

2014

Provision of adolescent reproductive and sexual health services in India: Provider perspectives

Shireen J. Jejeebhoy
Population Council

K.G. Santhya
Population Council

Santosh Kumar Singh
Population Council

Shilpi Rampal
Population Council

Komal Saxena
Population Council

Follow this and additional works at: https://knowledgecommons.popcouncil.org/departments_sbsr-pgy



Part of the [Demography, Population, and Ecology Commons](#), [Family, Life Course, and Society Commons](#), [Gender and Sexuality Commons](#), [International Public Health Commons](#), and the [Women's Health Commons](#)

[How does access to this work benefit you? Click here to let us know!](#)

Recommended Citation

Jejeebhoy, Shireen J., K.G. Santhya, Santosh Kumar Singh, Shilpi Rampal, and Komal Saxena. 2014. "Provision of adolescent reproductive and sexual health services in India: Provider perspectives." New Delhi: Population Council.

This Report is brought to you for free and open access by the Population Council.

किशोर-किशोरी
मैत्रीपूर्ण स्वास्थ्य शिक्षा केन्द्र

**PROVISION OF ADOLESCENT
REPRODUCTIVE AND SEXUAL
HEALTH SERVICES IN INDIA:
PROVIDER PERSPECTIVES**

Shireen J. Jejeebhoy
K. G. Santhya
Santosh Kumar Singh
Shilpi Rampal
Komal Saxena





The Population Council confronts critical health and development issues—from stopping the spread of HIV to improving reproductive health and ensuring that young people lead full and productive lives. Through biomedical, social science, and public health research in 50 countries, we work with our partners to deliver solutions that lead to more effective policies, programs, and technologies that improve lives around the world. Established in 1952 and headquartered in New York, the Council is a nongovernmental, nonprofit organization governed by an international board of trustees.

Population Council

Zone 5A, Ground Floor
India Habitat Centre, Lodi Road
New Delhi, India 110003
Phone: 91-11-24642901
Email: info.india@popcouncil.org
Website: www.popcouncil.org

Suggested citation: Jejeebhoy, S. J., K. G. Santhya, S. K. Singh et al. 2014. *Provision of Adolescent Reproductive and Sexual Health Services in India: Provider Perspectives*. New Delhi: Population Council.

PROVISION OF ADOLESCENT REPRODUCTIVE AND SEXUAL HEALTH SERVICES IN INDIA: PROVIDER PERSPECTIVES

Shireen J. Jejeebhoy

K. G. Santhya

Santosh Kumar Singh

Shilpi Rampal

Komal Saxena



**POPULATION
COUNCIL**

Ideas. Evidence. Impact.

List of Contents

List of Tables	v
Acknowledgements	vii
Chapter 1 Introduction	1
Chapter 2 Capacity building exposure of health care providers for adolescent friendly health service delivery	12
Chapter 3 Provider perspectives on the provision of sexual and reproductive health information, counselling and services to adolescents and youth	18
Chapter 4 Provider interaction with adolescents and youth	24
Chapter 5 Provider perspectives on barriers to providing services to adolescents and youth	38
Chapter 6 Summary and recommendations	47
References	53
Authors	54
List of investigators	55

List of Tables

Table 1.1:	Profile of the study districts and states	4
Table 1.2:	Description of study components	7
Table 1.3:	Selected background characteristics of study participants	9
Table 3.1:	Responses of health care providers about persons considered ideal to inform girls and boys about puberty and sexual and reproductive health matters	22

Acknowledgements

This study has benefited immeasurably from the inputs of many. We are extremely grateful to the John D. and Catherine T. MacArthur Foundation for their financial support which made this study possible.

The Population Council undertook this study at the request of the Ministry of Health and Family Welfare, Government of India. We are grateful for this opportunity and for the unstinting support that we received from the Ministry at all stages of the study. We take this opportunity to express our special thanks to Dr. Suresh Mohammed, IPS, formerly Director, Reproductive and Child Health, Ministry of Health and Family Welfare, Government of India, New Delhi; Dr. Kiran Sharma, formerly National Professional Officer, World Health Organization India Country Office, New Delhi; and Ms. Medha Gandhi, formerly Consultant, Adolescent Reproductive and Sexual Health, Ministry of Health and Family Welfare, Government of India, New Delhi.

We could not have successfully completed this study without the support of the Departments of Health and Family Welfare in Jharkhand, Maharashtra and Rajasthan. We would like to acknowledge with gratitude the support that we received from Shri Aboobacker Siddique P., IAS, formerly Mission Director, Jharkhand Rural Health Mission Society, Government of Jharkhand; Dr. Vinod Kumar Saha, formerly Chief Medical Officer, Jamtara District, Government of Jharkhand; Dr. Gopal Srivastava, formerly Chief Medical Officer, Palamu District, Government of Jharkhand; Shri Vikas Kharge IAS, Commissioner (Family Welfare) & Director (National Rural Health Mission), Government of Maharashtra; Smt. Gayatari Rathore, formerly Mission Director (National Rural Health Mission), Directorate of Medical and Health Services, Government of Rajasthan; and Ms. Archana Sharma, State NGO Coordinator/Consultant (Adolescent Reproductive and Sexual Health), Directorate of Medical, Health & Family Welfare, Government of Rajasthan. We would also like to acknowledge the contribution of various officials at the health facilities in which the study was conducted in Jharkhand, Maharashtra and Rajasthan.

We are grateful to Dr. Dinesh Agarwal, Policy Lead - Health and Disease Control, IPE Global Private Limited, New Delhi, and Ms. Dipa Nag Chowdhury, Deputy Director India, The John D. and Catherine T. MarArthur Foundation, New Delhi, for reviewing the earlier draft of this report and providing insightful comments and suggestions.

At the Population Council, several colleagues have supported us in both the technical and administrative aspects of this study. We are grateful to Rajib Acharya for reviewing the study design and helping with the training of field investigators, Shagun Sabarwal (formerly Programme Officer, Population Council) for analysing the survey data and M.A. Jose for ably managing the administrative aspects of the project. We would like to thank Jyoti Moodbidri for her editorial contributions. We also appreciate the efforts of our investigators who painstakingly collected the data and Monika Bindra, Sandeep Sharma, Anakshi Ummat Upadhyay and Samiha Grewal who diligently translated the transcripts.

Finally, and most importantly, we would like to thank the Accredited Social Health Activists (ASHAs), Auxiliary Nurse Midwives (ANMs), Staff Nurses, Counsellors and Medical Officers (MOs) in Jharkhand, Maharashtra and Rajasthan who generously gave us their time and shared their views and experiences with us.

Shireen J. Jejeebhoy
K. G. Santhya
Santosh Kumar Singh
Shilpi Rampal
Komal Saxena

Chapter 1

Introduction

The recently launched *Rashtriya Kishor Swasthya Karyakram* (RKSK) seeks to enable all adolescents and youth to realise their full potential by making informed and responsible decisions concerning their health and well-being and by accessing the services and support they need to implement their decisions (Ministry of Health and Family Welfare, 2014). In order to realise this vision, the RKSK framework acknowledges the strengthening of Adolescent Friendly Health Clinics (AFHCs) and providing correct knowledge and information through counselling services as two of its seven critical components (7Cs). As the government makes effort to roll out the RKSK programme at scale across the country, reviewing the experiences of the AFHCs established under the National Adolescent Reproductive and Sexual Health Strategy, the predecessor of RKSK, can provide useful lessons. With this in view, at the request of the Ministry of Health and Family Welfare, the Population Council conducted an assessment of AFHCs from the perspectives of adolescents and youth and of health care providers in three states in India. This report presents the findings of the study conducted among health care providers, including Accredited Social Health Activists (ASHAs), Auxiliary Nurse Midwives (ANMs), Counsellors and Medical Officers (MOs). Findings describing the perspectives of adolescents and youth are presented in a separate report (Santhya et al., 2014).

Study objectives

The goal of this study was to identify, from the perspectives of youth aged 15–24 and health care providers ranging from frontline workers to those based at AFHCs, the key components of sexual and reproductive health services that are responsive to the needs of adolescents and youth, and feasible at community and facility levels as well as to make recommendations regarding refinements in content and approaches for training various cadres of health care providers to better address these needs. Specifically, the study sought to

- Explore the perspectives of adolescents and youth about their health needs; the obstacles they face in obtaining sexual and reproductive health information, supplies and services, and their preferences about how and by whom information and services should be provided; and
- Explore the perspectives of health care providers, including ASHAs, ANMs, Counsellors and Medical Officers about their role in responding to the sexual and reproductive health needs of adolescents and youth, and the factors that facilitate or constrain them from providing information and services and effectively reaching out to adolescents and youth.

Background and rationale for the study

One of the key objectives of the RKSK is to increase the accessibility of quality counselling and health services for as well as their utilisation by adolescents and youth; consequently, strengthening AFHCs and providing quality counselling services are among the seven critical components (7Cs) identified in the RKSK to achieve this objective (Ministry of Health and Family Welfare, 2014). The RKSK seeks to develop community-based interventions that will offer information and commodities such as sanitary napkins, iron and folic acid tablets and non-clinical contraceptives, and strengthen facility-based services that will provide need-based counselling, and specialised medical and para-medical services to adolescents and youth.

With regard to facility-based services, the RKSK promises to establish at the sub-centre level, routine sub-centre clinics that will provide counselling on common health concerns of adolescents and youth and haemoglobin testing by ANMs or male Multipurpose Workers (MPWs). At the Primary Health Centre (PHC) level, it will run weekly AFHCs that will offer counselling services by ANMs, and management of common health problems and referrals by MOs. At the Community Health Centre (CHC) level, it will establish daily AFHCs that will provide counselling services by dedicated counsellors, and management of common health problems and referrals by MOs and Staff Nurses. At the District Hospital (DH) level, in addition to what is being promised at the CHCs, biweekly speciality AFHCs (S-AFHCs) will be conducted to offer management of speciality problems and referrals by gynaecologists and paediatricians. Finally, at the medical college level, S-AFHCs for speciality care will be conducted five days a week.

Adolescent Friendly Health Centres have been established as part of the earlier National Adolescent Reproductive and Sexual Health Strategy to provide preventive, promotive, curative and referral services to adolescents (Ministry of Health and Family Welfare, 2006a). Although known as 'adolescent' friendly clinics, these clinics are designed to meet the specific needs of young people, that is, adolescents (10–19 year-olds) and youth (15–24 year-olds). As of 2013, a total of 6,220 AFHCs have been established (Kumar, 2014). The AFHCs, however, have not made significant inroads into providing services for young people as evident from the *Youth in India: Situation and Needs* study and other evaluations. For example, in the *Youth in India* study, just seven percent of young men and three percent of young women reported that they had ever received information on sexual matters from a health care provider (International Institute for Population Sciences and Population Council, 2010). Likewise, of those who were aware of contraceptive methods, just 13–14 percent had received information on contraception from a health care provider. Besides, as many as 43 percent and 52 percent of young men and women, respectively, reported that they would be uncomfortable to obtain contraceptive supplies from any health care provider. Additionally, married youth were just somewhat more likely to report contact with health care providers than were the unmarried.

Moreover, a few evaluations of AFHCs, conducted in the early days of their establishment, have noted their uneven distribution, the limited utilisation of services by young people and the poor quality of services provided at these clinics (Centre for Operations Research and Training, 2009; International Institute of Health Management Research, 2010). Even in Gujarat, one of the states in which AFHCs are concentrated, evidence from an evaluation of 21 Adolescent Reproductive and Sexual Health (ARSH) clinics observes that not all were functional. Very few had separate OPD (Out-Patient Department) hours and days designated for adolescents and youth or provided auditory and visual privacy. Additionally, few young people were aware of these clinics and even fewer would use them because of lack of privacy, fear of attending clinics located in health centres and hospitals, and fear of service provider attitudes (Centre for Operations Research and Training, 2009).

The need for training programmes to orient various cadres of health care providers about the special needs of adolescents and youth has also been reiterated in the RKSK. The programme promises to provide both pre-service training and continuing education, including refresher courses and has revised or newly prepared orientation modules to enhance the capacity of various cadres, including peer educators, ANMs/Lady Health Visitors (LHVs), Counsellors and MOs (Ministry of Health and Family Welfare, 2014). Under the earlier National Adolescent Reproductive and Sexual Health Strategy, orientation modules were developed and training programmes were conducted to orient ANMs and MOs in the provision of various sexual and reproductive health services to adolescents and youth (Ministry of Health and Family Welfare, 2006b; 2006c). Likewise, the needs of adolescents and youth were also incorporated into ASHA training programmes (Ministry of Health and Family Welfare, 2006d).

Although training programmes on adolescent reproductive and sexual health have been imparted to various categories of health care providers, not all ASHAs, ANMs, Staff Nurses, MOs and other personnel have been trained or sensitised to the unique needs of adolescents and youth (Ministry of Health and Family Welfare, 2009). Moreover, training has not always combined a focus on the content of information to be imparted with strategies for imparting the information or attention to the clarification of values. Evidence from a small-scale study in Andhra Pradesh and Madhya Pradesh indicates that a major factor that might hinder the ability of health care providers to provide sexual and reproductive health services to young people is their discomfort in doing so. While most stakeholders were comfortable discussing such matters with married young women, sizeable proportions reported discomfort in addressing young men and even unmarried young women. Male health care providers were less uncomfortable providing information and services to young women than were female providers about providing such services to young men (Santhya, Jejeebhoy and Ghosh, 2007). Evaluations of AFHCs in Maharashtra and Gujarat also observe that the training of providers in ARSH service delivery is inadequate (Centre for Operations Research and Training, 2009; Institute of Health Management Research, 2010).

Likewise, although the guidelines for ASHAs do highlight, in general terms, the vulnerability of young women, and although over four-fifths (81%) of the 8.5 lakh enlisted ASHAs have received training in adolescent and youth issues (Ministry of Health and Family Welfare, 2012), the need still remains to provide more specific information on possible strategies for delivering services to young people. Indeed, the mid-term appraisal of the Eleventh Five Year Plan noted that ASHAs were inadequately trained, and because of their focus on the *Janani Suraksha Yojana* (a conditional cash transfer programme to promote institutional delivery and safe motherhood under the National Rural Health Mission), their activities have largely concentrated on facilitating institutional deliveries (Planning Commission, 2011). Evidence from a recent study of some 150 ASHAs in two districts of Rajasthan indicates that

their interactions with adolescent girls and young women remain limited; for example, just one-third of ASHAs reported that they had counselled newly married women about contraceptives (Santhya, Jejeebhoy and Francis, 2011a). Similarly, a companion study of women who had delivered in the one year preceding the interview reports that while just a quarter of young mothers had received assistance from the ASHA during pregnancy, even fewer had received assistance during delivery and the postpartum period (Santhya et al., 2011b).

Clearly, there exists a need to identify approaches to enhance service delivery through AFHCs on the one hand and to generate demand for such services among adolescents and youth on the other. There is also a need to identify what services adolescents and youth require, what is feasible at community and facility levels, and what is feasible for implementation by different cadres of health care providers.

Study setting

The study was conducted in three states—Jharkhand, Maharashtra and Rajasthan—selected jointly with the Ministry of Health and Family Welfare, Government of India.

The states reflect heterogeneity both geographically as well as in terms of the situation of young people, and their social, economic and demographic characteristics. Maharashtra is among the more economically progressive states in the country, while Jharkhand and Rajasthan are among the lesser developed states (Ministry of Statistics and Programme Implementation, 2008). Similarly, while Maharashtra is among the most urbanised states, Jharkhand and Rajasthan are characterised by large rural populations (Office of the Registrar General and Census Commissioner, 2011). The literacy rate ranged from a low of 67–68 percent in Jharkhand and Rajasthan to a high of 83 percent in Maharashtra.

Evidence from the *Youth in India: Situation and Needs* study indicates that sexual and reproductive health services have not reached most young people in these states (International Institute for Population Sciences and Population Council, 2010). For example, few young men and women had ever practised contraception within marriage: between 22 percent (Jharkhand) and 36–38 percent (Maharashtra and Rajasthan) among married young men, and between 24 percent (Jharkhand and Rajasthan) and 30 percent (Maharashtra) among married young women. Consistent condom use within pre-marital relationships was even less frequent—6–7 percent of young men who had engaged in a pre-marital relationship in Jharkhand and Rajasthan and 22 percent in Maharashtra reported consistent condom use; the corresponding percentages among young women were 2–4 and seven, respectively. Just 11–15 percent of young men in these states reported a health care provider as a source of information on contraception; among young women, 8–11 percent in Jharkhand and Rajasthan and 23 percent in Maharashtra so reported. A total of 180 AFHCs were functional in Jharkhand and 140 in Maharashtra (State National Rural Health Mission office in Jharkhand and Maharashtra, personal communication).

The present study was located in two districts in each selected state. The districts that were close to the state averages on such indicators as literacy rate of young women aged 15–24 and percentage of married young women aged 15–24 currently using contraceptive methods were first listed. Subsequently, as suggested by the Ministry of Health and Family Welfare, from the district list of each state, we selected one district in which the AFHCs had been functional for quite some time and one in which such clinics had recently been launched, for locating the study. These districts namely, Jamtara and Palamu in Jharkhand, Nashik and Chandrapur in Maharashtra, and Bhilwara and Karauli in Rajasthan, represented districts with long- and recently-established AFHCs, respectively, in the three states. A few key indicators of the study districts and states are presented in Table 1.1.

The study was fielded in rural areas of the study districts. Within each district, in consultation with the district health department, and using the records made available to us by the state health department, we prepared a list of all the CHCs (in Jharkhand and Rajasthan) and sub-district/rural hospitals (in Maharashtra) which had an AFHC. We restricted our study to AFHCs located in CHCs or sub-district/rural hospitals because at the time of our fieldwork, AFHCs had not been established at PHCs or those that existed were not functional. Based on the date of establishment of the AFHC and whether or not it was functional, one AFHC established before 2010 and one established in 2010 or later were selected randomly. In total, therefore, the facility-based components of this assessment were conducted in 12 AFHCs from the three states taken together. We note that in Rajasthan, there was no designated facility or fixed timings for providing services specifically to adolescents and youth in the CHC. These CHCs, however, were shown as housing AFHCs in the records of the state health department and provided services for adolescents and youth in the general OPD.

Table 1.1: Profile of the study districts and states

Characteristics	Jharkhand			Maharashtra			Rajasthan		
	Jamtara	Palamu	State	Chandrapur	Nashik	State	Bhilwara	Karauli	State
Population ¹	790,207	1,936,319	32,966,328	2,194,262	6,109,052	112,372,972	2,410,459	1,458,459	68,621,012
Overall sex ratio (F/M) ¹	959	929	947	959	931	925	969	858	926
Child sex ratio (0–6 years) (F/M) ¹	948	947	943	945	882	883	916	844	883
Male literacy (%) ¹	76.9	76.3	78.5	88.7	88.0	89.8	77.2	83.0	80.5
Female literacy (%) ¹	50.1	53.9	56.2	73.7	73.4	75.5	47.9	49.2	52.7
Of those married in the last three years, females married before age 18 (%) ²	40.4	36.0	35.9	2.1	22.4	17.6	59.6	47.2	39.9
Married women aged 15–24 currently using any contraceptive method (%) ²	10.8	9.6	11.9	27.7	28.0	26.6	24.7	16.0	22.7

Sources: ¹Office of the Registrar General and Census Commissioner, 2011. ²International Institute for Population Sciences, 2010.

For the community-based survey of adolescents and youth, we selected four villages systematically from among villages surrounding each AFHC, that is, within a distance of 5–10 kilometres from the AFHC. Specifically, we first collected information about all the villages surrounding the selected AFHCs. We then arranged the villages by their population size in ascending order, cumulated the population of the villages, and selected four villages systematically, using probability proportional to size. Thus, the community-based survey was located in a total of 48 villages from the three states taken together.

Study design

A community- and facility-based, multi-component study, using both quantitative and qualitative methods, was conducted between September, 2012 and January, 2013. The study comprised seven components in all, as summarised in Table 1.2 and described in detail in the following paragraphs. The first four components, involving in-depth interviews with ASHAs, ANMs, Counsellors and MOs, are explored in detail in this report; the latter three are explored in a companion report (Santhya et al., 2014).

In-depth interviews with ASHAs: In-depth interviews were conducted with ASHAs to better understand their perspectives about their interactions with adolescents and youth and the constraints that they face in reaching out to these groups. ASHAs were recruited from the survey villages; one ASHA was selected opportunistically from each village. A total of 48 ASHAs—16 ASHAs per state (4 per AFHC area)—were targeted for the in-depth interviews. As seen from Table 1.2, a total of 46 ASHAs were interviewed in depth from the three states. The discussion focused on the participant's experience as an ASHA; training received, particularly, in providing services to adolescents and youth; perceptions about the training received; interactions with adolescents and youth and constraints, if any, in reaching out to them; perceptions about the sexual and reproductive health concerns of adolescents and youth and their service needs, and suggestions for enhancing the ASHA's role and skills in meeting the health service needs of adolescents and youth.

