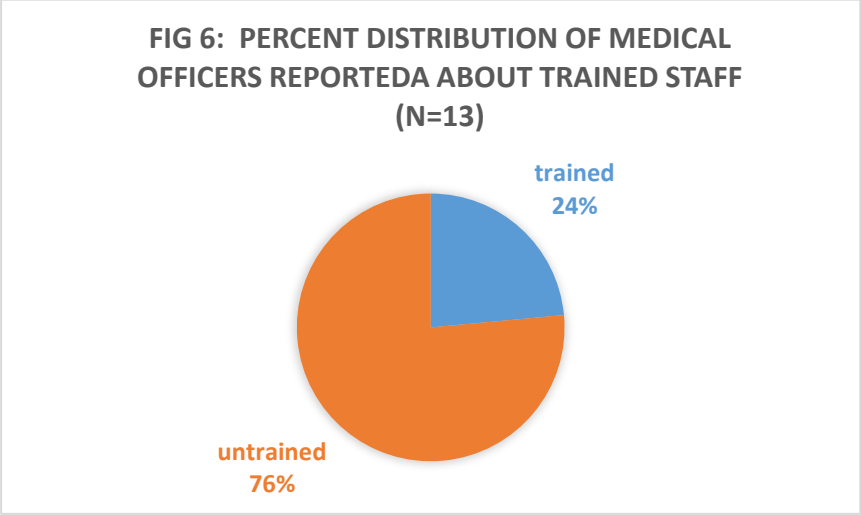


26% ASHAs were aware about Adolescent friendly health clinics and also about their schedule and running.

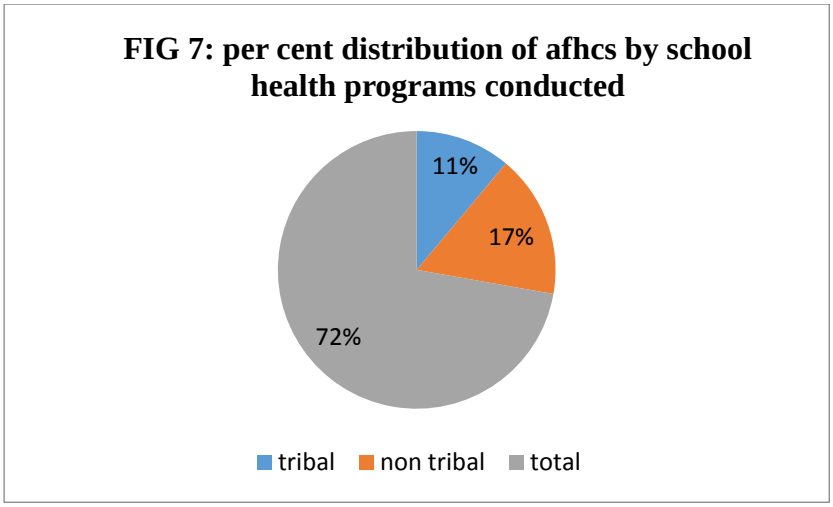
- Lack of Supplies: Inadequate resources to run the clinic. 20% facilities never had the infrastructure to provide services.



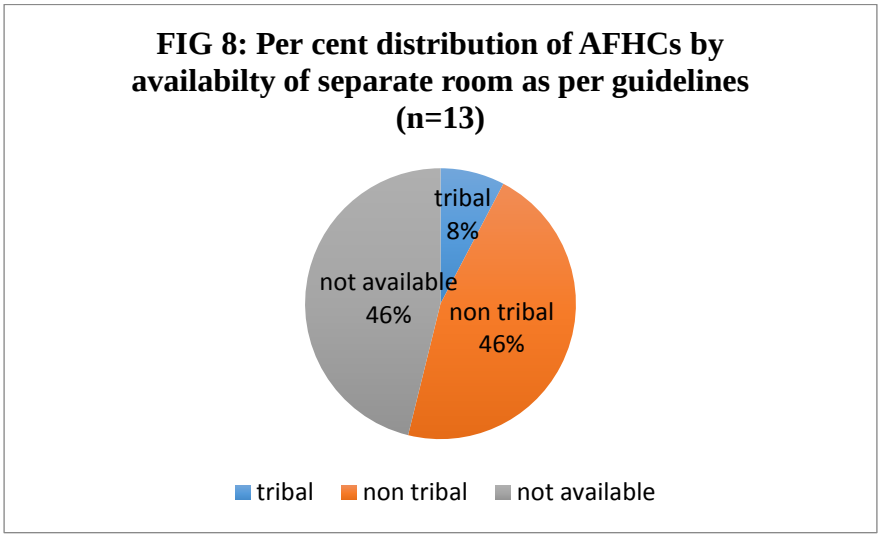
- Tribal area language gap is a major issue as understanding their language and delivering appropriate services is very difficult.
- All of the medical officers accepted that there is no direct supervision of peer educators, ASHA is the only link to convey messages.
- 9 of 13 Medical Officers reported that their nursing staff (head ANM) were not trained yet. However, they reported that they are planning to conduct train them on Adolescent Health:



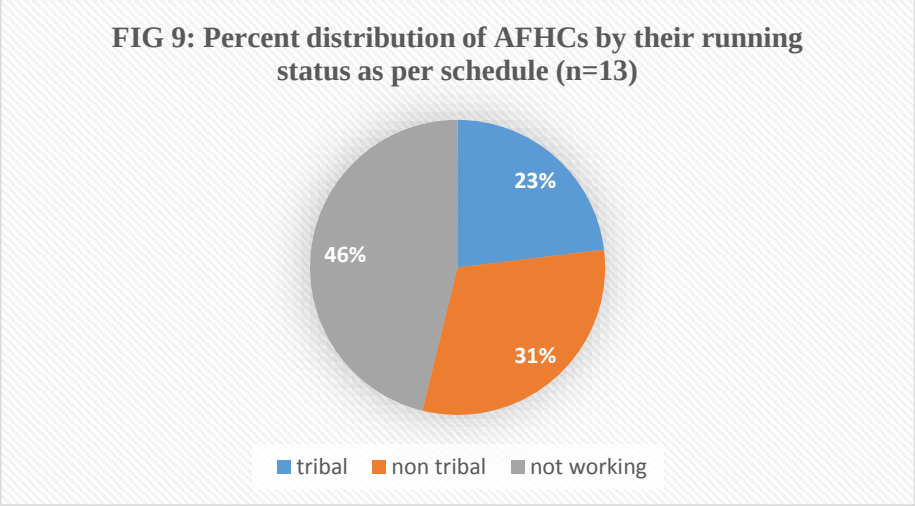
- School health programmes performed by AFHC



- Separate room for AFHC as per guidelines: 1 tribal and 6 non tribal AFHCs had separate room for adolescent clinic in facility as per guidelines.



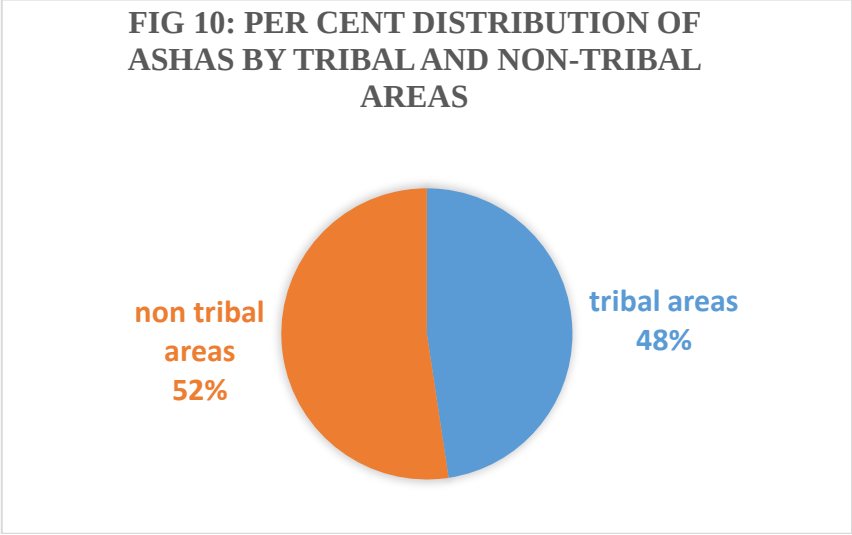
- AFHCs run as per schedule: 3 tribal and 4 non tribal AFHCs were working as per schedule till day of visit.



- Evidence of Medical Records: 1 non-tribal AFHC had the evidence of records.
- Availability of IEC material regarding adolescent health: 25% AFHCs had ARSH IEC material (1 tribal and 2 non-tribal).