In-depth interviews with ANMs, Counsellors and MOs: In-depth interviews were conducted with ANMs and MOs in the selected AFHCs to better understand their role in the AFHCs and the constraints that they face in providing services to adolescents and youth. As mentioned earlier, in Rajasthan, dedicated AFHCs were not available, but ARSH services that would have been provided in an AFHC were provided in the general OPD at the CHC. If any of the AFHCs (or OPDs providing ARSH services) had more than one ANM or MO and they were available for interview during the week in which the investigation was conducted, one of them was selected purposively. Thus, whereas a total of eight ANMs and four MOs per state were targeted, in effect, a total of 20 ANMs and 11 MOs were interviewed in-depth from the three states taken together. We note that of the 20 health care providers who were interviewed under the category of ANMs, three were Staff Nurses and one was a General Nurse Midwife (GNM). We also note that in Maharashtra, three Counsellors were also interviewed in-depth as they managed the AFHC as well. The in-depth discussion focused on the participant's experience as an ANM, Counsellor or MO; training received, particularly, in providing services to adolescents and youth; perceptions about the training received, services available and provided to adolescents and youth visiting the AFHCs; perceptions about the utilisation of these services by adolescents and youth and the constraints that they may face in accessing these services, as well as about the sexual and reproductive health concerns of adolescents and youth and their health service needs; views about the constraints that ANMs, Counsellors and MOs face in providing services to adolescents and youth, in general, and through AFHCs in particular, and suggestions for enhancing the capability of ANMs, Counsellors and MOs to provide the required services to adolescents and youth.

Observation of service delivery at AFHCs using mystery clients: Mystery client visits were undertaken to better understand facility-based interactions between young people and MOs and other health care providers, including nurses and ANMs. We followed the procedure for conducting mystery client visits as suggested in the guide published by Pathfinder International (Boyce and Neale, 2006). The study team identified young women and young men to serve as mystery clients with the help of local NGOs, from villages that were not located in close proximity to the AFHCs selected for the study. A young person was considered eligible to serve as a mystery client if she/he was aged between 18 and 24 years, she/he resided in a village that was not located in close proximity to the AFHC, she/he had not been to the AFHC before, she/he demonstrated a talent for role playing, and she/he displayed openness about discussing sexual and reproductive matters. The study team recruited four youth—two females and two males—per clinic to serve as mystery clients.

The mystery clients were trained by the study coordinators. During the training, the study coordinators familiarised the mystery clients with the scenarios they were expected to act out at the AFHC, helped them phrase their question(s) to the health care provider, gave them an opportunity to do a role play of the scenarios assigned to them and briefed them on potential criteria for evaluating the quality of services. The scenarios assigned to mystery clients included an unmarried young woman, aged 17, who felt pressured by her boyfriend to engage in pre-marital sex and was seeking oral contraceptives; a married young woman, aged 20, seeking information on protective actions to be taken in a marital relationship characterised by her husband's extra-marital partnership and perpetration of marital violence; an unmarried young man, aged 19, who was in a relationship with a girl and was seeking condoms; and a married young man aged 22, who had had sex with sex workers and wanted to undergo an HIV test. The mystery clients were informed about the AFHC that they should visit, and asked to observe everything that the health care provider did or said and not to mention any affiliation with the study during their visit. They were also instructed to refuse to undergo any physical examination. To keep the experience of the mystery clients as close as possible to that of genuine clients, no mystery client was sent to more than one clinic in a district. Mystery clients made visits in pairs—one was assigned to serve as the client and the other to serve as an additional observer—to minimise recall bias (Boyce and Neale, 2006), and were paid a monetary compensation of Rs. 1,000 per interview (approximately \$20) to cover their transportation and any other expenses incurred. A total of 24 mystery client visits—one visit each by a female and a male pair per clinic—were targeted and were successfully conducted.

Debriefing of mystery clients was done by the study team supervisors immediately after the AFHC visit at a place convenient to the mystery clients. A semi-structured questionnaire, prepared and translated into the local language, was used for debriefing. Each mystery client and observer was debriefed separately. They were probed about their experience in availing of services at the AFHC (registration process, waiting time to see the health care provider etc.), the information given by the provider (content, comprehensiveness etc.) and the provider's behaviour toward the client (provider objectivity, level of comfort in discussing sexual and reproductive health matters with the client etc.). We note that the narratives of the client and the observer did not differ in any of the mystery client visits; rather, their narratives supplemented each other's insights.

Exit interviews with clients accessing services at AFHCs: Exit interviews were conducted with adolescents and youth who had availed of services at the selected AFHCs to assess the characteristics of clients visiting these clinics, the health problems/concerns for which young people sought services from these clinics and their experiences at these clinics. Respondents for the exit interviews included adolescents and youth aged 15–24 who sought services from the AFHCs on the days when the research investigators from the study team—one female and one male—were stationed at these clinics. The research investigators were posted at each AFHC for a maximum of four to five clinic days. The sample size for the exit interviews was fixed at 10 per clinic and therefore, a total of 120 exit interviews were planned. However, we note that the study team was able to conduct just five exit interviews—four in Jharkhand and one in Maharashtra—because hardly any young people visited the AFHCs for services on the days when the exit interviews were conducted.

Female and male investigators administered a short, semi-structured questionnaire prepared in the local language, to female and male clients, respectively. The interview was conducted in the clinic premises that offered privacy for the interview. The questionnaire contained questions regarding the respondent's socioeconomic background, health problems/concerns experienced, treatment-seeking patterns for the problem experienced, perceptions about and experiences at the AFHC, the quality of services received and so on.

Survey of adolescents and youth in the community settings: To better understand the awareness of AFHCs among adolescents and youth and the barriers that they face in accessing services from these clinics, a survey was conducted among adolescents and youth aged 15–24, residing in selected villages surrounding the 12 AFHCs identified for the study. As mentioned above, four villages surrounding each AFHC, and therefore, a total of 48 villages, were selected for the survey. The sample size for interviews was fixed at 40 adolescents and youth per village—10 each of unmarried adolescents and young women, married adolescents and young women, unmarried adolescents and young men, and married adolescents and young men—and, therefore, 160 adolescents and young men and young women per AFHC area, and 640 adolescents and young men and young women per state. This sample size was inflated to 192 for each clinic area, 768 per state and 2,304 in all, assuming a 20 percent non-response rate for individual interviews.

A rapid household listing exercise was conducted in the study villages to identify married and unmarried young men and young women aged 15–24. The listing team visited all the households in the selected villages containing less than 300 households, and all households in selected segments (by probability proportional to size) of approximately 300 households in larger villages. Information was collected on the age, sex and marital status of all 15–24 year-old usual residents of the household from an adult member of the household and four sampling frames were prepared, one each for married males, unmarried males, married females and unmarried females who were eligible for enrolment in the study. These sampling frames were used to randomly select the required number of respondents from each category of adolescents and youth. Within each household, no more than one male and one female respondent were interviewed, resulting in a maximum of two interviews from any one household.

In each of the three states, the sample was weighted at the village level for males and females separately. The sample weight for each state (the state weight) was calculated based on the differential non-response rates as well as design weights for each village. For the combined sample (three states together), the overall sample weights were calculated as the product of the design weight for each state and the state weight. Finally, the weights were normalised at the state as well as overall levels so that the total number of weighted cases equalled the total number of unweighted cases.

Table 1.2: Description of study components

Study components	Respondents	Sample size targeted	Sample size reached
In-depth interviews with ASHAs	ASHAs residing in villages surrounding the selected AFHCs	48 (4 per clinic; 16 per state)	46 (15 in Jharkhand; 15 in Maharashtra; 16 in Rajasthan)
In-depth interviews with ANMs	ANMs serving the selected AFHCs ¹	24 (1–2 per clinic; 8 maximum per state)	20 (8 each in Jharkhand and Rajasthan; 4 in Maharashtra)
In-depth interviews with Counsellors*	Counsellors serving the selected AFHCs	None	3 (all in Maharashtra)
In-depth interviews with MOs	MOs serving the selected AFHCs ¹	12 (1 per clinic; 4 per state)	11 (4 each in Jharkhand and Rajasthan; 3 MOs in Maharashtra)
Mystery client interviews	18–24 year-old young men and young women residing in villages located away from the selected AFHCs and willing to act as mystery clients	24 (1 female and 1 male per clinic; 8 per state)	24 (8 each in Jharkhand, Maharashtra and Rajasthan)
Exit interviews	15–24 year-old young men and young women seeking services from the selected AFHCs	120 (10 per clinic; 40 per state)	5 (4 in Jharkhand and 1 in Maharashtra)
Survey of youth in the community	Adolescents aged 15–19 and youth aged 20–24, residing in selected villages surrounding the selected AFHCs	2,304 (192 per clinic; 768 per state)	2,131 (736 in Jharkhand; 682 in Maharashtra; 713 in Rajasthan)

Note: *In Maharashtra, the AFHCs were managed by Counsellors; ¹In Rajasthan, services for adolescents and youth were provided in the general OPD of the CHC.

A detailed questionnaire was administered to eligible respondents in their local language. The questionnaire contained questions regarding the respondent's socioeconomic background; selected sexual and reproductive health problems and mental health concerns experienced in the last three months; treatment-seeking patterns; reasons for not seeking treatment for those who had not sought treatment; awareness and perceptions of AFHCs; difficulties faced in seeking treatment from AFHCs, if any; interactions with frontline health care providers and community health workers namely, ASHAs and Anganwadi Workers (AWWs); perceptions about the key health problems faced by adolescents and youth, in general; the type of health services that adolescents and youth require, their preferences regarding the cadre of health care providers and the facilities that should provide these services and so on.

Out of the expected sample of 2,304 adolescents and youth in the three states (768 per state), a total of 2,137 were contacted for the interview (96% in Jharkhand; 93% in Rajasthan; 90% in Maharashtra); inability to contact the remaining largely reflected the paucity of married young men in the age group of 15–24. Of those contacted, 99 percent (a total of 2,131 adolescents and youth) were interviewed in the three states taken together; one percent either refused to participate in the survey or did not complete the interview. State-specific response rates were 99 percent in Jharkhand and Rajasthan, and 100 percent in Maharashtra.

We note that all the interviews were conducted in the local language—Marathi in Maharashtra, and Hindi in Jharkhand and Rajasthan. The survey questionnaires and in-depth interview guides were translated into the local language, back-translated, and field-tested among a small group of adolescents and youth and health care providers to see whether any questions needed to be modified.

Interviewers were recruited locally. A week-long training workshop was organised to acquaint them with the questionnaires and in-depth interview guides. Data received from the field were regularly checked to assess quality and feedback was provided to the investigators. The survey data were analysed using SPSS/STATA 12.0. The in-depth interviews were tape-recorded with the consent of the participants, transcribed in the local language and translated into English. The transcripts were coded thematically.

Background characteristics of study participants

A profile of the health care providers who participated in the study, by selected background characteristics, is presented in Table 1.3. Age distributions suggest that in all three states, ASHAs were typically aged 25–29 and 30–39 (35 of 46 ASHAs), while ANMs, Counsellors and MOs were largely in the ages 30 to 49 (14 of 20 ANMs, all three Counsellors, eight of 11 MOs). Educational profiles suggest that about one-half of all ASHAs had less than a high school education (21 of 46), most ANMs had completed Class 12 (13 of 20), all three Counsellors held a Master's degree, and among the 11 MOs, seven held MBBS degrees and four were specialists.

Overall, ASHAs in Jharkhand and Rajasthan had worked on the job for five to nine years, and in Maharashtra for fewer years (one to four years). The remaining three cadres of health care providers had worked for varying numbers of years; for example, 13 of the 20 ANMs and all the three Counsellors had worked for five or more years.

Given the relatively recent introduction of AFHCs, it is no surprise that most ANMs, Counsellors and MOs had been associated with AFHCs for fewer than five years. For example, 13 of the 20 ANMs and nine of the 11 MOs had been associated with the AFHC for less than two years.

Job profile of health care providers

The surveyed health care providers reported a range of responsibilities and the narratives of ASHAs, ANMs and MOs (and, to a lesser extent, those of Counsellors) highlight that ARSH issues or providing information and services at the AFHC is but one part.

Accredited Social Health Activists

Typically, in their interview, the ASHAs described their work responsibilities as focusing on maternal, newborn and child health. All 46 ASHAs described their role in providing information to women with regard to appropriate diet and care during pregnancy, detection of the danger signals of pregnancy, immunisation schedules, the importance of institutional delivery, appropriate lactation, appropriate newborn care, contraception and so on. Many discussed their role in accompanying women to a facility for delivery and remaining with them until they returned home. Most

Table 1.3: Selected background characteristics of study participants

Background characteristics	ASHA (46)			ANM (20)			Counsellor (3)			Medical Officer (11)		
	Jharkhand	Maharashtra	Rajasthan	Jharkhand	Maharashtra	Rajasthan	Maharashtra	Jharkhand	Maharashtra	Rajasthan	Maharashtra	Rajasthan
Age (years)												
20-24	3	—	—	—	—	—	—	—	—	—	—	—
25-29	6	4	8	2	1	—	—	—	—	—	—	—
30-39	3	9	5	5	1	3	3	2	3	3	3	3
40-49	3	2	3	1	2	2	—	—	—	—	—	1
50+	—	—	—	—	—	3	—	2	—	—	—	—
Education												
< Class 8	2	—	—	—	—	—	—	—	—	—	—	—
Class 8-9	4	7	9	—	—	3	—	—	—	—	—	—
Class 10-11	6	4	2	3	—	1	—	—	—	—	—	—
Class 12-13	3	2	2	4	—	1	—	—	—	—	—	—
BA/BEd/Bsc/GNM ¹	—	2	—	1	4	1	—	—	—	—	—	—
MA/MSW ²	—	—	1	—	—	2	3	—	—	—	—	—
MBBS ³	—	—	—	—	—	—	—	2	1	—	1	3
MD ⁴	—	—	—	—	—	—	—	2	2	—	2	1
Number of years worked as an/a												
<1	—	—	—*	—	1	—	—	1	—	—	—	—
1-4	3	12	2	4	—	2	—	1	2	2	2	2
5-9	12	3	13	3	1	—	2	1	—	—	—	1
10+	—	—	—	1	2	6	1	1	1	1	1	1
Number of years worked in AFHC⁵												
<1	NA	NA	NA	4	1	2	—	2	1	1	1	1
1	NA	NA	NA	3	1	2	1	1	1	1	1	3
2+	NA	NA	NA	1	2	4	2	1	2	1	1	—

Note: *Information was not available on the number of years worked by one ASHA in Rajasthan; ¹Bachelor of Arts/Bachelor of Education/Bachelor of Science/General Nurse Midwifery; ²Master of Arts, Master of Social Work; ³Bachelor of Medicine, Bachelor of Surgery/ ⁴Doctor of Medicine; ⁵In Rajasthan, services for adolescents and youth were provided in the general OPD of the CHC; the numbers refer to the number of years of providing services to adolescents and youth; NA: Not applicable.

suggested that they counselled newly-delivered women about contraception, advising them oral contraceptives, condoms, and, in case they want no more children, sterilisation. As such, they noted that the sub-groups they served were typically married pregnant women, those who had recently delivered and those who had small children. For example:

I take care of the pregnant woman—advise her if she has weakness or swelling of the hands or feet, take her to the health centre, take care of the mother and child up to seven days after childbirth and advise them (mother and accompanying family members) that the mother should feed her milk to the baby within one hour of delivery because it protects the baby from many diseases. I also provide door-to-door information regarding vaccinations. [ASHA, aged 29, working as an ASHA for seven years, Jharkhand, ID-9]

I tell ladies how to keep a gap between children... inform them about Mala-D, Nirodh and Copper-T, and motivate them for sterilisation. [ASHA, aged 27, working as an ASHA for seven to eight years, Rajasthan, ID-5]

We have eight tasks and I do all of them. I take pregnant women for delivery, explain things (healthy breastfeeding) to lactating mothers, tell women about family planning, escort men and women to health facilities..... [ASHA, aged 36, working as an ASHA for five years, Maharashtra, ID-9]

Other responsibilities, including the promotion and provision of family planning methods; DOTS (Directly Observed Treatment, Short Course) regimen for tuberculosis; treatment for other conditions including malaria, leprosy, diarrhoea and other illnesses, and raising awareness about water, sanitation and hygiene were described by many fewer, and, for the most part, state-wise differences were not observed.

Auxiliary Nurse Midwives

All the 20 ANMs in our study also described their work responsibilities as focusing on maternal, newborn and child health, and contraception; they also reported that they were responsible for providing general health services and worked largely at facility-level, but also in communities. As such, they noted that the sub-groups they served were typically married pregnant women, those who had recently delivered and those who had small children; most of these women were indeed young. Many discussed their role as providing immunisation and maternal health services, inserting IUDs and supporting women seeking sterilisation. While several did acknowledge providing information or services to adolescents and youth, this was clearly perceived as a secondary responsibility. For example:

I run the OPD in the Sub-centre and also do vaccinations. I get deliveries done, do home visits and give advice to pregnant women. I also give suggestions to youngsters about ARSH (matters). [ANM, aged 26, working at the AFHC for one year, Jharkhand, ID-2]

I do field work and also do immunisations (for measles and polio). When I am sent to the field once a month, I counsel teenage girls at the Anganwadi. I also do ANC (Antenatal Care) checkups for pregnant women—get them registered; take their weight; get their urine, sugar and blood pressure tests done and, if they have any problem, refer them to the doctor. I also tell them about family planning and the different ways of keeping a gap between children, immunisation schedules, seasonal diseases and how to maintain personal cleanliness. [ANM, aged 32, working at the OPD providing adolescent health services for 3–4 months, Rajasthan, ID-1]

Earlier, my work included outreach. I used to give information about immunisation and family planning, provide IFA (iron and folic acid) tablets for anaemia, do immunisation work, work in the ANC, conduct home visits and give services to women. But now, I work in the immunisation unit; I do immunisations, work in the ANC, advise (pregnant women) for sonography, and do other tasks in the hospital like providing services to adolescents and all that. [ANM, aged 42, working at the AFHC for three years, Maharashtra, ID-3]

Counsellors

The three Counsellors who participated in our study described their role in very specific terms, that is, mainly to manage Integrated Counselling and Testing Centres (ICTCs), and inform and counsel individuals concerned about their HIV status. They also recognised their role as managing the AFHC and addressing the needs of young clients.

As such, they perceived a direct responsibility for raising awareness and counselling individuals in general, including adolescents and youth, about sexual and reproductive health (SRH) matters:

I work at the ICTC and am the Counsellor for ART (Antiretroviral Therapy). I also work as an outreach worker. Besides this, I counsel and educate young people about the changes happening inside them, try to understand their current needs, find out what their problems are and whether they have any physical or psychological (problem), or if they have any difficulty—like sometimes there are affairs between boys and girls. (Counsellor, aged 33, working at the AFHC for one year, Maharashtra, ID-3).

Medical Officers

Several of the 11 MOs who were interviewed were specialists and, therefore, focused their attention on, for example, paediatrics, obstetrics or surgery. At the same time, all of them reported that they were responsible for managing the OPD, including both general health problems and emergency cases; some MOs stated that they were responsible for reproductive and child health, including deliveries, sterilisation, treatment of infections and neonatal care, stabilising and referring complicated cases and maintaining records. Some MOs also said that they performed surgery or provided anaesthesia, and one was also responsible for conducting post mortems. Aside from these responsibilities, all the MOs reported some level of provision of ARSH services; for some, it was described as a key responsibility; for most, a less important one. For example:

I am responsible for conducting deliveries, handling the OPD, providing treatment (giving medicines) for malaria, RTIs and STIs, and keeping a complete record of all this work. I also advise them (pregnant women) about antenatal checkups, provide proper education (correct information) about sex to young boys and girls and supply medicines for any problems that they may have. I also ask young girls to tell other girls that these facilities (sexual and reproductive health care) are now available in the hospital. I explain (sexual health matters) to boys also. [MO, aged 48, working at the OPD providing adolescent health services for one year, Rajasthan, ID-4]

I attend to patients in the OPD and labour room, and admit those who are seriously ill as indoor patients. I look after road accident cases (police cases) and also ARSH clients. [MO, aged 32, working at the AFHC for two years, Jharkhand, ID-4]

I am responsible for checking up children, treating them (for their complaints), looking after newborn babies, checking them up and attending to emergencies related to children. [MO, aged 31, working at the AFHC for two years, Maharashtra, ID-2]

Structure of the report

This report is divided into six chapters, including this introductory chapter. Chapter 2 describes the ARSH-related training that the health care providers in our study had received. Chapter 3 highlights provider perspectives on the provision of sexual and reproductive health information, counselling and services to adolescents and youth. Chapter 4 discusses the experiences of the health care providers in providing these services to adolescents and youth and Chapter 5 presents provider perspectives on the barriers inhibiting wider use of ARSH services and ways of overcoming these barriers. Chapter 6 summarises the main findings of this study and highlights the lessons garnered from them for improving the delivery of sexual and reproductive health services to adolescents and youth.

Chapter 2

Capacity building exposure of health care providers for adolescent friendly health service delivery

In order to place the interaction of health care providers with adolescents and youth in the context of their exposure to training on the needs of adolescents and youth, we sought to assess the extent to which providers had undergone training or orientation in the provision of adolescent friendly health services. This chapter describes the capacity building exposure of each of the four cadres of health care providers who participated in our study namely, ASHAs, ANMs, Counsellors and MOs.

Accredited Social Health Activists

Most of the ASHAs in our study (34 of 46) had undergone training in at least five modules of the ASHA training package and most recalled that each training module lasted four days. Across all three states, most ASHAs reported that the training programme had focused on maternal, newborn and child health, and contraception. Most ASHAs described the training as comprising both the provision of information and role plays of various situations in which they would be expected to provide services. While most ASHAs reported that the training programme they had attended had conveyed information about adolescent health and development, the topics discussed were mainly related to a healthy diet, menstrual hygiene, the use of sanitary napkins, and the provision of IFA tablets. Moreover, it appears from their narratives that the training given to them largely focussed on addressing the needs of girls and rarely on the needs of boys. For example:

Yes, we were told that young girls should not use only one cloth during their menses and they should, instead, be told to use the sanitary napkins that are provided by the government. They also told us about keeping the body clean. [ASHA, aged 24, working as an ASHA for four years, Jharkhand, ID-3]

(We were told) to make young girls understand (about menses), take them to the doctor if they have any (menstrual) problem, tell them about cleanliness. Also, if they have less blood (anaemia) or it (menstrual period) occurs every two to three months due to weakness, or if they have a lot of pain, to give them iron pills. Whatever I learnt was new. Earlier, I didn't know that girls should take iron pills. [ASHA, aged 25, working as an ASHA for eight years, Rajasthan, ID-4]

We were taught new things about how we should advise adolescent boys and girls. (We should tell) girls that they should keep their menses cloth clean. She may feel shy to talk to her mother, so we have to tell her. We should advise her mother too about her daughter's healthy food (requirement); we should ask her (mother) to give her daughter two to three meals (a day); we go to their home and give IFA tablets for blood (anaemia). We also visit high schools. We have asked Madam (teacher) of Janta Vidyalay (a school) to give (IFA) tablets (to girls). We tell girls that they should take these tablets every month; that if a girl takes these tablets now, she will have a healthy child when she gets married. [ASHA, aged 42, working as an ASHA for five years, Maharashtra, ID-3]

Training rarely addressed communication skills or overcoming discomfort in discussing with adolescents and youth such sensitive matters as sexual behaviour or condom use, the different needs of the married and the unmarried, and the rights of adolescents and youth. Moreover, the narratives of some ASHAs suggest that they might have been taught to convey somewhat judgemental counselling to the young; for example (I=Interviewer; R=Respondent):

I: Was there any discussion on the health of youngsters in the training programme in which you participated?

R: Yes, we were told that the blood test of young girls should be done, their height should be measured at the Anganwadi, and that we should take girls to the Anganwadi for getting rice, pulses, oil and soybean, etc.

I: What did you learn from this training?

R: I learnt that if attention is not paid to the diet of young girls, they could have trouble conceiving.

I: Did anyone tell you how to provide services to youngsters?

R: We were informed but the information was not complete.

I: Did anyone inform you about what are the problems of girls as compared to boys?

R: No, we were not told anything regarding this.

I: Did anyone inform you about the problems of the unmarried as compared to the married?

R: No one informed me regarding this.

I: Did anyone inform you about the right of youngsters to take services in privacy?

R: Nothing was mentioned about this too. [ASHA, aged 27, working as an ASHA for six years, Jharkhand, ID-14]

...from this training, I learnt how young people should be informed about their health. [ASHA, aged 47, working as an ASHA for four years, Jharkhand, ID-13]

I: In the training you participated in about girls and boys, were you oriented about how to serve them?

R: Yes, we were told that we should try to understand their feelings through games, songs and entertainment conducted in a light (relaxed) environment, and then explain that they should behave in this way (describe how they should behave) and do these things (describe the right things to do). Assure them by saying, "I am your friend, and all of you are my friends." In this way, (we should) give them information about menses and also explain the body changes happening in them such as voice change in boys etc.

I: What else were you told?

R: To tell boys not to feel shy, but to share the changes taking place (in their body) with their father.

I: Were you informed about the difficulties that young people face in accessing services?

R: We were not told this in the training.

I: Were you informed about the differences in the situation of boys and girls or about differences in the situation of the married and unmarried?

R: Yes, we were told that the unmarried are immature and the married live with some restrictions; that the girl is under the control of her mother-in-law and other family members. So, getting proper food is a problem for her.

I: What was told about the differences in the situation of boys and girls?

R: In today's society girls are looked down upon and boys are considered to be superior. (For example,) when it comes to serving food, if there is one chapatti (Indian flatbread), the parents tell the boy to have two-thirds of the chapatti; we were told about this.

I: Were you oriented about the secrecy and confidentiality to be maintained, or not to be judgemental?

R: No, but we were told about gender discrimination. We believe that boys are great or superior (to girls). We were told that we should explain to them (boys) with love, that they should not do this (discriminate against girls/women). [ASHA, aged 35, working as an ASHA for three years, Maharashtra, ID-13]

Yes, we were told to guide them (boys and girls) not to do anything wrong. We were also told that when girls grow up, their height and weight increases and the menstrual cycle also begins. The voice of boys becomes heavy; we were also told to advise boys not to have unsafe sex. Nothing was new for me; I knew everything (all this) beforehand. [ASHA, aged 40, working as an ASHA for six years, Rajasthan, ID-6]

Auxiliary Nurse Midwives

Many of the ANMs in our study had undergone training on the ARSH programme, though state-wise differences were apparent. In Jharkhand and Maharashtra, for example, all had undergone training; while training was provided over a five-day period in Jharkhand, it was provided over a three-day period in Maharashtra. In Rajasthan, not a single ANM had undergone specialised ARSH training, but six of the eight ANMs reported that they had been oriented about addressing the needs of adolescents and youth in the course of more general training programmes or, in one case, monthly meetings; however, two ANMs had never been exposed to any such orientation or training.

ANMs who had undergone ARSH training reported exposure to a range of topics: the definition of adolescent age groups, physical maturation during adolescence, menstrual hygiene, nutrition, pregnancy, contraception, abortion, infection, and the importance of using condoms if engaging in pre-marital relations, as the narratives below suggest:

(We were) told that as adolescents grow up, they experience various physical changes—like in girls, the breasts grow and menses starts; in boys, the voice changes, other organs also grow and there is hair growth in the private parts...(We were told) that if a girl is unmarried and her menses stops abruptly, she should get a pregnancy test done and if she is pregnant, she should be taken to a proper, trained doctor and get an abortion done so that her life can be saved.... (We were also told) that adolescents are at a growing stage, so they need a lot of nutrition and if they are not given proper food and nutrition at that time, they become anaemic; that during pregnancy, girls should get their blood pressure, haemoglobin and weight checked and take care of their food and eating habits; that if a woman already has a child/children and does not want any more, she should use a permanent method like tubectomy or vasectomy; she can also use Mala-N and condoms. They (trainers) also told us about the safe period....(We were told) that we should advise young people that they should use condoms whenever they have physical relations so that they do not get any infection or disease. [ANM, aged 26, working at the AHFC for one year, Jharkhand, ID-2]

Every month there is a meeting wherein we discuss healthcare services for teenagers. There, we are told about personal hygiene of teenagers, how girls should keep their private parts clean, to advise them to use sanitary pads during their periods, and as they grow up they should be careful and not let anybody touch them.... [ANM, aged 53; working at the OPD providing adolescent health services for two years, Rajasthan, ID-4]

Several ANMs who had undergone ARSH training reported that the training had raised their awareness about gender role disparities, including that compared to boys, girls have less freedom of movement and more housework responsibilities; gendered norms regarding the sexual behaviour of boys and girls; the differential needs of boys and girls and the importance of providing services to both boys and girls. For example:

Boys and girls should be given equal services (treatment). Many things (changes) happen in a girl's body as compared to a boy's, so there are more chances of girls being anaemic. That is why they (girls) must be told about good eating habits, cleanliness etc. [ANM, aged 32, working at the AFHC for three years, Jharkhand, ID-3]

Boys roam around; they go wherever they like. They don't face any restrictions whereas girls have restrictions; (girls) have to remain at home or at school only. A girl has to be at home by 5 pm, do all the housework, cook for all and serve food to all. We tell them (parents/elders) that it is ok if they want to put restrictions on girls, but there should not be so many restrictions that the girl's psychological development is affected by too much pressure.... (When) unmarried boys and girls have sexual relations (and the girl becomes pregnant), she is called a child mother; she is ignored and thrown away and not only society but also her parents ill-treat her; whereas, there is no tension for the married—if they have sexual relations (extra-marital) or even have an abortion, society cannot say anything to them. [GNM, aged 36, working at the AFHC for two years, Maharashtra, ID-1]

ANMs gave mixed responses about whether they had been given training on such issues as providing privacy, confidentiality and non-judgemental counselling to adolescents and youth. Some ANMs indicated that they had been informed about the need for ensuring privacy, confidentiality and non-judgemental services, as the excerpts below show:

If an unmarried girl has a boyfriend, we should try to talk to her in such a way that she is comfortable and talks to us openly. Later, we should give her advice about how to be safe... youngsters have the right to take services in privacy and we should maintain secrecy whenever youngsters come and discuss anything with us; only then they will trust us and come here again to avail of services... We were told that along with maintaining secrecy, we should not restrict them from getting any kind of service; we should not scold them and should give them whatever (service) they want. [ANM, aged 32, working at the AFHC for three years, Jharkhand, ID-3]

We were told that these boys and girls will not come directly and tell us things (their problems and concerns); we will have to talk with them in a very friendly manner by initiating a conversation about their family, their school, academic subjects, and then start talking about the main subject... (We were told to) tell girls in the 10–19 age group about menses and how to take care of oneself during menses because some girls ask their friends and not their mother and sometimes friends cannot give proper advice.... (We

were) told that we should communicate with them in a healthy manner, try to understand their problems and give services accordingly... (We were also) told that we have to take them into confidence and reassure them that whatever question they ask us or information we give them will not be discussed outside or shared with anybody. Only if this assurance is given to them will they share these things (sensitive/personal matters). We also received training on how to take them (adolescents) into confidence and work with them. [ANM, aged 42, working at the AFHC for three years, Maharashtra, ID-3]

Some other ANMs, however, suggested that the training that they had received did not contain any such discussion:

I: Were you informed about how you can provide services to teenagers?

R: No, we were not told anything about how to talk to teenagers.

I: Were you told that adolescents have the right to take services in private?

R: No, we were not.

I: Were you told that they have the right to confidential services?

R: No, we were not told about this.

I: Were you told about how we need to counsel adolescents and their parents?

R: No, we were not. [ANM, aged 50, working at the OPD providing adolescent health services for three years, Rajasthan, ID-3]

We note, however, that ANMs rarely described training to have encompassed communicating sexual health topics without discomfort or counselling boys. As a result, there was considerable interest in pursuing refresher training in adolescent reproductive and sexual health. Many suggested that the training programmes needed to focus greater attention on discussing such issues as nocturnal emission, STIs, RTIs, abortion and safe sex practices, about talking to boys and about talking to the unmarried.

Counsellors

In Maharashtra, two male Counsellors and one female Counsellor attached to the selected AFHCs were also interviewed. These Counsellors also served ICTCs, but had undergone a 2–3 day training programme on ARSH. As ICTC Counsellors they were used to addressing the counselling needs of adults, and the training focused on ways of addressing the more varied needs of adolescents and youth. Here, training was found to have been comprehensive and useful. For example:

Training focused on young people's attitudes, sex and sexuality. We were taught how to communicate with them about the changes happening during puberty, how cleanliness should be maintained during menses, how to communicate with parents and how to involve them; it focused on what is a girl and what is a boy; how they are similar and how they differ. There was a demonstration about establishing relationships with youth; about conducting programmes in schools and colleges; what should be done if, in these programmes, boys and girls come up with problems such as pimples, wanting to increase height or lose weight, or what food to eat to put on weight. (We were also told) to give medicines if they (young people) are anaemic and to refer them to a doctor if there is serious problem. We were taught that there should not be a distance between the counsellor and the client; there should be friendly communication. Clients should not feel that they have come to some 'Sir' or 'Doctor' as then they would be scared to talk to us; so, we need to talk like a friend. In the Maitree Clinic (AFHC), we need to have friendly discussions with adolescent boys and girls, understand their sexual problems and give them complete information; it is important to have a friendly environment. In the training programme, there was a cloth flip chart and pictures; they explained how a foetus is formed; told us about two types of condoms—male and female condoms, oral pills, the Copper-T and the emergency contraceptive pill that is taken within 72 hours (of intercourse). There was also a session on STIs and RTIs.... [Counsellor, aged 30, working at the AFHC for six years, Maharashtra, ID-1]

Medical Officers

Nine of the 11 MOs who were interviewed had undergone ARSH training for between two and six days each, mostly in the three years preceding the interview. The topics covered in the training programme were described as including not only puberty, nutrition, contraception, pregnancy and infection, but also the functioning of the AFHC, ways of

communicating with adolescents and youth, and holding non-judgemental attitudes. Many MOs highlighted that they were sensitised about providing counselling in private, maintaining confidentiality, providing non-judgemental guidance, and never scolding a young client. Many also suggested that they had been sensitised about gender differences and how girls experienced particular challenges in obtaining information, and how boys had more information but were frequently misinformed about sexual and reproductive matters. The following narratives illustrate the views of the MOs:

I used to think that patients would come and tell me directly about their sexual problems or infection but it is not like that. They always mention their problem indirectly and we should understand and give them treatment (accordingly). The most important thing we were told (at the training) is to keep the problem confidential...Girls feel shy and convey their problem indirectly like if they have a menstrual problem, they say they have a stomach ache, and if they have a problem of white discharge or infection, they say they have itching. Boys, talk about their problems comfortably. Married people don't hesitate either. We were also told that adolescents have the right to take services in private; we should provide them services in a separate room with curtains and furniture for privacy. Services should be provided in a way that they (young people) trust and come again to us for services. (We were also told that) we should not inform their parents (about their visit to the AFHC). [MO, aged 37, working at the OPD providing adolescent health services for one year, Rajasthan, ID-1]

(We were taught) what ARSH is, at what age a young person becomes eligible for services at the AFHC, what issues are to be dealt with among clients of this age group, how important ARSH is, the importance of counselling, how to give counselling to clients, how to give treatment in different cases, what is the setup of an ARSH clinic and how it is to be set up.....We were informed that counselling plays a very big role; the youngster should feel that privacy will be maintained when he is talking; he should feel that the service provider is talking to him as a friend and should not feel any embarrassment at all. If a girl believes that privacy will be maintained, she will start talking openly; otherwise, it is tough for girls. It is easier to provide services to the married than the unmarried, but if counselling is done properly then an unmarried girl can also talk openly. [MO, aged 32, working at the AFHC for one year, Jharkhand, ID-4]

Youngsters don't get enough information about the changes happening to them during this age (adolescence) from parents or elders who are around them. So, we need to counsel them and tell boys that these changes are normal. If (he is) sexually active, we should tell him about the precautions to be taken, how he can handle his regular life; to tell him, "Behave morally". It is better if they (boys) take precautions (use contraceptive methods like condoms) so as to prevent HIV infection. It is the MO's duty to give guidance, after that it is their (the boys') wish (whether or not to take the MO's advice). We learnt that we must explain to young people as a counsellor; I came to know the difference between communication and counselling. [MO, aged 32, working at the AFHC for six months, Maharashtra, ID-1]

We were told that the most important thing is to keep the problem confidential. For this, there should be a separate room. There should be curtains in this room so that if they (clients) have to show some body part, they can do so and the checkup can be done easily. If they tell you something very funny, we should control ourselves so that they may not feel that we are laughing at them or feel ashamed. [MO, aged 37, working at the OPD providing adolescent health services for 1.5 years, Rajasthan, ID-1]

Much more rarely discussed was whether training had encompassed skills in overcoming discomfort about addressing girls (all MOs serving the selected AFHCs were male). For example, in several excerpts, the narratives of MOs imply that training had reinforced perceptions that male MOs could not counsel girls; far fewer narratives suggest that these issues were tackled, and the majority do not discuss whether training had emphasised overcoming reservations in serving unmarried girls and boys. For example:

I: Were you told about how youngsters should be provided services? How girls should be provided services compared to boys?

R: We were told that boys talk openly to doctors but girls are not able to do so. So, there should be female staff. In the training programme, there were male and female doctors too. We were told that no matter how much training is given, one cannot talk openly to females, so there should be some female staff present; if not a female doctor, there should be a nurse or LHV. [MO, aged 50, working at the AFHC for one year, Jharkhand, ID-7]

I: Were you told about the differences in the way girls and boys take services?

R: No, this was not taught to us but we can read the faces of girls and call the lady staff or ANM and ask the girl to tell her problems to her (the female staff).

I: Did you ever have a chance to do a role play?

R: No, never. [MO, aged 48, working at the OPD providing adolescent health services for two years, Rajasthan, ID-4]

I: Did you learn something new about adolescents? Something you did not know before?

R: We know these things (factual information), but not how we should communicate these things to young people. Normally, we prescribe treatment to patients. But here, we learnt how to give information; counselling is different—we got information about counselling, how to guide them (young clients) properly when they come to the clinic... [MO, aged 31, working at the AFHC for one year, Maharashtra, ID-10]

Notwithstanding these limitations, the MOs unanimously acknowledged that the training programmes they attended had been useful. They highlighted that the role plays in which they participated had given them an opportunity to better understand *what patients feel when they have to go to a doctor with a problem*. A few MOs suggested that training should be conducted together with ANMs, and others proposed that since MOs are expected to train ANMs who work with them, MOs should receive special training to impart the requisite training to ANMs.

Summary

Most of the health care providers in our study had undergone some training or sensitisation on sexual and reproductive health issues of relevance to adolescents and youth. While for ASHAs and some ANMs, training took place in the context of their general training about their responsibilities, other categories of providers had undergone special training in ARSH. All those who had undergone training reported being exposed to sexual and reproductive health issues pertinent to adolescents and youth—while ASHAs and ANMs suggested that training had focused on such safer issues as nutrition and nutritional supplementation and menstrual hygiene, the training of Counsellors and MOs was also described to have encompassed sexual relations, infection, pregnancy and abortion. Such issues as privacy, confidentiality, non-judgemental interaction and promotion of informed choice were covered in somewhat fewer training programmes attended by the providers, and again, Counsellors and MOs were more likely than ANMs, and especially ASHAs, to have been so exposed. What was least likely to have been emphasised in training were communication skills, and notably how to convey information on sensitive matters to adolescents and youth and, in particular, to opposite-sex adolescents and youth. Although some health care providers discussed role playing in the course of training, it appears that efforts to enhance communication skills and break down provider discomfort were limited in most of these training programmes. Findings suggest that while the cascade approach to training has many advantages in terms of reaching large numbers of providers in a short span of time, it was not successful in building capacity on the more intractable aspects of providing services to adolescents and youth, namely, building communication skills and overcoming discomfort in talking about sexual health matters.

Chapter 3

Provider perspectives on the provision of sexual and reproductive health information, counselling and services to adolescents and youth

Provider perspectives were also sought about the ideal age at which adolescents and youth should be informed about physical maturation and sexual and reproductive matters, and the ideal person to provide such information to them. This chapter focuses on these perspectives.

Appropriate ages for informing adolescents about puberty

Most health care providers in our study believed that information about physical maturation should be provided to girls and boys before these changes take place. For example, 36 of 46 ASHAs, 18 of 20 ANMs, all three Counsellors and all 11 MOs suggested that girls should be provided such information in advance so that menstruation does not frighten them and menstrual hygiene is maintained. Likewise, 31 of 46 ASHAs as well as all ANMs, Counsellors and MOs maintained that it is important to provide such information to boys in advance so that voice change and other changes do not raise anxiety among them. The following narratives highlight their views:

Girls should get information about menstruation beforehand because if they have this knowledge in advance, they will not feel scared when menses starts. Boys should also get information before their moustache starts to grow because a boy will see what is happening to him and get worried. Thus, information should be provided in advance and at the age of 14–15 years only. [ASHA, aged 29, working as an ASHA for six years, Jharkhand, ID-5]

For girls, it (information about physical maturation) should be given before their menstruation begins because by knowing this, they can protect themselves. [ASHA, aged 25, working as an ASHA for eight years, Rajasthan, ID-4]

(Information about physical maturation should be given to girls) before puberty and they should be told that these things happen at this age and there is nothing to worry about. (They should be told that) whenever they get their period, they must use sanitary pads, must stay clean and not use dirty cloth pads as there is a possibility of getting reproductive tract infection. They should be told all this beforehand so that they don't get scared....[ANM, aged 41, working at the OPD providing adolescent health services for 7–8 years, Rajasthan, ID-5]

(Information about menstruation) should be provided before menses—at the age of 10 years. The girl should be informed that it is time for her menses (to start) and that she could get a stomach ache or a headache, and bleeding would occur. Therefore, information regarding how to keep the private parts clean should be given so that the girl does not feel afraid, thinking what could be happening to her. [ANM, aged 46, working at the AFHC for two months, Jharkhand, ID-7]

(Girls should be informed) before (menses starts), about (the approximate age) when menses begins. We should tell girls not to worry because it (menses) happens (to all girls); it is normal and there is nothing to get frightened about. [Staff Nurse, aged 28, working at the AFHC for 7–8 months, Maharashtra, ID-4]

(Information about physical maturation should be given) before (puberty sets in) because if boys have this information well in advance, they will not get scared because they will know that this (growing up) is a natural process. Otherwise, they can feel scared to see hair growing in different parts of their body and can even fear that they could be suffering from some serious illness. [ANM, aged 26, working at the AFHC for four years, Jharkhand, ID-2]

Girls should be told around the time when menstruation starts; when they are mature. But those who wish to get information earlier or those who ask questions on their own, should get information at whatever age they seek it; they should not get a negative sense that they have asked something but did not get an answer...The same goes for boys; if they ask, then information should be provided to them. [MO, aged 34, working at the AFHC for three months, Jharkhand, ID-2].