Findings related to ASHAs (n=21)

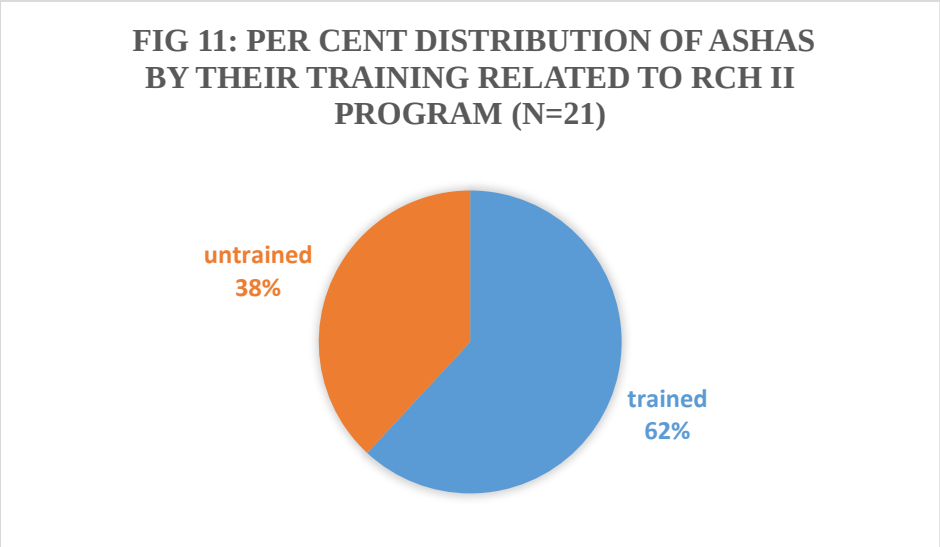
- ASHA serving in tribal and non tribal areas:



- According to ASHA the reasons for less involvement of beneficiaries to this program are :
  a. Keeping it secret from rest of the community
  b. Lack of money
  c. Not good connectivity or lack of conveyance

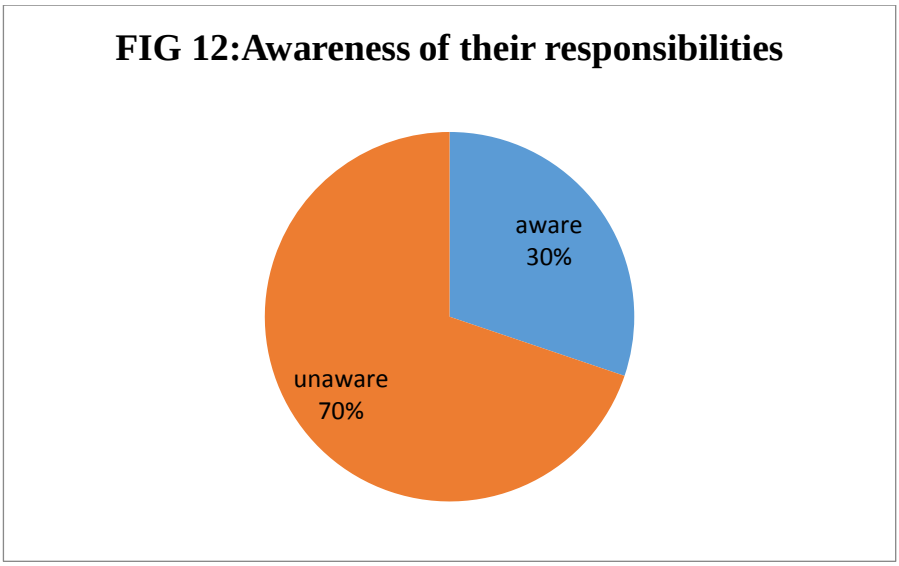
d. Adolescent were involved in family business, opportunity cost was keeping them away from the benefit

- None of the ASHA was aware of the eligible couple definition.
- ASHAs trained for RCH II Programme:



Peer educators (n=53)

- Peer educator approach was present in non tribal areas only.
- Few irregularities were found as respondents were beyond 20 years of age.
- Awareness about their responsibilities



- 22 out of 53 peer educators were unaware of they have been appointed as peer educators.
- All of them were getting incentives i.e 50 rs in month, in the form of bag cap, diary, book ,pen.
- 9 peer educators were performing activities to create awareness between peer,

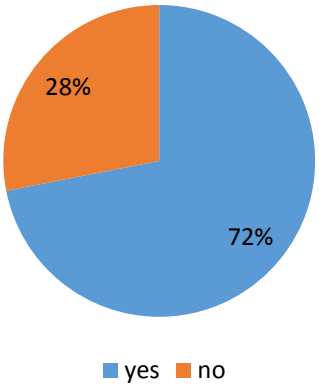
ANMs (n=21)

- Total of 24 ANMs were included and 21 were available.