Girls should be given information around the age when menses starts—by the age of 11 years; around 12 years, they need information about SRH. If they get this knowledge at these ages, they will not be scared in future. They should know that it (menstruation) is not a genetic illness but a natural event; that every woman gets this cycle. (Likewise,) boys should be told by the age of 14 years; by this age changes begin in boys. They should be told about the changes that happen in the genital organs so that (when these changes occur) they will not get a complex and be able to accept themselves. [MO, aged 35+, working at the AFHC for two years, Maharashtra, ID-3]

Some health care providers, while acknowledging that adolescents should be given information about physical maturation before they experience puberty, noted that information should be given age-appropriately:

Girls should be informed when they are 12–13 years old; at this age they are able to understand. At the age of 12 they should be informed about normal development—(physical maturation) and menses and its problems, and after that, about sexual problems; but, it has to be told gradually. Boys should be told at about 14–16 years, before marriage, so that they know about physical development, sexual illnesses, reproduction and sex. [MO, aged 31, working at the AFHC for one year, Maharashtra, ID-2]

The few health care providers who believed that adolescents should be informed about menstruation and body change after the changes take place were more concerned about frightening the girl or boy at an early age than considering it inappropriate. For example:

Girls should get information (about physical maturation) after they start menstruating because if we provide information in advance, the girl will feel shy and her mother will say that her village people will speak badly of her daughter (because she knows this already). Boys too should get information after their moustache starts to grow because if they are informed in advance, they will feel shy. [ASHA, aged 47, working as an ASHA for six years, Jharkhand, ID-8]

Appropriate ages for informing adolescents and youth about sexual and reproductive health matters

Typically, all cadres of health care providers—ASHAs, ANMs, Counsellors and MOs—believed that girls and boys should be informed about sex, pregnancy and infection during their adolescent years and before marriage: 37 and all of 46 ASHAs so believed for girls and boys, respectively, as did all ANMs, Counsellors and MOs.

A key reason, most frequently articulated, related to protecting adolescents and youth from taking a 'wrong path' and equipping them to protect themselves from the consequences of unsafe sex, irrespective of when sexual relations are initiated. Some health care providers elaborated that such information may help adolescents and youth abstain from sex before marriage or from extra-marital sex, to take precautions against contracting sexually transmitted infections, and to engage in safe sexual practices within marriage. While narratives of some of the providers were proscriptive, like 'girls should keep away from boys', others acknowledged that attractions between opposite sexes do take place in adolescence, and that adolescents and youth should be 'informed' early on: For example:

If they (boys) are given the information (about SRH matters) early, they may not get infected by having unsafe sexual relations. If they have this information before they get married, they will be able to maintain good relations with their wife and will not engage in wrong (extra-marital) relations. Young boys should know that they should not have relations with others (with sex workers or someone other than their wife); they should know about (sexually transmitted) diseases and how to take care of themselves. [ASHA, aged 23, working as an ASHA for four years, Jharkhand, ID-2]

SRH information should be given to boys before they get their beard and moustache because then they will not do anything wrong; they will act intelligently. (Giving this information) before marriage will help them to take protection after marriage; they will know what they should and should not do within marriage.

Boys should be given information about cleanliness and about not doing anything wrong. [ASHA, aged 25, working as an ASHA for eight years, Rajasthan, ID-4]

Girls should be advised to stay away from boys or not to have relations with them. (She should be told that she has) got her menses and so, she should keep away from boys and be aware (take care of herself). We should tell her that she will get married between the age of 18 and 21, and that if she takes care of herself now, she will have a healthy child. We should give such advice to boys also. It should be given during puberty, and also before puberty and marriage, because they should not have relations with others (other women after marriage); that after marriage, if they are honest (faithful) to one (their wife), then they will not get diseases like HIV/AIDS. [ASHA, aged 42, working as an ASHA for five years, Maharashtra, ID-3]

(Girls should be informed) before marriage so that they do not face problems that may arise after marriage. In India, girls are unaware of the menstrual period, birth control, diseases that they may become infected with and whom they should contact if this happens; so, they should get this information early. Boys should get this information between the ages of 14 and 15 years because at this time their sexual organs develop and they begin to get attracted to the opposite sex. In order that they do not take any wrong step, they should be informed well in time. For example, if they are told, they will be aware that discharge is not a weakness. [MO, aged 36, working at the OPD providing adolescent health services for eight years, Rajasthan, ID-R3]

A second set of reasons expressed by the surveyed health care providers focused on preparing adolescents and youth for married life, that is, delaying the first pregnancy, avoiding unintended pregnancy, practising contraception and obtaining appropriate pregnancy-related care. As the narratives below indicate, providers suggested that information provided during the adolescent years would enable young people to be better prepared for married life and to adopt health-promoting behaviours once married:

Girls should get information about sexual matters before marriage because if a girl is going to get married and she doesn't have any knowledge about pregnancy, she will definitely get pregnant even if she doesn't wish to have a child soon. Hence, she should have information about contraceptives. Information on sexual matters should be given to boys before marriage because a boy gets married at the age of 20–22 years. So, information should be given in advance regarding physical changes, methods of contraception etc. [ASHA, aged 29, working as an ASHA for seven to eight years, Jharkhand, ID-5]

Because if girls are aware of it (contraception), they will not take any wrong step. (I remember) a recent case—a 20 year-old girl came to the clinic. She was already a mother and had conceived again; if she had been aware of contraception before marriage, she would have asked her husband to use a contraceptive.... Boys should know in advance about the changes that take place during the teenage years so that they do not make any mistake in future, and take all the necessary steps in time, after marriage—like (tetanus) injections if their wife is pregnant, and family planning. [ANM, aged 32, working at the OPD providing adolescent health services for 3–4 months, Rajasthan, ID-1]

Adolescents should be provided information before marriage regarding sex-related issues and how to protect themselves from infection, how to prevent pregnancy, how to keep a gap between children. Moreover, some get married at an early age and they should not feel scared about all this (sex, pregnancy, infection). Therefore, this information should be provided to them earlier.... If boys have this information before marriage, they will be prepared for protection (safe sex). [ANM, aged 35, working at the AFHC for ten days, Jharkhand, ID-6]

If adolescents don't have this information before marriage, they may get an infection that is caused by having unsafe sexual relations—diseases like RTIs, STIs, AIDS etc. If they have information, they will have safe sexual relations and keep themselves protected from such infections. [MO, aged 50, working at the AFHC for one year, Jharkhand, ID-3]

Some health care providers also noted that adolescents and youth typically get information about sexual matters from friends and neighbours and since such information may not be accurate, it would be better to give them correct information on sexual and reproductive health early on:

(This information should be given) before marriage so that in future, there is no threat. In adolescence, physical and psychological changes occur and, in the beginning, they (boys and girls) are confused about what is happening with them. But the information they get from friends or neighbours may not be correct,

and so they should get correct information from the start... Nowadays, boys and girls are together, and boys feel like staring at girls, and as they grow up, they get attracted to girls. If they are not informed at this age, they could go astray later. [Staff Nurse, aged 42, working at the AFHC for one year, Maharashtra, ID-2]

Ideal person to inform adolescents and youth about puberty and sexual and reproductive health matters

The health care providers were also asked about who the ideal person is for providing information to girls and boys about puberty and sexual and reproductive health matters. Table 3.1 indicates that gendered responses were given by most categories of health care providers, with the exception of the three Counsellors. As far as the provision of information to girls is concerned, ASHAs, ANMs and MOs alike maintained that ASHAs and ANMs, along with Anganwadi Workers (AWWs) in a few instances, were qualified to offer sexual and reproductive health information. Indeed, 35 of 46 ASHAs and 17 of 20 ANMs considered ASHAs and ANMs, respectively, equipped to provide such information to girls. This opinion was shared by the MOs in that while seven believed MOs were appropriate, an appreciable number—10 and six—believed that ANMs and ASHAs, respectively, were ideal for conveying this information to girls. Finally, every cadre of providers believed that providing this information to girls was their mother's responsibility, an opinion expressed by 10 ASHAs, 12 ANMs and seven MOs; they acknowledged, however, that in many instances, mothers did not communicate with their daughters on these matters as the following narratives suggest:

Parents are not much educated and the Didi (Sister, as ASHAs and ANMs are addressed locally) can inform them nicely (without discomfort); so, she could provide this information to girls properly. Also, girls talk to me without hesitation and I also talk to them openly. [ASHA, aged 29, working as an ASHA for seven years, Jharkhand, ID-9]

Girls should be provided information by the ASHA because she lives in the same village and she meets all of them regularly. The ANM comes from outside the village and girls feel shy to talk to her. [ASHA, aged 29, working as an ASHA for seven years, Rajasthan, ID-11]

Mothers should give this information to girls. Now, as ASHAs, we also give this information, but as women, we can tell girls (about such sensitive matters) but not boys. [ASHA, aged 27, working as an ASHA for four years, Maharashtra, ID-6]

Provider perceptions about the ideal person/s to provide information about puberty and sexual and reproductive health matters to boys were quite different. Now, just 14 of 46 ASHAs and five of 20 ANMs perceived ASHAs and ANMs, respectively, equipped to communicate with boys on these issues (Table 3.1). Indeed, ASHAs and ANMs alike were most likely to believe that MOs (16 and 14, respectively) and other males in authority in the health system (11 and 13, respectively) were best suited to inform boys about such matters. The MOs in our study also believed (8 of 11) that MOs were well equipped to communicate with boys, with several (5 of 11) also acknowledging that males in authority were well suited to convey this information to boys. Male doctors, in particular, were perceived to be better qualified to impart health information than other categories of health care providers and were more credible; some providers suggested that boys would be shy and uncomfortable to obtain this information from a woman, and that men are best placed to inform boys. For example:

Boys should get information through doctors because doctors can provide information to boys properly, and they (boys) also understand a doctor better. [ASHA, aged 29, working as an ASHA for seven years, Jharkhand, ID-9]

Boys should be provided information by (male) health service providers from the hospital who can explain it (sexual and reproductive matters) to them properly. [ASHA, aged 29, working as an ASHA for seven years, Rajasthan, ID-11]

If boys come to us, we can give them information. If they want to know about diseases, we can tell them but not in detail or with clarity. For example, we can only tell them (indirectly) not to do that thing (sexual relations); or that 'You will get an infection, so keep away from these things'. Men can tell boys clearly and openly as they know about these diseases; they (men) also get these diseases. [ASHA, aged 27, working as an ASHA for four years, Maharashtra, ID-6]

Table 3.1: Responses¹ of health care providers about persons considered ideal to inform girls and boys about puberty and sexual and reproductive health matters

Ideal person to impart information	Jharkhand		Maharashtra		Rajasthan		Total	
	Girls	Boys	Girls	Boys	Girls	Boys	Girls	Boys
A. ASHAs (N=46)								
ASHA*	13	5	10	5	12	4	35	14
AWW	1	0	1	0	0	0	2	0
ANM or nurse	2	2	5	4	4	3	11	9
Doctor	0	6	0	4	1	6	1	16
Male in authority**	0	1	0	4	0	6	0	11
Mother/Father	2	1	7	5	1	1	10	7
Sibling/Friends	1	3	0	0	0	1	1	4
B. ANMs (N=20)								
ASHA*	2	0	0	0	5	1	7	1
AWW	3	0	0	0	4	0	7	0
ANM or nurse	8	3	1	0	8	2	17	5
Doctor	4	6	2	2	3	6	9	14
Male in authority**	0	6	0	0	0	7	0	13
Teacher	1	2	0	1	5	6	6	9
Mother/Father	8	3	3	2	1	1	12	6
Sibling/Friends	1	3	0	0	0	0	1	3
C. Medical Officers (N=11)								
ASHA*	3	0	0	0	3	2	6	2
AWW	0	0	0	0	1		1	0
ANM or nurse	3	0	3		4	3	10	3
Doctor	2	3	3	3	2	2	7	8
Male in authority**	0	2	0	1	0	2	0	5
Teacher	0	2	0	0	1	1	1	3
Mother/Father	3	1	1	1	3	0	7	2
Friends	1	2	1	0	0	0	2	2
NGOs	1	0	1	2	0	0	2	2

Note: *Includes Sahiyas in Jharkhand; **Includes supervisor, compounder, male health activist, educated person, multipurpose worker, prerak, any 'educated person' or 'gentleman'; ¹Multiple responses permitted; NB: All three Counsellors believed that they were qualified to provide SRH information to adolescents and youth.

Summary

The majority of health care providers in our study believed that adolescents should be provided information about physical maturation before menstruation (girls) or voice change (boys) has taken place; most suggested that fears about body change and menstrual bleeding would be avoided if such information is provided in advance. Most providers also believed that information about pregnancy and contraception should be imparted to young people during their adolescent years and before they are married. Three reasons were offered—so that adolescents do not 'go astray' and engage in safe sex, before and within marriage; they are prepared for pregnancy- and contraception-related matters after marriage, and they get accurate information early on.

Gendered responses were obtained with regard to who the ideal person is to inform girls and boys about puberty and sexual and reproductive health matters from most categories of health care providers. As far as the provision of information to girls is concerned, most believed the responsibility lay with mothers, along with such female provider categories as ASHAs and ANMs. Ideal sources of information for boys, in contrast, were perceived to be other males, notably those in authority, such as MOs, other males within the health system such as Counsellors and compounders; ASHAs and ANMs were considered appropriate by relatively fewer respondents from all provider categories.

Chapter 4

Provider interaction with adolescents and youth

Our interviews also sought to better understand the extent and nature of the interaction of health care providers with adolescents and youth, particularly in relation to the provision of sexual and reproductive health information, counselling and services. Specifically, we probed about the extent of attendance at AFHCs; the adolescent or youth group with whom providers were most likely to interact; and the information, counselling, supplies and services they provided to adolescents and youth. This chapter describes the experiences of providers in serving adolescents and youth.

Provider perceptions about attendance at AFHCs

In general, all cadres of health care providers noted that the attendance at AFHCs was sparse. This observation was also corroborated in a companion study of adolescents and youth (Santhya et al., 2014). For example:

I: According to you, do adolescents use the services of this centre?

R: Very rarely. They are not aware that this service is available for them. [MO, aged, 37, working at the OPD providing adolescent health services for one year, Rajasthan, ID-1]

The AFHC centre is closed. Very few young people come here. [MO, aged 36, working at the OPD providing adolescent health services for three years, Rajasthan, ID-3]

Although there are Yuva Maitri Kendras (AFHCs) here, very few youth actually come here. [MO, aged 50, working at the AFHC for one year, Jharkhand, ID-7]

Yes, attendance is low. It is not up to our expectations. [Counsellor, male, aged 37, working at the AFHC for two years, Maharashtra, ID-2]

Very few young people take advantage of the centre; very few. They don't come to the centre; there is not enough awareness. [MO, aged 31, working at the AFHC for one year, Maharashtra, ID-10]

Sub-populations most likely reached

Almost all categories of health care providers reported that they served communities at large, including females and males, the married and the unmarried, and adults as well as adolescents and youth. Although all categories of providers had experience serving both girls and boys, and the married and unmarried, the narratives presented below suggest that service provision is largely gendered, with ASHAs and ANMs serving girls more often than boys, and MOs, particularly male MOs, serving boys more often than girls. The Counsellors were an exception in that they provided services to both girls and boys, largely in their facilities but also, occasionally, through outreach services in schools as suggested by the following narrative.

I counsel boys and girls who approach me. I talk to them about sexual and reproductive health matters, for example, give some information about what happens during puberty, and show them some pamphlets, books and kits. [Counsellor, aged 30, working at the AFHC for six years, Maharashtra, ID-1]

In contrast, MOs (all male) focused more on boys than girls, and several reported that they referred girls who sought services from them to female MOs and ANMs or nurses if available; some also acknowledged that few adolescents and youth, particularly the unmarried, sought their services. For example:

I: Which kind of teenagers come with these kinds of problems (physical maturation)?

R: Adolescents between the ages of 15 and 18 years. If Madam (female MO) is available, we send girl clients to her. I have provided advice related to body development to one or two girls and two boys. No

unmarried girl has ever come to me for contraceptives. A married girl had come to see me once; she had a six month-old child. [MO, aged 32, working at the OPD providing adolescent health services for one year, Rajasthan, ID-2]

I: Which group of adolescent people comes to you with this type of problem?

R: Only boys come to me.

I: In the last one month, how many boys have come with the problem of body growth to you?

R: Three to four adolescents have come to me.

I: If any unmarried girl comes to you?

R: No unmarried girl has ever come to me for contraceptives. [MO, aged 32, working at the OPD providing adolescent health services for one year, Rajasthan, ID-2]

I: Have you ever advised youngsters?

R: Yes.

I: (Have you advised) unmarried girls about menses?

R: No. Recently, no unmarried girl has come to us with problems related to menses.

I: Has any unmarried boy (come) with problems related to physical growth?

R: No such boy has come to us.

I: What kind of youngsters and of what age group come to you with problems related to physical growth?

R: Boys, 18–20 years of age, come and meet us. In the last one month, I have given advice to eight boys. No unmarried girl has come to me for contraceptives. [MO, male, aged 50, working at the AFHC for 1.5 years, Jharkhand, ID-7]

On the other hand, ASHAs and ANMs expressed in their interview, that they were more likely to serve girls than boys. Indeed, as many as 33 of 46 ASHAs reported that they had almost no contact with unmarried boys, although some ANMs (7 of 20) reported that they had provided services to unmarried boys in clinic settings. Many justified their focus on girls by explaining that girls had more problems than boys and girls were the ones most in need of special care since menstruation and pregnancy would happen to them; as such, therefore, they saw their role as focussing attention on informing unmarried girls about menstruation or providing them iron supplementation, and informing married girls about conception, family planning and maternal and child care. They also justified their lack of focus on boys on the grounds that boys go for work and, therefore, are not available for interaction, but that they are in touch with the wives of young men. For example:

I mostly meet younger girls because there is a need to give them information regarding menses. [ASHA, aged 36, working as an ASHA for five years, Jharkhand, ID-11]

I give iron tablets to teenage girls. [ASHA, aged 40, working as an ASHA for six years, Rajasthan, ID-6]

As a part of our work we meet girls twice a month after the 1st—on the 10th and at the end of the month, by the 22nd or 23rd. If there is any other work, say a delivery, then there is no meeting. We don't meet boys often; they go for work. So, we don't get them but girls come...[ASHA, aged 42, working as an ASHA for five years, Maharashtra, ID-3]

Usually, we communicate more with girls because they need more of our attention. We concentrate more on girls, so we talk to them more (about various health matters). (We) usually talk more (often) to married girls because we take them to the health centre with us. [ASHA, aged 23, working as an ASHA for four years, Jharkhand, ID-2]

Generally, I don't meet men, but the wives of those men who get married at an early age come here with them when they face any problem. Young men rarely come to the clinic because they don't have any problem; usually, we are in touch with the wife. [ANM, aged 53, working at the OPD providing adolescent health services for two years, Rajasthan, ID-4]

Men come to the clinic if they have any problem like if they can't get children or want a family planning method. [ANM, aged 42, working at the AFHC for two years, Maharashtra, ID-2]

Unmarried boys also come to the clinic if they have something to ask. I meet girls between 10 and 12 years of age when we go to schools. Also, when we go for immunisation, we tell everyone about the Maitree Clinic (AFHC)...[ANM, aged 42, working at the AFHC for two years, Maharashtra, ID-2].

Among girls, ASHAs and ANMs were more likely to focus on married girls rather than the unmarried because the married need information about how conception occurs, how to take care of the mother and the baby, how to ensure spacing between births and so on. Indeed, narratives of both groups suggest that they typically served recently-pregnant or recently-delivered young women and those with small children. Several acknowledged that they rarely approached newly married girls because these girls were secluded and rarely came out when the health workers visited their home, or visited the health centre. Many ASHAs and ANMs also observed that not only did the gatekeepers of newly-married girls restrict their mobility but also discouraged health care providers from discussing with them such topics as delaying the first pregnancy. The following narratives illustrate these observations:

I mostly meet women who have been married recently because they need to know how a woman becomes a mother after marriage, how a child is conceived when menses stops, how a child grows in the womb, its care during pregnancy... [ASHA, Aged 36, working as an ASHA for five years, Jharkhand, ID-11]

I meet women of young ages, 25 years or less, who have been married for a short time. I mostly meet pregnant and dhagi (postpartum) women. [ASHA, aged 28, working as an ASHA for six years, Rajasthan, ID-1]

Mostly, I speak to married women because we go to them more often. We go to take care of those who are pregnant and so there is no need to go to unmarried women. That is why most interaction or talking is done with the married. [ASHA, aged 25, working as an ASHA for six years, Rajasthan, ID-2]

Mostly, (I meet) married (women). We have to give advice to the married about keeping a gap between two children. [ASHA, aged 42, working as an ASHA for five years, Maharashtra, ID-3]

In community work, we meet younger and older women equally (above and below age 25); mostly, those who have been married for some time. We meet fewer women who have been married recently because many of them feel shy and don't come out of their houses as they are not allowed to do so; the ANM cannot even meet them in their homes. I meet pregnant women and those who have delivered a child recently. At the clinic also, we meet all women but women who have been married for some time come here often whereas newlyweds come rarely because they are not allowed to go out; these women don't even like to come to the centre. [ANM, aged 26, working at the AFHC for one year, Jharkhand, ID-2]

I meet all women but mostly those who are married. I advise them to wait for two years (space births); when they get pregnant, I give them injections (immunisation). I meet those who are newly married less frequently because their mothers-in-law are orthodox and uneducated, and tell us not to give them (their daughters-in-law) anything that will stop them from conceiving. So, it is only the ones who have studied a little who meet us in a friendly way... Mostly, women who are expecting come to the clinic to get their blood pressure, haemoglobin and weight etc. checked. Women who have already delivered rarely come because we provide immunisation services at home. [ANM, aged 53, working at the OPD providing adolescent health services for two years, Rajasthan, ID-4]

Mostly, I meet pregnant women and recently-delivered women. [GNM, aged 42, working at the AFHC for two years, Maharashtra, ID-2]

Services provided

The health care providers were probed about the services they provided to adolescents and youth, irrespective of whether these services were provided through AFHCs or in their routine community- or facility-based work. As expected, considerable differences were observed in the typical setting in which each category of providers offered services. ASHAs met adolescents and youth in the course of their community-based work, in the homes of adolescents and youth, at the Anganwadi Centre, or even sometimes on the road or at their own homes. ANMs provided services to adolescents and youth sometimes in the course of outreach work in communities, but far more often in the course of their work in schools, and/or in their facilities, both through OPD services and at the AFHC. Counsellors and MOs rarely made community-level contacts with adolescents and youth. Rather, they interacted almost exclusively from within their facilities (PHC or CHC) and the AFHC; most did, in addition, conduct school visits.

Descriptions of experiences in serving adolescents and youth also differed by provider category. ASHAs reported serving adolescents and youth in the following ways: providing counselling about physical maturation, supporting

pregnant girls, providing contraceptive advice and supplies, and referring them to ANMs and doctors. The services provided by Counsellors also focused on information, counselling, provision of contraceptive supplies and referrals. ANMs and MOs reported a wider set of responsibilities. ANMs reported that they provided general health services as well as services for maternal health, family planning and symptoms of infection. Many ANMs also described counselling adolescents and youth for a range of problems—stress; concerns about body image, acne, menstruation, attraction to the opposite sex, pre-marital sex and condom use; supplying them with contraceptives, iron and folic acid tablets and sanitary pads, and providing treatment and referrals as appropriate. Several ANMs also discussed addressing concerns about infertility among young women and, sometimes, their husbands. MOs provided all of these services in addition to performing deliveries and abortions, and treating infections among adolescents and youth. At the AFHC, the services they described focused largely on providing information and counselling for various concerns, provision of contraceptives and referrals to higher-order facilities.

General counselling on physical maturation and sexual matters

Although most of the health care providers in our study reported providing information and counselling to adolescents and youth, they tended to serve a particular group of adolescents and youth—the married, the unmarried, girls, boys—rather than all of these groups. Overall, for example, the ASHAs served, on average, fewer than five adolescents and youth (mostly married girls) in a month, the ANMs reported counselling fewer than 10 girls and fewer than five boys a month; most Counsellors and MOs reported counselling 10–15 girls and boys per month, largely through school programmes and other outreach activities rather than at the AFHCs.

Counselling on physical maturation

All categories of health care providers reported providing information to adolescents and youth on general health concerns as well as physical maturation and the importance of diet for physical maturation. Their experiences and the concerns they addressed differed by the sex of the young client as well as the category of the provider. We note that married girls and boys rarely sought counselling about physical maturation. Since provider experiences of serving unmarried girls and boys differed, we explore these experiences separately.

Unmarried girls

While the health care providers we interviewed acknowledged that they counselled relatively few unmarried girls, most had some experience in counselling them on issues related to physical maturation. They reported that unmarried girls largely approached them for such physical maturation concerns as breast development, acne and menstruation, including menstrual problems such as heavy bleeding, irregular bleeding and menstrual cramps; generalised weakness and stress were also described. Many providers, in all four categories, had informed or counselled unmarried girls at some point on these issues as indicated by the following narratives:

They (unmarried girls) come with worries about body growth that is, when the breast size increases, about menstruation and also about mental stress. [ASHA, aged 31, working as an ASHA for seven years, Rajasthan, ID-12]

A girl may come to me with excessive bleeding. I advise her to use sanitary pads and also to keep herself neat and clean. I tell her that the pain she has during her periods is normal and that she will be all right after three to four days. Even after that, if she complains about pain, I give her a tablet and tell her that she will become all right after marriage. [ANM, aged 55, working at the OPD providing adolescent health services for 1.5 years, Rajasthan, ID-7]

Unmarried girls have problems of abdominal pain, leucorrhoea, burning sensation while passing urine and menstruation..... [ANM, aged 32, working at the OPD providing adolescent health services for 3–4 months, Rajasthan, ID-1]

Unmarried girls come when their breasts start growing because they usually suffer from pain in the breasts during that time. (They also come) if they have a lot of pain or excessive bleeding during their menses.... [ANM, aged 26, working at the AFHC for four years, Jharkhand, ID-2]

Girls come with concerns that their breasts have not grown and they need some medicine... I give all services to young people so that their problems can be sorted out by explaining to them. Sometimes, I refer

young people to a doctor if they come with problems other than those concerning physical maturation. I try to understand them, discuss with them and then it becomes easy to give them options. [Counsellor, aged 37, working at the AFHC for two years, Maharashtra, ID-2]

I also get girls who are worried about the MC (menstrual cycle). I tell them that it is natural; that after the age of 11–12 years, hormonal changes take place and body change happens like increase in breast size and the starting of menses. So, there is nothing to worry about. [MO, aged 50, working at the AFHC for one year, Jharkhand, ID-3]

I tell unmarried girls about menses and the role of menses. I tell them how nature has made boys and girls differently. That this (menses) is a process of changing a girl into a woman.... that when she grows up to be 18, her reproductive organs will be fully developed so that she can conceive; (after that) she becomes ready for marriage. This is how I counsel them....[MO, aged 32, working at the AFHC for six months, Maharashtra, ID-1]

The health care providers also described specific incidents in which they had counselled an unmarried girl; several providers highlighted incidents of girls who were afraid when they began menstruating and had not disclosed this to anyone in their family or peer network. All the providers suggested that interaction comprised reassuring girls that menstrual bleeding was normal, advising them about menstrual hygiene and informing them about sanitary napkins:

An unmarried girl came to me saying that she had a bleeding problem. She had not told anyone in her family about it. I asked her if it had happened for the first time or whether it had happened earlier also. She told me that it had happened for the first time. So I explained to her that her menstrual cycle had started and she would have this bleeding every month but that there is nothing to get scared about—it is natural and every girl of her age goes through this. I told her to keep her private parts clean and to use fresh sanitary napkins and cloth. [ANM, aged 26, working at the AFHC for four years, Jharkhand, ID-2]

An unmarried girl had come to me with a menses problem—when menses do not occur in a 15–17 year-old girl, she tends to think that she is suffering from some disease. I explained to her that sometimes menses starts at an early age and sometimes at the age of 16–17; but, there is nothing to be afraid of. (I told her so) because the girl who had come to me was 17 years old and her menses had not started; I took her to the CHC with me. [ASHA, aged 35, working as an ASHA for six years, Jharkhand, ID-7]

An unmarried girl once came saying she had a lump in her breast. After examining her, I counselled her saying that there is nothing to be worried about and what she was experiencing was normal and not a lump... Another girl had come when her periods did not occur for one month... I counsel them; I tell them that this is natural and happens with everyone. I listen to their problem patiently and then advise them; sometimes, I also give them treatment. [MO, aged 36, working at the OPD providing adolescent health services for two years, Rajasthan, ID-3]

Unmarried boys

As mentioned earlier, ASHAs and ANMs were rarely approached by unmarried boys. The few who were approached reported that the boys had articulated such concerns as body image, growth of body and facial hair, and the Adam's apple and voice change as illustrated by the following narratives:

They come here to know about changes in their body that is, hair growth on internal body parts. Yes, one boy who had come, complained about discharge and was looking for advice for the problem. [ASHA, aged 45, working as an ASHA for eight years, Rajasthan, ID-9]

Unmarried boys come because of concerns about the change in their voice or a husky voice, pimples on their face, their height not increasing, or being very thin. So, they request a meeting with 'Sir' (the MO) and ask for medicines. I tell them about having a healthy diet and give them folic acid tablets. [ANM, aged 42, working at the AFHC for three years, Maharashtra, ID-3]

Unmarried boys come to us if their Adam's apple is protruding, if they see some other change or if they face the problem of nightfall. [ANM, aged 26, working at the AFHC for four years, Jharkhand, ID-2]

The three Counsellors and 11 MOs had more experience in serving boys than did the ASHAs or ANMs. Although most of their unmarried, young male clients sought care for the same concerns as reported by ASHAs and ANMs, the

concerns expressed were more wide-ranging; for example, they included nocturnal emission, masturbation and penis size, issues that were rarely discussed with female health care providers:

A boy who had come to me told me about the physical changes in his body and also that he had started masturbating. I told him that there is no harm in masturbating and there is nothing to worry about, as usually, all boys of his age group do so. I also tell boys that hormonal changes occur at the age of 11–12 years, so hair starts growing on some body parts, and some body parts also start to grow... [MO, aged 50, working at the AFHC for one year, Jharkhand, ID-3]

One boy regularly comes to me with concerns about nightfall. I have counselled him and made him aware of the changes (that take place in boys of his age). Other boys come for problems of pimples, nightfall and masturbation. [MO, aged 32, working at the AFHC for six months, Maharashtra, ID-1]

Counselling on sexual matters, including pre-marital sex

The narratives of the health care providers suggest that adolescents and youth do occasionally approach them with concerns about sexual matters, including pre-marital sex. The sexual concerns of the unmarried and married differed.

Very few health care providers, regardless of their category, suggested that they had been approached by unmarried girls who had engaged in or were thinking about engaging in pre-marital sex. In the rare instances in which unmarried girls had approached them for sexual concerns, the typical case seems to be of a girl who had missed her periods after engaging in a pre-marital relationship, and the typical response of service providers appears to be that of advising the girl to undergo a pregnancy test, as the narratives below suggest. Also notable from the narratives is that unmarried girls who intended to engage in a pre-marital relationship rarely approached them for information about safe practices within such relationships. Findings are mixed with regard to the extent to which providers counselled these girls comprehensively and without judgement:

A girl was not getting her periods and she had a boyfriend—what advice should be given? This unmarried girl had come; she had missed her menses. Then, we did a pregnancy test. It was positive. So, I told her mother that the girl is pregnant and asked her the number of months that had passed since her last menses. Then, we took her to the doctor (MO) and he gave her some tablets. After that, she got her menses. [ASHA, aged 45, working as an ASHA for four years, Maharashtra, ID-4]

Once a girl came to me and said that she had not been getting her period. I told her to get a pregnancy test done and it was positive. When I told her that the test is positive she said that it could not be possible. Her mother began to cry, anxious as to what would happen to her daughter. Then I told them that what has happened is past (they should now think of what can be done about it). (I told her mother to) take her to a doctor. [ANM, aged 32, working at the OPD providing adolescent health services for X years, Rajasthan, ID-1]

If it (the pregnancy test) is positive, then I advise the girl to share this (her situation) with her mother; that if she does not tell her parents, she will face a big problem in future. [GNM, aged 36, working at the AFHC for two years, Maharashtra, ID-1]

A girl (studying in Class 10) who had relations with her cousin came to me directly from school, without informing her family members. I tried to understand her concern; she said she could not concentrate on her studies and also had a menses problem. However, in the course of enquiry and discussion, she opened up. I first asked her about her problem, why she did this (had a relationship with her cousin); that he was her brother, that is, her uncle's son which is as good as a real brother. (I asked her) what had happened to make her go to him. Then, I explained everything to her, made her talk, and she said that she would not do so again. First, we have to listen to her (the client's) problem, (understand) what is in her mind, why she did so (took such a wrong step), what are her wishes and what should be done in future. Only then (after listening to the client), we should counsel the client. [Staff Nurse, aged 42, working at the AFHC for one year, Maharashtra, ID-2]

A girl had come to the clinic, saying that she has had physical relations with someone and was afraid that she would become pregnant. She asked me what she should do. I told her that she need not worry and

should take these I-pills. (Giving her the pills), I told her that there are two pills and she has to consume them within 72 hours. I advised her to take one pill at night and the other the next day. [MO, aged 48, working at the OPD providing adolescent health services for two years, Rajasthan, ID-4]

Very rarely did ASHAs or ANMs report counselling sexually active unmarried boys on safe sex. Indeed, one or two ASHAs reported that they had been approached by a sexually active unmarried boy, but they had simply referred him to a male health care provider or to a health facility. Nevertheless, although more Counsellors and MOs had been contacted by this client group, their narratives also contained very few examples of such incidents, suggesting perhaps that sexually active boys have more sources of information and supplies than just the health care provider or AFHC. The boys who had approached Counsellors and MOs had discussed with them their worries about acquiring STIs and HIV from pre-marital relationships and enquired about safe practices that they or their partners could follow, as the narratives below indicate:

Unmarried boys come to us if they have kept wrong relations. One such unmarried boy had once come to me with a problem of white discharge. I enquired if he has had sexual relations with someone and suggested that he go to the hospital and get himself checked up. [ASHA, Jharkhand, aged 23, working as an ASHA for four years, ID-2]

A boy who had had sexual relations with his girlfriend came to see me. He was disturbed. After my programme, he approached me. He said that he had come because he was scared that he may have got a sexual problem (infection). He was scared of HIV. He said that he got information (about HIV/AIDS) by attending my ARSH programme and so he had come to me. He said that he had had relations with a girl two months back. She was his classmate, and they had fallen in love and had had sexual relations. In this situation, he had approached me for counselling and (HIV) testing. [Counsellor, aged 30, working at the AFHC for six years, Maharashtra, ID-1]

If an unmarried boy comes and says that he is having sex (is sexually active), I usually ask him to use condoms. But I ask him to avoid sex. If he cannot do so, only then I tell him to use condoms. [MO, aged 31, working at the AFHC for one year, Maharashtra, ID-2]

An unmarried boy, studying in Class 9, came to me recently. He said, 'Sir, please give me some solution (contraceptive) that the girl can use.' I asked him if he was married and he said, 'No, Sir.' but added that he has a girlfriend. I did not give him oral pills as it would make the girl's family suspicious (if they came to know about her taking oral pills). So I gave him the emergency pill and told him that the girl must take it within 72 hours of having sex, otherwise she may become pregnant. [MO, aged 48, working at the OPD providing adolescent health services for two years, Rajasthan, ID-4]

In rare cases, unmarried boys had approached a Counsellor for pre-marital counselling as well:

A boy came, not for a problem, he wanted some information. He was getting married and he wanted information about whether he should do some tests like HIV. When we started talking, other things also came up that he was curious to know about. He wanted to know about HIV, about sexuality, also when he should have a baby, how to plan for it as also financial planning. So, we talked about his work, when he should have a baby, what he should do for financial planning, what (contraceptive) he should use—Nirodh or some other device like oral pills. I also explained to him the role of his partner: what he thinks is one way but what his partner wants could be quite another and so, he should try to understand her. I told him all this during counselling. He said that he would also bring his wife to the clinic after marriage. So, where it (consultation) started (the conversation started with a query about HIV tests) and where it ended (led on to contraception and finally, to financial planning)! (Thus, for him), the benefit of coming here was also planning for the future. [Counsellor, aged 37, working at the AFHC for two years, Maharashtra, ID-2]

Boys also come if they have had sexual relations with a girl. Then (in such cases), they ask for condoms.... Unmarried girls and boys come too. Then, we first talk to them. Later, we give them sex education and counselling (as required). [Counsellor, aged 30, working at the AFHC for six years, Maharashtra, ID-1]

Although rare, Counsellors and MOs were approached by married girls about sexual matters, such as, for example, concerns about pain during sexual relations and fears about HIV. Few providers had counselled married women in the recent past, but described those they had ever counselled to have expressed these concerns:

Married girls who come for counselling (often) want information about AIDS; they are scared they may be infected and their children may also be infected. (They) also come for (treatment for) UTIs, RTIs and STIs. [MO, aged 50, working at the AFHC for one year, Jharkhand, ID-3]

They (married girls) come for treatment of white discharge. Also, they are always anxious about pain during sexual relations. These are their main problems and they don't know what to do. [MO, aged 35+, working at the AFHC for two years, Maharashtra, ID-3]

Married girls do not come with just one complaint; they come with several complaints. Many of them come because of concerns about their first contact after marriage; they experience pain and then they don't want to keep contact. Then, they come with questions like: Why does this (pain) happen? What is the female internal structure? What is the male internal structure? Why is this happening? [Counsellor, aged 37, working at the AFHC for two years, Maharashtra, ID-2]

Finally, while married boys rarely sought counselling from health care providers, the few providers from whom they had sought such services reported concerns about such issues as nocturnal emission, premature ejaculation and extra-marital relations. By and large, it was Counsellors and MOs who were approached for counselling on sensitive topics such as nocturnal emission, masturbation and sexual performance, including, for example, premature ejaculation, inability to satisfy their wife, and so on. For example:

Married boys' problems are about wet dreams or premature ejaculation, and some say that they cannot make their wife happy. They want to talk to someone but don't know to whom. We try to understand (their problem) first, and then send them to Sir (the MO). [GNM, aged 36, working at the AFHC for two years, Maharashtra, ID-1]

They complain that during intercourse, they ejaculate very early; they are scared because they have read a poster about early discharge causing problems. Thus, they have misconceptions about it. I tell them that it is all right and everything will be fine after some time. [MO, aged 37, working at the OPD providing adolescent health services for one year, Rajasthan, ID-1]

Sometimes, even after two to three months of marriage, boys are not satisfied. Some have a problem of premature ejaculation; they ask whether it is an illness and whether it can be cured because they cannot satisfy their wife. [MO, aged 35+, working at the AFHC for two years, Maharashtra, ID-3]

Contraception: provision of information, counselling and supplies

Provision of contraceptive information, counselling and supplies varied widely both by provider category and group of young people. Contraceptive counselling and supplies were overwhelmingly provided to married girls by all the providers: 35 of 46 ASHAs, 19 of 20 ANMs, 10 of 11 MOs and all three Counsellors. Indeed, providing contraceptives to the married was seen as part of their general responsibilities by almost all ASHAs and ANMs. Other categories of adolescents and youth were far less likely to have been served. Just 15 of 46 ASHAs, six of 20 ANMs, six of 11 MOs and all three Counsellors had ever provided supplies to married boys, and even fewer—2–3 ASHAs, 3–4 ANMs, 5–6 MOs and the three Counsellors—had provided contraceptive counselling or supplies to the unmarried. Further, among those who reported providing such services, not a single ANM had distributed contraceptives to five or more adolescents and youth in the month preceding the interview; not a single ASHA reported that she had provided contraceptives to an unmarried girl, or indeed that she had been approached by an unmarried girl, and several MOs and Counsellors reported that they had requested young clients to take contraceptives (condoms) from a box they maintained outside their office or from the OPD.