- 3 ANMs were not aware of RCH program as they were newly appointed.

- Only 5 out of 21 were aware of ARSH program is running for adolescent beneficiaries and specific day and timings of AFHC clinics.

Fig13: Per cent distribution of ANMs by their awareness regarding ARSH program



- Only 2 ANMs were aware that their Sub -centre is the part of AFHC as the Adolescent friendly health club.

- 6 ANMs were correct in defining the real age group comes under ARSH program.

- In all 21 SC the main concerns of adolescent health are nutrition SRT/RTI family planning and early age pregnancies. However RTI/STI and early age pregnancies were more serious in tribal areas.

- 18 ANMs clearly knew about IEC material but none of them could show any iec regarding adolescent health.

- 16 ANMs did school health program to create awareness in particular age group about sexual health. Frequency of programs were once in year.

- In tribal areas mobile network was the concerning issues as ANMs said they do not get vehicle or help on time when its required for sending patients to facilities.

- 8 ANMs said that adolescents are not coming to facility as they have fear to community or feel shy as their identity will be revealed in community if they consult for sexual health.

Conclusion:

- As per the results for the better understanding it was reliable to represent the conclusion as SWOT analysis i.e. mentioned below:

Strengths:

1) All the functional AFHCs (46%) are in non tribal areas
2) One tribal and one non tribal AFHCs had adequate resources
3) 28% (3 non-tribal and 2 tribal) ASHAs aware of the program and its schedule.
4) 23% (3 non tribal and 2 tribal) ANMs were aware of this program and schedule.
5) 31% peer educators out of 53 available (70 total) were aware that they were appointed as peer educators. 30 % peer educators who were aware of their responsibilities were non-tribal
6) 10% (all in non-tribal areas) sub centres were found functional as adolescent health clubs.
7) 25% AFHCs had ARSH IEC material (1 tribal and 2 non tribal)
8) 26% AFHCs performed adolescent health programmes at schools (2 tribal and 3 non tribal)
9) AFHCs is a platform where counsel adolescents for delay the sexual exposure.

Weaknesses:

1) No counsellor has been appointed till the day of visit
2) Inadequate resources to run the clinic. 20% facilities never had the infrastructure to provide services
3) Peer approach was absent in tribal areas.
4) Lack of supervision
5) 46% ANMs were trained for RKSK but not aware about ARSH program

6) Communication /language gap in tribal areas
7) ANMs and ASHA were not aware of eligible couple definition
8) Biased Selection of ASHA and peer educators.
9) Lack of Convergence with government health functionaries and NGOs
10) Teenage marriages are resulting in increased IMR MMR and HIV in tribal areas.
11) Adolescents do not come to facilities

Opportunities:

1) 27% of early age pregnancies in Valsad and therefore, they can be contacted during ANC visits
2) Adolescents are demographic dividend and investing in adolescents will go long way
3) No private organizations are working in tribal areas for sexual health.

Threats:

1) Tribal Social norms and customs like SATHIPATI and live-in relationships.
2) Early age drop outs from school
3) HMIS is perceived as threat because the health functionaries may disclose the identity
4) AFHCs are established in health facilities and in general health facilities are the centres for treatment not for learning.
5) Lack pf public transport to tribal areas
6) Poor mobile network

ANNEXURE:

SNAPSHOT:

Date	Location	Task	Achievement
3 -10 April	DPMU	Observe and learn	Structure of health department and various health facilities.
11- 20 April	DPMU	Observe/National Health programs and formulate topic for project	Functioning of Health programs, Financing ,logistics , IEC material management, attended Taluka Meetings
21-30 April	DH, CHC, PHC, SC, AWC	Observational and Learning Visits	General working of health facilities and health workers
1-5 May	DPMU	Study proposal and discussion (preparation of tools)	Review of literature and pilot testing of tools
5-25 May	Field visits (in 6 talukas of Valsad district)	Data collection and Data entry	Data collected in tribal and non - tribal areas.
25-3 June	DPMU	Data Analysis and report making	Report discussed