The narratives of the health care providers highlight that most providers were well informed about methods appropriate for the unmarried, the newly married and those who already had children. Several suggested, moreover, that they were aware that they were expected to exhibit non-judgemental attitudes and provide information about all contraceptives but allow the client to choose the one most suitable to her/him, as the following narratives indicate:

No, I have not given any contraceptives to unmarried girls; only to married girls. One girl came here to take Mala-N; I told her to start the tablets after the fifth day of menstruation and if she misses it for a day, she should take two tablets the next day, and if she misses it for a third consecutive day she should start the course all over again. I also gave her Nirodh (condoms) for her husband. [ASHA, aged 27, working as an ASHA for seven to eight years, Rajasthan, ID-5]

We tell newly married couples that if they don't want a child they should use condoms; that whenever they have sex, the woman should clean her private parts so that she does not catch any venereal disease; that when they want a child, they should stop using the method. If a couple wants a gap between children, we give them tablets (oral contraceptive pills), condoms and also emergency tablets (I-pill); we also tell them that they could use a Copper-T. Sometimes, we also provide condoms and I-pills to the unmarried. These days, young people are very smart. We don't have to tell them anything; they use all these things (contraceptives) on their own.... [ANM, aged 53, working at the OPD providing adolescent health services for two years, Rajasthan, ID-4]

An approximately 23 year-old girl, who got married when she was studying, did not want her first child immediately. She asked for a solution: 'What shall I do?' I told her to use the safe period method, that ten days before and after MC it is a safe period, the other ten days are risky and so she should tell her husband to use a condom (on these days). I also told her that whenever they want a child, they should stop using the condom; then, I gave her a packet of condoms. I have not given contraceptives to married boys or unmarried persons. [ANM, aged 41, working at the OPD providing adolescent health services for 7-8 years, Rajasthan, ID-5]

A married girl, with a child of 5-6 months, who did not wish to have another child soon, came asking for Mala-N. I explained to her that she should not take Mala-N in this condition (when breastfeeding) because it could affect her baby. I told her about Nirodh and also gave it to her. An unmarried boy had also come asking for Nirodh; so I gave it to him. A married boy who had a child and didn't wish to have another child asked me to give him some remedy (contraceptive). I told him about Mala-N, Nirodh and Copper-T. He asked for Mala-N, so I gave him Mala-N and Nirodh, and told him that if his wife forgets to take the pill, he should use the condom.... [ANM, aged 34, working at the AFHC for one year, Jharkhand, ID-5]

I have given Nirodh to a married woman of 19 years; she had come for Nirodh. I also gave her oral pills. [ANM, aged 42, working at the AFHC for three years, Maharashtra, ID-3]

No unmarried girl has ever come to me. A married girl had come; she had a six-month-old child and didn't want another right then. Since her periods had not come, I sent her for a pregnancy test which was negative. Then, I advised her not to use Mala-D while she is breastfeeding and to tell her husband to use condoms....No unmarried boy has come to me because I have placed condoms on the counter outside; whosoever needs condoms can come and take them from there.... A married boy had come because he didn't want a child, so I advised him to use a condom during sex or his wife could get a Copper-T inserted. [MO, aged 32, working at the OPD providing adolescent health services for one year, Rajasthan, ID-2]

No unmarried girl has ever come to me, but an 18-year-old married girl had come to consult me. She had not come for contraceptives; still, I told her about some methods to avoid pregnancy. She had never heard about Copper-T or Mala-N. An unmarried boy had also come for condoms. I told him to take as many as he wanted from the nurse sitting outside. I told him that he could give some to his friends also. No married boy has come (to consult me). [MO, aged 50, working at the AFHC for one year, Jharkhand, ID-3]

I have given Mala-D to a married girl. A married boy had also come; I gave him a packet of condoms and explained how to use a condom; gave him a demonstration. [MO, aged 35+, working at the AFHC for two years, Maharashtra, ID-3]

From the above narratives, it is clear that health care providers described their interactions with the married in far greater detail than they did their interactions with the unmarried, and that the married sought advice for delaying the first birth as well as spacing births. In a couple of instances, it appears that the providers may have had some discomfort in providing contraceptive information and supplies to the unmarried. One ASHA suggested, for example, that she had referred the unmarried girl to a doctor; while a MO suggested that he had referred the unmarried boy to the assistant from whom he was expected to collect condoms:

An unmarried girl had come to me for advice. She had relations (was in a sexual relationship) and wanted to know what can be done (to prevent pregnancy). I told her to go to a doctor and if she wanted to have relations again, they (she and her partner) should use condoms. [ASHA, aged 31, working as an ASHA for seven years, Rajasthan, ID-12]

In addition, the narratives of a few ASHAs suggest some misconceptions and judgemental attitudes even while providing contraceptive information and supplies to the married, such as, for example, advising married girls to refrain from contraception until after the first child, and taking oral contraceptives half an hour prior to sexual relations:

A married girl had come here to take Nirodh. I gave her Mala-D and gave Nirodh to the boy (her partner). I told her to take the tablet half an hour before having sex...[ASHA, aged 28, working as an ASHA for eight years, Rajasthan, ID-3]

Only recently, a married girl had come to get Nirodh from us. I gave her the contraceptive pill, Mala-N, and advised her not use protection now and to have a baby, but she said she didn't want to do so. [ASHA, aged 37, working as an ASHA for seven years, Rajasthan, ID-8]

A few ASHAs (5 of 46) noted that contraceptive services were hampered by the erratic supply of contraceptives, notably oral contraceptive pills and condoms. This concern was expressed across all three states; moreover, these ASHAs reported accompanying adolescents and youth to a facility to obtain them:

No, we do not have contraceptives and nobody has come to us. [ASHA, aged 30, working as an ASHA for two years, Maharashtra, ID-15]

Provision of pregnancy-related information, counselling and services

The provision of pregnancy-related information, counselling and services is a key responsibility of ASHAs, ANMs and several of the MOs and, as such, many of these health care providers reported interaction with pregnant girls, and sometimes their husbands, in the course of their regular duties. Narratives suggest that almost all ASHAs provided pregnancy, delivery and/or postpartum-related counselling and support to married young women:

R: A married girl comes with problems related to pregnancy like she has conceived and is suffering from vomiting, loss of appetite, dizziness, swelling in the hands and feet. These girls bring these kinds of problems to me.

I: Okay Didi, can you give me a recent example?

R: Yes. I advised a girl who had come with problems related to pregnancy. Her name was Meena Devi and she had swelling in the legs and complained of a burning sensation in the stomach. [ASHA, aged 36, working as an ASHA for five years, Jharkhand, ID-11]

Almost all ANMs provided antenatal and delivery services to married young women. Indeed, seven ANMs reported that they had provided services for 10–19 married girls, and another seven for fewer than 10. Antenatal services involved such services as antenatal checkups, including taking blood pressure, a haemoglobin test and weight; immunisation, and providing iron and folic acid tablets. Narratives further suggest that almost all ANMs counselled pregnant girls on diet, rest, regular check-ups and immunisation schedules; several discussed postpartum contraception and a few recommended HIV testing. Besides, several ANMs also informed pregnant girls about refraining from sexual relations, and a few emphasised the need to deliver in a facility and save for emergencies. We note that all of these tasks fall within their responsibilities relating to pregnancy care in general, and not specifically those intended for adolescents and youth. For example:

We have an ANC (antenatal care) Clinic. We give all things (services) to her (young pregnant woman) there. We give her information right from pregnancy to delivery—what care she should take, what treatment she should take, and how she should prepare for delivery and after delivery. [ANM, aged 42, working at the AFHC for one year, Maharashtra, ID-2]

I tell pregnant young women not to have sexual relations during pregnancy and advise them to take a proper diet in the first and third trimesters. I tell them regarding cleanliness; I advise them to take rest, not to pick heavy weights, to come for regular checkups every month and to consult the doctor if there is any problem. [ANM, aged 35, working at the AFHC for one month, Jharkhand, ID-6]

I tell young women about immunisation, nutrition and personal health. I also tell them how they should take care of their baby, how they should feed the baby and about contraception. This is the period when they listen and do what you advise. I tell them not to hurry for a second child so that they can take good care of the first baby. [Staff Nurse, aged 28, working at the AFHC for eight months, Maharashtra, ID-4]

Almost all the ANMs we interviewed reported that they generally counselled the husbands of pregnant young women as well. While it is unclear whether they did so for husbands of most of their pregnant clients, many ANMs suggested that they advised husbands to ensure that their wife received a healthy diet, sufficient rest and regular checkups, and did not carry heavy objects. Several also mentioned advising husbands to refrain from sex during certain months of pregnancy. In a couple of cases, ANMs reported advising husbands to prepare for delivery, save for emergencies, and use available transport facilities to transport women at the time of delivery; a few also advised HIV tests and condoms if engaging in extra-marital relations. For example:

I tell them (husbands) that after the 28th week they should not have sexual relations with their wife. I tell them that she (the wife) should not pick up heavy things, she should drink milk and eat green vegetables and fruits, and that the delivery should be done in a hospital only. [ANM, aged 53, working at the OPD providing adolescent health services for two years, Rajasthan, ID-4]

I advise the husband not to trouble his wife and not to scold her, not to let her pick up heavy weights, to save money for an emergency because no one knows where he may have to rush his wife to at the last moment (for delivery). I also advise him to help his wife always. [ANM, aged 46, working at the AFHC for two months, Jharkhand, ID-7]

We tell husbands to have an HIV test; we give information to husbands once or twice. [Staff Nurse, aged 42, working at the AFHC for one year, Maharashtra, ID-2]

Most MOs also provided pregnancy-related services as part of their general health facility duties for all women, including young women. Narratives suggest that they provided pregnancy-related counselling and services to 3–10 girls per month. Counselling focused on diet, immunisation and the importance of regular checkups; many MOs also advised refraining from sexual relations during certain months of pregnancy. Eight of the 11 MOs in our study had also counselled the husbands of pregnant women on how to care for their pregnant wife and when sexual relations are not advisable:

I normally advise pregnant girls about diet, TT (tetanus toxoid) injections, iron pills and regular checkups etc. I advise the husband to make sure that his wife goes for regular checkups at two-month intervals, does not pick up heavy weights, takes a proper diet etc. [MO, aged 34, working at the AFHC for three months, Jharkhand, ID-2]

I advise the pregnant woman to be alert about the day when she misses her menses; that she should come to the clinic and get her urine and blood tests done, take a booster dose after the completion of the first three months, register for ANC and get her height, weight and complete blood tests done—which include haemoglobin and HIV tests. I tell them about the diet they should take and about taking iron tablets. I get their lab tests done free of cost. The husband usually asks about sexual intercourse during pregnancy, that is, up to which month they can have sex. I just give them advice. [MO, aged 35+, working at the AFHC for two years, Maharashtra, ID-3]

A few health care providers, largely ANMs and MOs, reported that they had been approached by married girls who were concerned about difficulty in getting pregnant, excessive bleeding and symptoms of infection, or wanted to undergo an abortion as the following narratives suggest:

Married girls come mostly with problems about their menstrual period; some say that the bleeding is too little and some that they bleed excessively. Also, some worry that they are not able to give birth to a child while some are pregnant or about to deliver. [ANM, aged 32, working at the OPD providing adolescent health services for 3–4 months, Rajasthan, ID-1]

Some girls who have been married at a young age and their child has got aborted on its own (have had a spontaneous abortion), want to know why this has happened to them. I suggest that till the time they turn 18 (and their reproductive organs develop fully), they should use condoms or Mala-N; after that, they should be fine. [ANM, aged 32, working at the AFHC for three years, Jharkhand, ID-3]

A married girl had come to me for advice because she was pregnant and did not want the baby. I told her that it could not be cleaned (she could not have an abortion) as her in-laws wanted it (the child) but to be careful the next time. [ASHA, aged 28, working as an ASHA for six years, Rajasthan, ID-1]

Symptoms of infection: provision of information, counselling and services

Among the health care providers we interviewed, mainly ANMs and MOs reported that they had treated adolescents and youth with symptoms of infection. ANMs (14 of 20) were usually approached by girls whose typical concerns included burning during urination, heavy bleeding and discharge, although a few had also sometimes served girls with genital ulcers, itching and so on. While MOs reported to have treated both boys and girls, just two ANMs reported serving boys, largely with concerns about discharge. Most ANMs had considered these symptoms serious and referred them to the MO in their facility or to a higher-order facility. The majority of MOs had been approached by adolescents and youth seeking counselling or treatment for symptoms of infection during the course of their general practice, although in the month preceding the interview, seven of the 11 MOs in our study had provided such counselling and treatment through the AFHC. The following narratives affirm these reports:

A married girl complained about a burning sensation while passing urine. I examined her and found that there was redness in her private parts and itching too. Hence, I told her that till such time as the redness subsides, she should not have sex and took her to the doctor for medicine. I tell all girls who come to me to maintain cleanliness and use undergarments washed with Dettol. I also tell them not to use someone else's undergarments. I tell married girls that they should not have sexual relations with their husband till the infection subsides, and to take their medicine (regularly). [ANM, aged 32, working at the OPD providing adolescent health services for 3-4 months, Rajasthan, ID-1]

Some girls come with the problem of vaginal infection... An unmarried girl had come to me; she complained of itching and swelling in her private parts. I examined her and saw that she also had some kind of watery discharge and boils in her private parts. I took her to Sir (the MO) and explained everything. He gave her medicine and told her that if she did not feel better, she should come again.... A married girl had once come to me. She was also suffering from itching in her private parts. When I examined her, I found that her private parts were very dirty. I told her that she should keep herself clean and if she uses a cloth (during her menses), she should sterilise it. I tell everyone to use sterilised cloth. I also tell them that if they face any serious problem, they can come and meet Sir (the MO). [ANM, aged 32, working at the AFHC for three years, Jharkhand, ID-3]

A married girl had come some time ago, complaining of burning while passing urine, irritation and some inflammation of her private parts. I told her about regular cleanliness and most other details; I also told her to use soap and take the prescribed tablets on time. I counselled her and asked her husband to use a contraceptive till she gets cured (of the infection)... (In the case of) girls who complain of bleeding, we should explore the reason for the bleeding. If she is married, then we should find out why she is bleeding; was she pregnant and if so, for how many months? (We should do this) so that the ANM or Staff Nurse can explain everything to the doctor. In the case of boys, I refer them to the doctor; they will get medication from the doctor. [Staff Nurse, aged 28, working at the AFHC for eight months, Maharashtra, ID-4]

An unmarried girl had come with a problem of itching and discharge. I counselled her accordingly and treated her, advising her to take such-and-such medicine (prescribed) for so many days (specified) and then come back if she feels like consulting me again... A pregnant woman had also come, complaining of white, milky discharge.... An unmarried boy who had an infection on his penis had come once; I advised him regarding hygiene and also gave him an antibiotic... [MO, aged 32, working at the AFHC for three years, Jharkhand, ID-4]

An unmarried girl had come to me; she had acne and had had contact with her boyfriend. I did all the tests. It was a regular RTI; she had heavy white discharge. So, I treated her accordingly. For the unmarried boy (her partner), I gave some treatment and counselling simultaneously. [MO, aged 32, working at the AFHC for six months, Maharashtra, ID-1]

Referral

Many of the ASHAs, ANMs and Counsellors in our study reported that they had referred clients, including adolescents and youth with conditions that they could not resolve, to more qualified health care providers or higher-order facilities. For example, several ASHAs reported that they had referred a married girl in need of contraception to the ANM, or a girl suffering from weakness to the ANM or to a health facility. As is evident from the above narratives,

ANMs tended to refer girls reporting symptoms suggestive of infection, heavy bleeding, urinary tract problems, concerns about infertility and anaemia to MOs. A number of ANMs also reported referring most of the boys who approached them to a MO, compounder, MPW or other male health care provider. Likewise, Counsellors referred young clients who required treatment to other departments of the facility in which the AFHC or ICTC was housed or to a higher-order facility. A few health care providers had, however, referred a young client in the month preceding the interview, and those who had done so, described the concerns of their clients as follows:

I have not referred any unmarried girl. But yes, I have referred a married girl who was anaemic at the time of pregnancy. I referred her to the CHC. I took her there because the ANM Didi advised me to take her to another place (service centre) because there were no facilities here (at the AFHC). (So far,) I have not referred any married boy to any health service centre. [ASHA, aged 40, working as an ASHA for six years, Jharkhand, ID-4]

Yes, a married girl's delivery was due so I took her to the PHC but, since the ANM was not available, I referred her to the CHC in Hindon. In the last one month, I have referred only one person. [ASHA, aged 38, working as an ASHA for seven years, Rajasthan, ID-7]

A girl came complaining about pieces (clots) during her periods, so I asked her if anyone had touched her and the date of her last period. She told me that nothing like that had happened (no one had touched her). I told her that we should get her checked up and sent her to the CHC for a checkup.... Once, while on fieldwork, I met a married girl who said she didn't want another child. She already had a boy and a girl and had not got her period for the past two months. So I sent her to the CHC and told her to get a pregnancy test done and get advice from Madam (the lady MO). [ANM, aged 53, working at the OPD providing adolescent health services for two years, Rajasthan, ID-4]

I have referred an unmarried girl who was about 16 or 17 years old. She had come with her sister as she didn't know about these things (getting pregnant, abortion). She was four months pregnant and asked if anything could be done about it. So, I sent her to Madam (female MO). I don't know whether she went to her or not.... When boys come after having relations and feel something is wrong with them, I refer them for an HIV test. When girls come with menses problems, I refer them to the gynaecologist, and for skin problems, I refer them to the doctor. [Counsellor, aged 30, working at the AFHC for six years, Maharashtra, ID-1]

As expected, MOs referred only the most serious cases or those for which treatment at their facility was not available. Because they typically served in facilities in which other specialists were on hand, referrals were a relatively rare event and just two MOs reported that they had referred a young person to a higher-order facility in the month prior to the interview. Nonetheless, all reported that if required, they referred cases to the District Hospital or another higher-order facility. Narratives suggest that the condition for which MOs were most likely to refer adolescents and youth was symptoms suggestive of reproductive tract infections or sexually transmitted infections, and unintended pregnancy and abortion. They described their recent experience thus:

An unmarried girl had had unsafe sex and wanted a tablet (to prevent pregnancy). I told her to go to the AFHC where they have trained staff who would give her the medicine. An unmarried boy had also come complaining about pimples on his private parts. I examined him; there were red spots on his penis. I sent him to a private clinic as we don't have treatment for this (at this facility). If a male has ulcers on his penis and other such problems which cannot be treated easily, I refer him to a skin specialist. [MO, aged 32, working at the OPD providing adolescent health services for one year, Rajasthan, ID-2]

An unmarried girl had come to see me. She was 13 years old and her parents had brought her. She said she had a stomach ache. On asking many times, she admitted that a little bleeding had occurred and then it had stopped. I referred her to Sadar (District) Hospital. Once a married girl had come saying that she was 3-4 months pregnant as her period had stopped 3-4 months ago. I did a urine test and found that she was not pregnant. Then, I asked her whether she had some other problem, and she said that there was a little swelling in her internal body (private) parts. So, I gave her some first aid and referred her to Sadar Hospital. [MO, aged 34, working at the AFHC for three months, Jharkhand, ID-2]

A married boy had come with a genital infection. He had had it for many days but said that it had started only two to three days earlier. I gave some first aid and referred him to the District Hospital... [MO, aged 34, working at the AFHC for five months, Jharkhand, ID-2]

Summary

In describing their experiences, all four categories of health care providers consistently suggested that few adolescents and youth attended AFHCs and that few were even aware of their existence. Settings in which interaction occurred with adolescents and youth differed by provider category. ASHAs met adolescents and youth in the course of their community-based work, in the homes of adolescents and youth, at the Anganwadi Centre, or even sometimes on the road or at their own homes. ANMs provided services to adolescents and youth sometimes in the course of outreach work in communities, but far more often in the course of their work in schools, and/or in their facility, both through OPD services and at the AFHC. Counsellors and MOs rarely made community-level contacts with adolescents and youth. Rather, they interacted almost exclusively from within their facility (PHC or CHC) and the AFHC; most, in addition, conducted school visits.

Although all categories of providers reported that in the course of carrying out their responsibilities, they served both girls and boys, and the unmarried and the married, their narratives suggest that the thrust of provider-youth interaction was largely gendered. While Counsellors tended to report a more gender-balanced clientele, ASHAs and ANMs acknowledged that they were more likely to serve girls than boys, and the married more than the unmarried, and MOs (all male) reported that while they served both girls and boys, they were more likely to focus on boys, and more likely to refer girls to female MOs and other female staff such as ANMs or nurses, if available.

Even so, many of the health care providers did have some contact with each of these different groups of adolescents and youth that the ARSH programme is intended to serve. Descriptions of experiences in serving adolescents and youth differed by provider category and the group of young people served. While all provider categories were approached for counselling about physical maturation and sexual matters, Counsellors and MOs appeared more likely than ASHAs and ANMs to be approached for more sensitive issues such as masturbation, nocturnal emission, sexual performance and pre- and extra-marital relations among boys, and concerns about breast development, unwanted pregnancy, contraception for the unmarried and so on among girls.

Counselling on physical maturation and sexual matters focused largely on menstrual hygiene, breast development and diet for unmarried girls, and growth of facial hair, voice change, nocturnal emission and so on for unmarried boys. Married girls and boys rarely approached health care providers for concerns about physical maturation. Besides, very few providers had been consulted by unmarried adolescents and youth who had engaged in or were thinking about engaging in pre-marital sex. Counselling of boys was largely conducted by Counsellors and MOs, although some ASHAs and ANMs also did so.

Counselling on contraception and pregnancy-related care; provision of contraceptive supplies and support; and services for women requiring contraception, or during pregnancy and delivery continued to be the main focus of contact between the health care providers (aside from Counsellors) and, as such, the focus was largely on married girls and conducted in the course of fulfilling family planning and maternal health responsibilities rather than ARSH, per se. A few providers, largely ANMs and MOs, had counselled or treated married girls who were also concerned about difficulty in getting pregnant. Fewer—about one-third of ASHAs and ANMs and more than one-half of MOs (and all Counsellors)—had also provided contraceptive supplies to married boys. Most ANMs and MOs had provided pregnancy-related counselling to husbands of pregnant girls, including advising them on delivery-related preparations, saving for emergencies, transport facilities, HIV testing, and refraining from sexual relations during certain months of pregnancy. While rare, adolescents and youth with gynaecological problems and symptoms of infection had also approached the health care providers, although ASHAs and ANMs were hardly ever approached by boys. ANMs and MOs described treating or counselling girls, and MOs described doing so for boys as well. Most frequently described were such concerns as burning during urination, heavy bleeding and discharge among girls, and discharge among boys. Finally, the providers were responsible for referring adolescents and youth with conditions that they could not resolve to more qualified health care providers or higher-order facilities. Such cases were referred (by ASHAs, ANMs, Counsellors), treated (by ANMs, MOs) or, rarely, referred to higher-order facilities by MOs.

Most health care providers were well informed about contraceptive methods appropriate for the unmarried, the newly married and those who already had children as also the need to be non-judgemental and to respect the client's right to choose. Nevertheless, narratives do suggest discomfort in addressing sexual matters, in general, and those relating to an opposite-sex young person, in particular. Indeed, in several instances, ASHAs and ANMs referred boys who approached them to male MOs and other male providers, and, likewise, MOs (all male) reported referring girls to female MOs, ANMs and other female staff, as available.

Chapter 5

Provider perspectives on barriers to providing services to adolescents and youth

Health care providers acknowledged during interviews that very few adolescents and youth approached them for services and took advantage of the services provided at the AFHC. Accordingly, we sought their perceptions about the obstacles they faced in delivering services to adolescents and youth. Our findings are described in this chapter.

The health care providers listed a range of obstacles. Some of the obstacles were related to adolescents and youth, while some were linked to their gatekeepers; yet other barriers were provider- and facility-based. We note that providers from all three states perceived a similar set of obstacles that inhibited them from providing quality services to adolescents and youth.

Adolescent- and youth-related barriers

All cadres of health care providers identified lack of awareness about AFHCs among adolescents and youth; their discomfort in discussing sexual health topics, particularly with opposite-sex providers; and their concerns about the quality of care, including privacy and confidentiality of services, as major obstacles to delivering services to adolescents and youth.

Limited awareness of AFHCs: Most of the MOs (8 of 11) and several ANMs (13 of 20) expressed concern about the limited awareness among adolescents and youth about the AFHC, the services it provided and their right to make use of them, and called for more publicity, including awareness-raising campaigns at the community and school levels. For example:

They (adolescents and youth) are not educated (aware of the AFHC and its services); they don't have this information. [ANM, aged 41, working at the OPD providing adolescent health services for five years, Rajasthan, ID-5]

I: Why do only few people come here to take services?

R: In our community, girls are not very outgoing. Therefore, they do not share (voice) their problems, and even if they do, they are taken in a wrong sense (misunderstood).

I: Do you think because of lack of information people don't come here?

R: Yes. [MO, aged 36, working at the OPD providing adolescent health services for X years, Rajasthan, ID-3]

....because of lack of information, youngsters rarely come (to the AFHC). [ANM, aged 32, working at the AFHC for three years, Jharkhand, ID-3]

Information should be provided in every village by the Village Health Committee through role plays, display boards, TV as well as through the Assistant or Anganwadi Worker. Then, more and more youngsters will come to this Centre and get good services. [ANM, aged 35, working at the AFHC for seven years, Jharkhand, ID-6]

Actually, very few people know about Maitree Centre (AFHC). Even when we go to schools, we don't reach all (students); suppose there are 100 students in the school, we give information to just one or two classes. Thus, the AFHC is known to very few; so, few young people come to us. Nobody knows about it, neither the students nor the teachers talk about it, and hence very few (young people) come to the Centre. (Counsellor, male, aged 37, working at the AFHC for two years, Maharashtra, ID-2).

Very few adolescents and youth—only 10 percent of OPD patients—come to the ARSH clinic. The reason is that they lack information because there has been no publicity about it. [MO, aged 32, working at the AFHC for two years, Jharkhand, ID-4]

Very few take advantage; there is not enough awareness. [MO, aged 31, working at the AFHC for one year, Maharashtra, ID-2]

Advertising is very necessary. It can be done either through mikes or pamphlets. There should be one trained person in the village to do so (publicity) through role plays and street plays. [MO, aged 32, working at the OPD providing adolescent health services for one year, Rajasthan, ID-2].

Discomfort in discussing sexual health matters with health care providers: ASHAs, ANMs and MOs observed that adolescents and youth are generally embarrassed and shy to discuss sensitive health issues with health care providers and that they feel particularly uncomfortable about seeking services from opposite-sex providers. This poses a challenge to the providers, particularly ASHAs, in delivering services to adolescent boys and young men. Many ASHAs reported that boys are reluctant to seek services from them, that boys are concerned about what the provider will think about them if they ask for condoms or that boys may get scared if they discuss sexual health topics with them. For example:

(We discuss sensitive matters) mostly with girls because boys can talk only to boys and girls only to girls. I talk to girls because girls don't feel shy with each other and talk openly...[ASHA, aged 25, working as an ASHA for six years, Rajasthan, ID-2]

Yes, young boys feel awkward to talk to us because (we will come to know that) they know about the condom and its uses. So, they feel shy to ask us (for information or services). [ASHA, aged 29, working as an ASHA for six years, Jharkhand, ID-5]

Boys feel shy to tell us their problems. They are reserved or they cannot come close. [ASHA, aged 45, working as an ASHA for four years, Maharashtra, ID-4]

Talking to boys is difficult because when the ASHA talks to a boy, he (tends to) think that this woman (the ASHA) is talking to me about these (sensitive) things, and may get scared of her. [ASHA, aged 26, working as an ASHA for four years, Maharashtra, ID-1]

(It is) difficult to do so (talk on sensitive matters) as there are very few girls who are able to talk about their problems openly. [ANM, aged 26, working at the AFHC for one year, Jharkhand, ID-2]

Very few young people take services (from AFHCs)... because of shyness, hesitation. [MO, aged 32, working at the OPD providing adolescent health services for one year, Rajasthan, ID-2]

Young people are also shy. [MO, aged 31, working at the AFHC for one year, Maharashtra, ID-2]

Concerns about quality of care: Finally, all cadres of health care providers acknowledged that adolescents and youth are concerned about the quality of care that they receive at the AFHCs. For example, many ASHAs argued that the quality of care received by adolescents and youth who they referred or accompanied to health care facilities was judgemental and uncaring and resulted in their losing the respect of the young people they had intended to serve. They also suggested that adolescents and youth are deterred from seeking services from AFHCs because of lack of medicines, lack of privacy and lack of cleanliness at the facility. The narratives below verify these concerns:

While talking, the youngsters tell us their problems—that when they go to the health centre, their medical treatment is not done properly and they also don't get medicines. The doctors neither give them any medicines nor do they talk to them nicely; rather, they scold them for one or the other matter. These are the problems that the youngsters face. [ASHA, aged 27, working as an ASHA for six years, Jharkhand, ID-14]

Young people tell us that they don't get all the medicines at the government hospital. There are no rooms for checking up patients; (they say that) there should be more rooms and that more doctors and medicines should be made available. (They) also say that there should be cleanliness in the AFHC. (All this should be provided) so that the youngsters don't come and complain to us. [ASHA, aged 23, working as an ASHA for five years, Jharkhand, ID-15]

They (service providers) should talk nicely and properly to patients. [ASHA, aged 26, working as an ASHA for four years, Maharashtra, ID-1]

When they (young clients) come to the health centre, they are afraid that Sister (Staff Nurse) will say something to (scold) them. They themselves feel like this and so, if they come to us, I tell Sister to please

give them what they want. Sister has to make more effort to talk to them. [ASHA, aged 42, working as an ASHA for five years, Maharashtra, ID-3]

Similarly, several ANMs (11 of 20) and MOs (7 of 11) reported that adolescents and youth were concerned about lack of privacy at the facility and confidentiality. For example:

They (adolescents and youth) are also worried about their privacy. [ANM, aged 41, working at the OPD providing adolescent health services for five years, Rajasthan, ID-5]

If two people are sitting in your room and a young girl comes and you take her to a separate room to ask her about her problem and advise her, when she comes out, the people sitting there will ask her what happened inside. [ANM, aged 26, working at the AFHC for one year, Jharkhand, ID-2]

There is a social reason, that is, if someone sees them (young boy or girl) coming here (to the AFHC), what will that person say? There may be fear about confidentiality—what if the ANM tells someone about their discussion? [Staff Nurse, aged 42, working at the AFHC for one year, Maharashtra, ID-2]

Young people may be concerned about secrecy (confidentiality). They wonder how they could possibly discuss their problem in front of so many people. [MO, aged 32, working at the OPD providing adolescent health services for one year, Rajasthan, ID-2]

There is also a fear of lack of confidentiality. [MO, aged 31, working at the AFHC for one year, Maharashtra, ID-2]

Gatekeeper-related barriers

The health care providers acknowledged that influential adults in the lives of adolescents and youth also sometimes posed challenges to them in delivering services to young people. The obstacles posed by gatekeepers operated differently in the case of ASHAs compared to other cadres of health care providers in that mothers and mothers-in-law were suspicious of the ASHAs' attempts to contact their daughters and daughters-in-law, respectively; as a result, ASHAs had to spend considerable time to make their role understood to these gatekeepers before getting access to the girls. For example:

Sometimes we face obstructions; for example, initially, we go to the mother-in-law and explain to her (why we want to meet her daughter-in-law). If she doesn't understand the first time, we go to her a second and a third time and only then she understands and allows her daughter-in-law to talk to us. They (mothers-in-law) say that they (ASHAs) should not disclose SRH matters to just anyone. [ASHA, aged 38, working as an ASHA for five years, Jharkhand, ID-1]

Some people are uneducated and don't let us meet the girls (in their family), thinking that we might guide them incorrectly. [ASHA, aged 29, working as an ASHA for seven years, Rajasthan, ID-11]

Several ANMs (8 of 20) and MOs (6 of 11) expressed that lack of family support prevented many adolescents and youth from accessing services from the AFHCs. For example:

There is a lack of family support. [ANM, aged 41, in AFHC for 5 years, working at the OPD providing adolescent health services for 7–8 years, Rajasthan, ID-5]

There is also a lack of family support in some cases; some young people have to come alone. [ANM, aged 32, working at the AFHC for three years, Jharkhand, ID-3]

There is also a lack of family support. So, if the problem worsens, their families are not aware of it. [MO, aged 32, working at the OPD providing adolescent health services for one year, Rajasthan, ID-2]

They also lack family support. [MO, aged 32, working at the AFHC for two years, Jharkhand, ID-4]

Provider-based barriers

All cadres of health care providers cited a range of provider-based barriers to delivering services to adolescents and youth. These included the lack of awareness among frontline health workers about AFHCs and adolescent

friendly services, providers' own discomfort in delivering sexual and reproductive health information and services to adolescents and youth, concerns about lack of credibility, competing responsibilities and lack of time, insufficient training and lack of support.

Poor awareness among frontline workers about AFHCs and services for adolescents and youth: Limited awareness was displayed by the small number of ASHAs who were aware of AFHCs, or of dedicated services or clinics for adolescents and youth. Indeed, of the 46 ASHAs in our study, just two ASHAs from Jharkhand, one from Rajasthan and nine from Maharashtra reported any awareness of AFHCs. Moreover, many of those who reported awareness qualified this by indicating that they had just heard about these facilities but did not know where they were or what services they provided; the few who had some knowledge reported misgivings about them and noted that attendance at these clinics was limited as the following narratives reveal:

Yes, I have heard (about AFHCs). I learnt about this in the training programme at the CHC. [ASHA, aged 31, working as an ASHA for seven years, Rajasthan, ID-12]

I have heard that at Niphad, this clinic (AFHC) will be opened for boys and girls up to 24 years of age, and tests will be done there. That's all I have heard, nothing else. In our meeting, Madam (female MO) told us this much—that a new clinic would be set up in the health centre at Niphad and tests would be done there. [ASHA, aged 26, working as an ASHA for four years, Maharashtra, ID-1]

Yes, I have heard that young boys and girls of 15, 20 or 22 years go to take services. Some young people don't go because of shyness because there is no lady doctor, and some don't go because of lack of information. The time which is fixed for meeting the youngsters is also wrong (inconvenient) as it is just for two days in a week i.e. on Mondays and Fridays, from 3.00 to 5.00 p.m. This is also why very few people go to the AFHC. [ASHA, aged 36, working as an ASHA for five years, Jharkhand, ID-11]

Discomfort in delivering services to opposite-sex adolescents and youth: Many ASHAs were uncomfortable about going beyond providing information on menstruation and menstrual hygiene to unmarried girls, and providing any sexual and reproductive health information and services to boys. Some justified their reluctance to serve adolescent boys and young men, stating that girls have greater need for information and services than boys, and that boys typically do not pay attention to them as the following narratives indicate:

I also find it a problem to talk to them (opposite-sex adolescents and youth). If there is a male assistant along with the ANM Didi, it would be easy for us to provide information to boys. [ASHA, aged 29, working as an ASHA for six years, Jharkhand, ID-5]

Normally, I talk to youngsters in the ages 15 to 24, and I talk mostly to girls. I also talk to boys but very little because there is much need to provide information to girls. I can't talk to boys openly... [ASHA, aged 40, working as an ASHA for six years, Jharkhand, ID-4]

We visit girls but we don't meet boys; the girls are from the neighbourhood here. Yes, there is not much discussion with boys. I have not done any SRH topic for boys. If we go to talk to boys or ask them anything, they just don't listen. [ASHA, aged 26, working as an ASHA for four years, Maharashtra, ID-1]

Similarly, ANMs expressed discomfort about providing services to adolescents and youth, especially boys, or preferred that the responsibility is placed on others. Indeed, as many as six of the 20 ANMs suggested that a male—counsellor, doctor, compounder or other health worker—attends to boys along with the ANM. For example:

It is difficult to explain to some boys who speak nonsense. [ANM, aged 34, working at the AFHC for one year, Jharkhand, ID-5]

I feel that most children should be informed through schools. [ANM, aged 42, working at the AFHC for three years, Maharashtra, ID-3]

It is difficult for Staff Nurses as some boys are polite but some are very naughty and rude; they ask questions deliberately and the Staff Nurse would definitely feel awkward (to respond). [Staff Nurse, aged 28, working at the AFHC for 7–8 months, Maharashtra, ID-4]

If we get a compounder (usually male) along with the ANM, it would become easier to provide better services to people and especially to the unmarried. [ANM, aged 50, working at the OPD providing adolescent health services for three years, Rajasthan, ID-3]

It is difficult (to talk to boys). If there is a male staff member, then it is good because he can explain properly to boys and we can explain properly to girls. If we had one male staff member, we would have been able to provide more and more services to youngsters. [ANM, aged 36, working at the AFHC for one year, Jharkhand, ID-4]

Narratives of Counsellors and MOs were less likely to directly articulate this discomfort; however. Many MOs suggested a need for more ANMs, female MOs and other female staff to address the needs of girls, perhaps reflecting their discomfort. For example:

A married girl came to me. She told me that she was suffering from white discharge. So I gave her Candid B. But I don't know whether she got any relief or not. We would like to have female providers to look after such cases of girls. [MO, aged 50, working at the AFHC for 1.5 years, Jharkhand, ID-3]

Perceptions about lack of credibility: Also repeated often by ASHAs and ANMs was the perception that they were not credible in their communities. For example, ASHAs reported that they were perceived as poorly trained and poorly equipped frontline workers and were often bypassed by the community in favour of ANMs and doctors:

Yes, I face a lot of problems. Some people understand whatever I tell them (and take me) seriously and some make fun of me. Sometimes, when a lady is in a hurry she tells me to come some other day as she has work to do. [ASHA, aged 36, working as an ASHA for four years, Rajasthan, ID-10]

People don't take us seriously and don't even respond properly. They don't share their problems; we have to constantly ask them. They don't bring their children for injections (immunisation); we have to remind them again and again to do so. [ASHA, aged 42, working as an ASHA for nine years, Rajasthan, ID-14]

Likewise, some ANMs referred to the limited credibility of their facilities. For example:

(It is) difficult to convince young people to come to these centres (AFHCs). Some young people do not believe that this is a good place because it is a government centre; some young people don't trust us and don't understand that we are advising them for their own benefit... [ANM, aged 26, working at the AFHC for one year, Jharkhand, ID-2]

Competing responsibilities and lack of time: Facility-based providers noted the competing responsibilities that reduced the amount of time they could spend for providing services to adolescents and youth. For example, six of 20 ANMs pointed out that as a result of their multiple responsibilities they were unable to devote as much time as needed to provide counselling and services to adolescents and youth. The following narratives illustrate their views:

We are not able to give enough quality time because we have a big workload. If the staff strength increases and a lady doctor also works in the facility, our services will become much better. [ANM, aged 41, working at the OPD providing adolescent health services for 7–8 years, Rajasthan, ID-5]

Our main problem is our work load. If four more trained staff are appointed here, then the quality of services will improve. [ANM, aged 32, working at the AFHC for three years, Jharkhand, ID-3]

Too few staff; staff strength should be increased. [Staff Nurse, aged 28, working at the AFHC for seven to eight months, Maharashtra, ID-4]

The obstacles expressed by the Counsellors focused entirely on their workload and their dual responsibilities in ICTCs and AFHCs:

Counsellors don't have much time as they have to do both ICTC and ARSH work. So, there should be a separate counsellor for ARSH work. [Counsellor, aged 33, working at the AFHC for one year, Maharashtra, ID-3]

Medical Officers also cited work overload and staff shortage as barriers that precluded them from adequately addressing the needs of adolescents and youth. Many MOs (6 of 11) complained that they were overburdened, and that there was a need for more trained staff to support them in providing services to adolescents and youth; some specifically recommended a female MO or other female staff member (2 of 11) who could counsel and treat girls, and one recommended that MOs who serve adolescents and youth must be young themselves. Further, while some also recommended restructuring the commitments of MOs so that they may spend more time in consultations with

young clients, others emphasised that their role was to provide facility-based services and that information and counselling should be provided by other staff. The opinions expressed by the MOs are narrated below:

Special staff must be in place to attend to young people. [MO, aged 48, working at the OPD providing adolescent health services for two years, Rajasthan, ID-4]

Teenagers and adolescents need health services related to nutrition, body development and sexual relations. This information should be provided by ASHAs and ANMs because the PHC and CHC are 40–50 kms away from some villages.... The doctor can also train ANMs and ASHAs to provide better services. But we need manpower and money power. There is a lack of manpower as the MO has to look after emergencies, the OPD, attend meetings, visit the field as well as check other patients like those suffering from diarrhoea or dengue. So, the doctor doesn't have time to look after young people's needs. [MO, aged 32, working at the OPD providing adolescent health services for one year, Rajasthan, ID-2]

Our main problem is shortage of staff; this shortage must be addressed at the ministerial level. [MO, aged 32, working at the AFHC for two years, Jharkhand, ID-4]

Lower-level staff have to be trained as there is a shortage of doctors; besides, doctors have a huge workload... [MO, aged 58, working at the AFHC for four months, Jharkhand, ID-1]

There should be a separate team that can do more work. If we have extra manpower it would be good. [MO, aged 31, working at the AFHC for one year, Maharashtra, ID-2]

The doctor should only give treatment which is offered in hospitals and clinics; other peripheral information can be given by others like the social worker or ANM. The MO can get help from ANMs as they have a good rapport with the village people and can motivate young people who have problems visiting the AFHC. [MO, aged 31, working at the AFHC for one year, Maharashtra, ID-2]

Limited training: Inadequately trained health care providers are acknowledged as one of the reasons for the limited utilisation of services by adolescents and youth. For example, more than one-half of all ASHAs (24 of 40) reported that they were not sufficiently trained to provide sexual health information to girls and especially to boys, and articulated the need for better and more regular training programmes for ASHAs. For example:

If we are properly trained and given the necessary information, we can also talk about SRH to youth. [ASHA, aged 31, working as an ASHA for four years, Maharashtra, ID-12]

We should get training more often so that we can explain it (sexual health matters) to them (adolescents and youth) in a better way. [ASHA, aged 40, working as an ASHA for six years, Rajasthan, ID-6]

We people should get much better training. We should also be trained to do checkups of patients. [ASHA, aged 29, working as an ASHA for seven years, Jharkhand, ID-9]

In order to provide information to boys, there should be training (for us) on how to give this information not only to young boys but also to married men. [ASHA, aged 26, working as an ASHA for four years, Maharashtra, ID-1]

Almost all ANMs (17 of 20) also noted the need for more training at regular intervals:

All ANMs should get training and it should be at regular intervals. [ANM, aged 50, working at the OPD providing adolescent health services for three years, Rajasthan, ID-3]

If training regarding youth-responsive services is imparted to all ANMs, then it will be very useful. [ANM, aged 35, working at the AFHC for seven years, Jharkhand, ID-6]

There should be training organised once a month or fortnightly. If trainers come once in 15 days and remind us about everything (refresh our knowledge), then Staff Nurses can work in a better way and can learn how to talk to youth in a good way (professionally). [Staff Nurse, aged 28, working at the AFHC for eight months, Maharashtra, ID-4]

All three Counsellors noted the need for training; indeed, training was the only recommendation that Counsellors made. For example, one Counsellor reflected that while they had been provided training on other issues—ICTC

counselling, for example—they had not obtained similar training on how to address the needs of adolescents and youth. For example:

As we were oriented for ICTC, a similar refresher training should be organised (for ARSH); it would be good for Counsellors. (Counsellor, aged 37, working at the AFHC for two years, Maharashtra, ID-2).