QUESTIONNARE:

FOR MEDICAL OFFICER/ DOCTOR:

1. S.no. :
2. Date :
3. Taluka:
4. Facility:
5. Respondent:
6. Tribal / non tribal area:
7. Age
8. Sex
9. Education
10. Professional experience
11. Experience working at facility

Questions:

1. Have you received any special training for arsh programme?

a) Yes
b) No

2. Who organized the training programme?

3. Training details

a) date
b) duration
c) venue
d) resource persons
e) contents
f) useful(y/n)
g) (if yes useful, how it was useful, what learning has been utilized)----------

4. If yes, then what type of training does the government provide?

5. According to you what is the need of arsh programme?

6. What are your main concerns regarding adolescent issues?(rank the following)

a) Reproductive -----
b) Sexual ------
c) Maternal -------
d) Social -------
e) Personal-------
f) Physical changes/ physiological--------
g) psychological ----------

h) General --------

7. What additional resources do you require at your health facility for this programme?

8. Are the resources at your health facility adequate for this concern?
a) Yes
b) No
9. If no, then what is the reason?

10. Since when there is this lack in resources?
A) More than 1 year
B) 12 months
C) Between 9-12 months
D) Between 6-9 months
E) Between 3-6 months
F) Less than 3 months
G) Not available since start

11. According to you how much do the adolescents respond to these type of programmes? (on a scale of 1 to 10)

12. What type of services are provided at the afhc clinic?

13. What are the processes that are run in an adolescent friendly clinic (AFCI)?

14. What is the schedule of the training?

15. Do the adolescent clinics run as per schedule?
a) Yes
b) No

16. If no, specify the reason: ----------

17. Is there any other support centre in your area?
a) Yes
b) No

18. What staff is required for assistance?

19. Do you have sufficient staff for assistance of such cases?

a) Yes
b) No

20. Has your staff been provided training(as per what is present at the facility)

21. How many peer educators are there in your area? ---------

22. How do you monitor peer educator?

23. Is peer approach effective in your area ?

a) Yes
b) No, specify--------
c) Not available

24. Is there any behaviour change workshop/ programme for adolescents?

a) yes
b) no

25. How many adolescents report cases of:

a) Sit/rti ------
b) Early age pregnancy --------
c)Still birth ---------
d)Maternal death -------
d)Infant death -------
e) Social violence --------
f) any other problem ---------

26. What IEC material is available for assisting communication with the adolescents?

---

27. How do you assure the privacy of adolescents?

IF RESPONDANT IS ANM/ LHV:

1. S.NO. :
2. DATE :
3. TALUKA:
4. FACILITY:
5. RESPONDANT:
6. TRIBAL / NON TRIBAL AREA:
7. Age
8. Sex
9. Education
10. Professional experience
11. Experience working at facility

Questions:

1.are you aware of rch ii programme?
A) yes
B) no,
2.if yes, what programmes come under rch ii?
---
3) Do u know about arsh programme?
a) yes
b) no
if yes answer question 4) , if no answer 5
4)what age group people come under arsh programme?
---
5) do people of age group 10-19 years come to your facility with problems?
a) yes
b) no
6) if yes, which problems that are their main concern?

a) sexual reproductive health (SRH)issues
b) Gender based violence
c) nutrition related problems (IFA supplements)
d) Anaemia or any other blood disorders
e) Family planning (contraception and spacing)
f) Common rti/ sti
g) Menstrual disorders
h) Teenage pregnancy
i) Unsafe abortion
j) Personal/Menstrual hygiene
k) Basic health issues
l) Others , specify

7) any married person below 20 years age reports for:

a) marital problems
b) personal problems
c) family planning
d) if others, please specify

8) do you know about IEC material?
If yes,
9) how do you use it?

10) Have you ever met an adolescent about any of the above problems?

a) Yes
b) No

11)Have you ever received any training regarding arsh programme?

a) Yes
b) No

12)What care/ resources you provide to the adolescent: ----------

13) If ans to 10 is yes, what are there concerns:----------

14)What do you do to increase the awareness for adolescents in your area ?

15) Do you get assistance from the govt. for this program ?

if no what is the reason ? ----------

16)any other social groups or non government offering you help for adolescent health ?

17)what are the difficulties you facing in delivering the services ?

18)are there any individuals who consult you privately but don't want to come at the facility? if yes what is the reason ? ----------

19)what steps do you follow when a person comes for assistance?

IF RESPONDENT IS COUNSELLOR :

1. S.no. :
2. Date :

3. Taluka:
4. Facility:
5. Respondant:
6. Tribal / non tribal area:
7. Age
8. Sex
9. Education
10. Professional experience
11. Experience working at facility

Questions:

1. Have you been provided training for arsh programme?(y/n)

2. How any visits have you done : -------

3. What are the various concerns of adolescent in these areas?----------

4. How often does adolescents visit you

A) Daily

B) Weeky

C) Monthly

D) More than a month

5. What resources you require for more effective counselling other than what is provided by the government?

6. Is privacy being assured?(y/n)

7. Do you need any staff for assistance?(y/n)

8. Do you ever conduct group discussions?(y/n)

9. Have you ever referred any adolescent who is socially discriminated for their better treatment to any other organization ?(y/n)
10. Have you feedback system?(y/n)
11. What do you do with problems of adolescents when it is out of your work field , like judicial and domestic violence or discrimination cases ?
12. According to you, the IEC material provided by government is effective in your PHC area ?(y/n)
13. If no, please specify the above reason .

If respondent is peer educator :

1. S.no. :
2. Date :
3. Taluka:
4. Facility:
5. Respondant:
6. Tribal / non tribal area:
7. Age
8. Sex
9. Education
10. Experience working at facility

Questions:

1. Have you been given training regarding arsh programme?

a) Yes
b) No

2. What do you discuss with yours peers?
3. What are your responsibilities?

4. What issues generally come up?

5. Do you get any resources?(y/n)
6. If yes, What are those

7. What activities do you do with your peers?

8. How do you make people aware ?

9. How often do your peers approach you?

a) Daily
b) Weekly
c) Once in 15 days
d) monthly

10. How often do you visit your peers?

a) Daily
b) Weekly
c) Once in 15 days
d) Monthly

11. Do you get any incentives? (y/N)
12. If yes , specify --------

IF RESPONDENT IS ASHA:

1. S.no. :
2. Date :
3. Taluka:
4. Facility:
5. Respondant:
6. Tribal / non tribal area:
7. Age
8. Sex
9. Education
10. Professional experience

11. Experience working at facility

Questions:

1. What do you do when you meet people between age 10 – 19 with sexual and reproductive health problems ? (CAN OPT MORE THAN ONE option)

A) TAKE them to sub centre

B)take them to phc for ARSH clinics

C) recommend them to CHC

2. What do you do at your own level for such problems?

3. Have you been trained for RCH II program ?

4. How often you meet people with such problems ?

5 if yes, they all come for the consultation ?

6 if they are not coming for the consultation what are their reasons ?

Checklist (made with reference to the government provided checklist for the program)

I. IEC material related to RMNCH +A / RCH -II

II. IEC MATERIAL RELATED TO ARSH PROGRAMME

III. Workshops held till now

IV. Supervision visits

V. Iec name and specifications

VI. Training material

VII. Ifa report

VIII. Facility check:

1. Condoms (Nirodh)
2. Contraceptive pills(Mala -D and N , ocp's)
3. Emergency contraceptive pills(mifpristone etc)
4. Iron tablets
5. Iron with folic acid tablets
6. Vitamin a
7. Zinc tablets

8. Pregnancy testing kit(Nischay)
9. Referral card
10. Sanitary napkin
11. Dicylomine
12. Bp apparatus
13. Thermometer
14. Cold box
15. Oxygen bag and mask
16. Testing: hb, urine, blood sugar
17. Antibiotics:
18. Cap/inj. Ampicillin
19. Metronidazole
20. Amoxycillin
21. Inj. Gentamycin
22. Inj, ceftriaxone
23. Paracetamol
24. Cleanliness
25. Electricity
26. Adolescent tool kits
27. Location of facility :

A) Away from opd

B) Near opd/ crowded area

28. Does consultation ensure privacy
29. Bmi charts present
30. Human resource:

a) medical officer
b) anm/lhv
c) counsellor(ah/ictc/rmnch+a)

31. presence of committee
32. presence of health clubs

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