Most MOs (8 of 11) too underscored the need for a greater emphasis on staff training:

Training should be given. Doctors may be well qualified for giving medicines, examining patients and also for giving treatment. However, for providing counselling (to adolescents and youth), even they need training. [MO, aged 36, working at the OPD providing adolescent health services for two years, Rajasthan, ID-3]

The basic thing required is training. ...if higher authorities like the Civil Surgeon and Deputy Superintendent are given management training in big hospitals, doctors are trained, and a seven-day training is imparted to ANMs, much better services can be provided. [MO, aged 58, working at the AFHC for four months, Jharkhand, ID-1]

Training for updates (updating knowledge) is necessary to help them (service providers) to improve their knowledge. [MO, aged 35+, working at the AFHC for two years, Maharashtra, ID-3]

Although service providers are always ready to attend to them, there should be trained staff and some special arrangements for young people. [MO, aged 32, working at the OPD providing adolescent health services for one year, Rajasthan, ID-2]

Lack of support from higher-level providers: Finally, ASHAs and ANMs cited lack of support from higher-level service providers as an impediment to delivering services to adolescents and youth. For example, ASHAs believed that they did not get sufficient support from ANMs and MOs, that it was the role of the MO or ANM to convey the ASHA's role at the community level. Indeed, more than one-third of ASHAs (14 of 46) called for greater support from ANMs, MOs and senior management, more generally as suggested by the narratives below. A number of ANMs (8 of 20) recommended more support from MOs and the need for male staff or additional staff to support them in carrying out their responsibilities.

If we get cooperation from the ANM Didi from the government hospital, it will be easy for us to work. If the ANM Didi explains to youngsters, our work will become easier and the youngsters will also obey us. [ASHA, aged 38, working as an ASHA for five years, Jharkhand, ID-1]

For enhancing the ASHA's skills, it would be good if a doctor can accompany her once a month, have group meetings and give information. It would be useful for girls to get explanations (on SRH matters) from a doctor. If they have problems (doubts, queries) even after the doctor has given information, then we can tell them more about the topic. [ASHA, aged 32, working as an ASHA for three years, Maharashtra, ID-2]

A number of ASHAs (10 of 46) also called for additional salary or incentives to ASHAs and some suggested that transportation facilities by way of bicycles be provided to them. For example:

For this, our payment should be increased. We should get some means of transport to visit everyone in the village, and also a good uniform; the dresses that we have got are like a sweeper's. We should get all the facilities that an ANM gets. [ASHA, aged 40, working as an ASHA for six years, Rajasthan, ID-6]

As we people (ASHAs) work without money, we should at least get some incentive; then we will feel happy to move ahead. ASHAs who have good information should also get medicines to distribute, and as we have to travel in the field, we require transport too. [ASHA, aged 29, working as an ASHA for eight years, Jharkhand, ID-9]

Facility-related barriers

A range of facility-based barriers, including erratic supplies, inconvenient clinic timings, distance to the AFHCs, and infrastructural limitations leading to the inability of AFHCs to ensure privacy for services, were identified.

Many ASHAs expressed frustration that they did not have the supplies—sanitary pads, condoms, IFA tablets and so on—to serve adolescents and youth better; indeed, 37 of 46 ASHAs reported that they did not have regular supplies

of sanitary napkins, and 17 did not have supplies of IFA tablets. They called for a more regular availability of these supplies with ASHAs. The following narratives point to these barriers:

Sometimes, even when young people ask us for medicine for some small health problem, we are not able to give it to them because we do not have those medicines. They also complain about the same. So, we should have some medicines available with us. [ASHA, aged 47, working as an ASHA for four years, Jharkhand, ID-13]

When we make home visits, they (girls and young women) ask for IFA tablets. We don't have IFA tablets, or even those for malaria and fever. [ASHA, aged 35, working as an ASHA for three years, Maharashtra, ID-13]

Unlike ASHAs, ANMs were generally satisfied with their access to supplies, with just a few (3 of 20) calling for more or a more regular availability of supplies:

All the medicines should be available. [ANM, aged 35, working at the AFHC for seven years, Jharkhand, ID-6]

If any unmarried girl comes to me, I cannot do anything as medicines are not available here. [ANM, aged 32, working at the OPD providing adolescent health services for 3–4 months, Rajasthan, ID-1]

Inconvenient clinic timings and long distance to the AFHCs were also among the barriers mentioned albeit by a few providers:

It is possible that the clinic timings are not convenient for them (adolescents and youth). [Staff Nurse, aged 42, working at the AFHC for one year, Maharashtra, ID-2]

The distance (to the AFHC) is too much; it is around 25 km from some villages. The timings of the centre are also inconvenient—just half an hour for the AFHC. [MO, aged 32, working at the OPD providing adolescent health services for one year, Rajasthan, ID-2]

Both ANMs and MOs called for facilities that offer greater privacy to young clients. For example, one-third of ANMs (7 of 20) called for more private counselling facilities in which they could discuss adolescents and youth problems without discomfort either to the young client or to the ANM. Many MOs (5 of 11) argued, similarly, for improvements in the quality of services rendered in AFHCs: they called for a separate facility and privacy for consultations with adolescents and youth, and better quality (informational) materials that could be shared with young clients as the following narratives suggest:

Many young people may be afraid of lack of privacy as they wonder how they could possibly discuss their problem in front of so many people. There should be a separate arrangement for (consultations with) them. The AFHC should be entirely separate (from the rest of the health centre departments). [MO, aged 32, working at the OPD providing adolescent health services for one year, Rajasthan, ID-2]

Services that are available at the AFHC are not sufficient—there is a room but very little space, the lighting is poor and it is very congested. We need a separate place for washrooms with running water. I feel that when there is more space and better facilities, more youngsters will come for services. [MO, aged 50, working at the AFHC for one year, Jharkhand, ID-3]

I do not have any difficulty, but there are not enough patients and there is no follow up of patients. We need to talk nicely with young people, make them aware of their problems, keep the clinic open for a longer time and follow up with them. We can solve their problems if we follow them up. [MO, aged 31, working at the AFHC for one year, Maharashtra, ID-2]

Summary

The health care providers in our study perceived a number of obstacles that inhibited them from providing high quality services to adolescents and youth. The obstacles were youth-, gatekeeper-, provider- and facility-based. Among youth-based obstacles, providers noted the reluctance of adolescents and youth to approach providers for sexual and reproductive matters, their lack of awareness of the AFHCs and their concerns about the quality of services. Many also argued that the attitudes of gatekeepers inhibited adolescents and youth from seeking services; that parents did not permit their children to visit AFHCs, or that mothers-in-law did not permit their daughters-in-law to reveal even pregnancy-related matters to ASHAs and ANMs.

More obstacles were perceived at provider and facility levels. While all the health care providers appreciated the training they had received, ASHAs repeatedly pointed out that the lack of dedicated training inhibited them from providing quality services to adolescents and youth and particularly, from communicating with them. Also evident was the limited awareness of AFHCs among frontline workers; few ASHAs were aware of the programme, and even those who had heard about AFHCs were vague about its operation. Both ASHAs and ANMs noted their own discomfort in addressing sexual matters and communicating with boys. Similarly, ASHAs and ANMs suggested that their credibility at community level was limited; in particular, ASHAs believed that they were not perceived with respect in their communities, and ANMs believed that community members did not perceive the facilities to which they were attached as providing quality services. Many ASHAs, moreover, felt constrained by the lack of support they received from the health system, and notably professional support from MOs and ANMs, and support in terms of regular supplies of contraceptives, sanitary pads and IFA tablets that would enable them to provide better services to their communities. Several ANMs, Counsellors and MOs, in contrast, cited competing responsibilities and constraints on the time they could spend with young clients as a limitation, and quality of services and care, ranging from the lack of a dedicated space for consultation to disrespectful interactions with clients was cited by both ASHAs and MOs as a key constraint to the provision of quality services to adolescents and youth. MOs tended to perceive their role to be largely focused on facility-based treatment, and perceived their responsibilities toward adolescents and youth somewhat narrowly as addressing complex issues that ANMs, ASHAs and Counsellors (as appropriate) could not resolve.

All four cadres of health care providers called for more training and regular refresher training, many specifically citing the need for training in communicating sexual and reproductive health messages on the one hand, and counselling opposite-sex adolescents and youth on the other. Several providers called for improved quality of services in different ways: regular availability of medicines, contraceptives and other supplies (ASHAs), private facilities for consultation (ANMs, MOs), enhancing community awareness about AFHCs and ARSH services (ANMs, MOs), and more staff support including of those of the opposite sex (ASHAs, ANMs, MOs).

Chapter 6

Summary and recommendations

In this chapter, we summarise the key findings of the study and outline recommendations emerging from them in terms of the exposure of health care providers to training programmes and their readiness to provide sexual and reproductive health services to adolescents and youth; their perceptions about their role in providing such services; their interaction with adolescents and youth both, in general, and through the AFHCs where appropriate, and the obstacles perceived in serving adolescents and youth. Providers, in general, observed that adolescents and youth do not access the sexual and reproductive health services available at the community level or at AFHCs at the facility level. The reasons may well lie in the failure of the health services to adequately incorporate the three essential components of sexual and reproductive health services for adolescents and youth as defined by the World Health Organization namely, that service providers must be trained about the needs of adolescents and youth, how to communicate and counsel them effectively, and how to provide services in supportive, non-threatening ways; facilities must be welcoming, services must be of good quality and acceptable to adolescents and youth, must protect their privacy and confidentiality, must be offered at subsidised rates or free of cost; and must engage the community and make specific efforts to inform adolescents and youth about the availability of services for them. (Dick et al., 2006).

Summary

Most of the health care providers in our study had undergone some training or sensitisation on sexual and reproductive health issues of relevance to adolescents and youth. While training for ASHAs and some ANMs took place in the context of their general training about their responsibilities, other cadres of providers had attended special training on ARSH. All those who had undergone training reported being exposed to sexual and reproductive health issues pertinent to adolescents and youth—while ASHAs and ANMs suggested that training had focused on such safer issues as nutrition and nutritional supplementation and menstrual hygiene, the training of Counsellors and MOs was also described to have encompassed sexual relations, infection, pregnancy and abortion. Such issues as privacy, confidentiality, non-judgemental interaction and promotion of informed choice were covered in somewhat fewer training programmes attended by the health care providers, and again, Counsellors and MOs were more likely than ANMs, and especially ASHAs, to have been so exposed. What was least likely to have been emphasised in training were communication skills, and notably how to convey information on sensitive matters to adolescents and youth, and, in particular, to opposite-sex adolescents and youth. Although some health care providers discussed role playing in the course of training, it appears that efforts to enhance communication skills and break down provider discomfort were limited in most of these training programmes. Findings suggest that while the cascade approach to training has many advantages in terms of reaching large numbers of providers in a short span of time, it was not successful in building capacity on the more intractable aspects of providing services to adolescents and youth, namely, building communication skills and overcoming discomfort in talking about sensitive matters.

The majority of health care providers believed that adolescents should be provided information about physical maturation before menstruation (girls) or voice change (boys) has taken place; most providers suggested that fears about body change and menstrual bleeding would be avoided if such information is given in advance. Most providers also believed that information about pregnancy and contraception should be provided to young people in adolescence and before they are married. Three reasons were offered—so that adolescents do not 'go astray' and engage in safe sex, before and within marriage; they are prepared for pregnancy- and contraception-related matters after marriage, and they get accurate information early on.

Gendered responses were obtained with regard to who the ideal person is to inform girls and boys about puberty and sexual and reproductive health matters from most categories of health care providers. As far as the provision of information to girls is concerned, most believed the responsibility lay with mothers, along with such female health care provider categories as ASHAs and ANMs; indeed, narratives of several MOs suggested that female MOs were necessary to provide counselling or treatment to girls. Ideal sources of information for boys, in contrast, were perceived to be other males, notably those in authority, such as MOs, and other males within the health system such

as Counsellors and compounders; ASHAs and ANMs were considered appropriate by relatively fewer respondents from all provider categories.

In describing their experiences, all four categories of health care providers in our study consistently suggested that few adolescents and youth attended AFHCs and that few were even aware of their existence. Settings in which interaction occurred with adolescents and youth differed by provider category. ASHAs met adolescents and youth in the course of their community-based work—in the homes of adolescents and youth, at the Anganwadi Centre, or even sometimes on the road or at their own homes. ANMs provided services to adolescents and youth sometimes in the course of outreach work in communities, but far more often in the course of their work in schools, and/or in their facility both through OPD services and at the AFHC. Counsellors and MOs rarely made community-level contacts with adolescents and youth. Rather, they interacted almost exclusively from within their facility (PHC or CHC) and the AFHC; most, in addition, conducted school visits.

Although all categories of health care providers reported that in the course of carrying out their responsibilities, they served both girls and boys, and the married and the unmarried, their narratives suggest that the thrust of provider-youth interaction was largely gendered. While Counsellors tended to report a more gender-balanced clientele, ASHAs and ANMs acknowledged that they were more likely to serve girls than boys, and the married more than the unmarried, and MOs (all male) reported that while they served both girls and boys, they were more likely to focus on boys, and more likely to refer girls to female MOs and other female staff such as ANMs or nurses, if available.

Even so, many health care providers did have some contact with each of the different groups of adolescents and youth that the ARSH programme is intended to serve. Descriptions of experiences in serving adolescents and youth differed by provider category and the group of young people served. While all provider categories were approached for counselling about physical maturation and sexual matters, Counsellors and MOs appeared more likely than ASHAs and ANMs to be approached for more sensitive issues such as masturbation, nocturnal emission, sexual performance and pre- and extra-marital relations among boys, and concerns about breast development, unwanted pregnancy, contraception for the unmarried and so on among girls.

Counselling on physical maturation and sexual matters focused largely on menstrual hygiene, breast development and diet for unmarried girls, and growth of facial hair, voice change, nocturnal emission and so on for unmarried boys. Married girls and boys rarely approached health care providers for concerns about physical maturation. Besides, very few providers had been approached by unmarried adolescents and youth who had engaged in or were thinking about engaging in pre-marital sex. Counselling of boys was largely conducted by Counsellors and MOs, although some ASHAs and ANMs also did so.

Counselling on contraception and pregnancy-related care, and provision of contraceptive supplies and services during pregnancy and delivery continued to be the main focus of contact between the health care providers (aside from Counsellors) and adolescents and youth and, as such, their attention was directed largely to married girls and conducted in the course of fulfilling family planning and maternal health responsibilities rather than ARSH, per se. A few providers, largely ANMs and MOs, had counselled or treated married girls who were also concerned about difficulty in getting pregnant. Fewer—about one-third of ASHAs and ANMs and more than one-half of MOs (and all Counsellors)—had also provided contraceptives to married boys. Most ANMs and MOs had provided pregnancy-related counselling to husbands of pregnant girls, including advising them on delivery-related preparations, saving for emergencies, transport facilities, HIV testing and refraining from sexual relations during certain months of pregnancy. While rare, adolescents and youth with gynaecological problems and symptoms of infection had also approached the health care providers, although ASHAs and ANMs were hardly ever approached by boys. ANMs and MOs described treating or counselling girls, and MOs described doing so for boys as well. Most frequently described were such concerns as burning during urination, heavy bleeding and discharge among girls, and discharge among boys. Finally, the providers were responsible for referring adolescents and youth with conditions that they could not resolve to more qualified health care providers or higher-order facilities. Such cases were referred (by ASHAs, ANMs and Counsellors), treated (by ANMs and MOs) or, rarely, referred to higher-order facilities by MOs.

Most health care providers were well informed about contraceptive methods appropriate for the unmarried, the newly married and those who already had children, the need to be non-judgemental and to respect the client's right to choose. Nevertheless, narratives do suggest discomfort in addressing sexual matters, in general, and those relating to an opposite-sex young person, in particular. Indeed, in several instances, ASHAs and ANMs referred boys

who approached them to male MOs and other male providers and, likewise, MOs (all male) reported referring girls to female MOs, ANMs and other female staff, as available.

The health care providers in our study perceived a number of obstacles that inhibited them from providing high quality services to adolescents and youth. The obstacles were adolescents/youth-, gatekeeper-, provider- and facility-based. Among obstacles related to adolescents and youth, providers noted the reluctance of adolescents and youth to approach them for sexual and reproductive matters, their lack of awareness of the AFHCs and their concerns about the quality of services. Many providers also argued that the attitudes of gatekeepers inhibited adolescents and youth from seeking services; that parents did not permit their children to visit AFHCs, or that mothers-in-law did not permit their daughters-in-law to reveal even pregnancy-related matters to ASHAs and ANMs.

More obstacles were perceived at the provider and facility levels. While all health care providers appreciated the training they had received, ASHAs repeatedly pointed out that the lack of dedicated training had inhibited them from providing quality services to adolescents and youth, and particularly in communicating with them on sensitive matters. Also evident was the limited awareness of AFHCs among frontline workers; few ASHAs were aware of the programme, and even those who had heard about AFHCs were vague about its operation. Both ASHAs and ANMs noted their own discomfort in addressing sexual matters and communicating with boys. Similarly, ASHAs and ANMs suggested that their credibility at the community level was limited; in particular, ASHAs believed that they were not perceived with respect in their communities, and ANMs believed that community members did not perceive the facilities to which they were attached as providing quality services. Many ASHAs, moreover, felt constrained by the lack of support they received from the health system, and notably professional support from MOs and ANMs, and support in terms of regular supplies of contraceptives, sanitary pads and IFA tablets that would enable them to provide better services to their communities. Several ANMs, Counsellors and MOs, in contrast, cited competing responsibilities and constraints on the time they could spend with young clients as a limitation, while quality of services and care, ranging from the lack of a dedicated area for consultation to disrespectful interactions with clients was cited by both ASHAs and MOs as a key constraint to the provision of quality services to adolescents and youth. Medical Officers tended to perceive their role to be largely focused on facility-based treatment, and perceived their responsibilities toward adolescents and youth somewhat narrowly as addressing complex issues that ANMs, ASHAs and Counsellors (as appropriate) could not resolve.

All four categories of health care providers called for more training and regular refresher training, many specifically citing the need for training in communicating sexual and reproductive health messages on the one hand, and counselling opposite-sex adolescents and youth on the other. Several providers called for improved quality of services in different ways: regular availability of medicines, contraceptives and other supplies (ASHAs), private facilities for consultation (ANMs, MOs), enhancing community awareness about AFHCs and ARSH services (ANMs, MOs), and more staff support including of those of the opposite sex (ASHAs, ANMs, MOs).

Recommendations

Several lessons can be drawn from the experiences of health care providers that may inform the delivery of the RKSK programme at community and facility levels, and are relevant for improving the quality of services delivered by outreach and facility-based health care providers.

Clarify the responsibilities of each category of health care providers and encourage a seamless linkage between community- and facility-level service delivery

Findings indicate that most frontline workers are unaware of the existence of AFHC services, that no more than weak links exist between various categories of health care providers in delivering services to adolescents and youth, and that referrals to AFHCs are rare calls for multiple actions. Efforts are needed that raise awareness of AFHCs and ARSH services among frontline workers. ASHAs, in particular, must be familiarised with ARSH services and AFHC facilities and they, along with ANMs and AWWs, made responsible for informing adolescents and youth and their gatekeepers at the community level about these services, including the fact that frontline and facility-based providers are trained to provide services to adolescents and youth, and that they offer privacy, confidentiality and non-judgemental information, counselling and services. At the same time, frontline workers must be equipped with IEC (information, education and communication) and other materials and messages through which to connect with

adolescents and youth and their gatekeepers, and the equipment and supplies through which to serve the needs of adolescents and youth for information and services, and must be familiarised with the referral network through which to link adolescents and youth in need with higher-order facilities.

ANMs, Counsellors and MOs also need to be made aware of their roles and responsibilities. These providers represent a vital link in the health system: they conduct outreach in communities and schools, they provide supportive supervision to frontline health workers, and provide counselling, supplies and services to adolescents and youth attending AFHCs. These roles and responsibilities—including their responsibility for ensuring seamless linkages and referrals between communities and schools on the one hand and the AFHC and the health system more generally, on the other—must be reinforced.

Sensitise and build communication skills of health care providers to respond to the needs of all categories of adolescents and youth, including the unmarried and opposite-sex clients

Findings suggest that while the cascade approach to training has many advantages in terms of reaching large numbers of health care providers in a short span of time, it was not successful in building capacity on the more intractable aspects of providing services to adolescents and youth, namely, building communication skills and overcoming discomfort in communicating sexual health matters. A key recommendation, therefore, is to review capacity building approaches and consider different models of training, mainly those in which capacity building activities are more interactive and include hands-on mentoring and support, particularly for frontline workers and ANMs.

Findings suggest that ASHAs have not been adequately exposed to capacity building on issues relating to adolescents and youth, and training of health care providers, more generally, did not concentrate sufficiently on reversing traditional gendered norms in service provision and, thereby enable providers to overcome inhibitions about addressing sexual health matters and addressing the concerns of the unmarried and opposite-sex adolescents and youth. Indeed, even while some ASHAs reported exposure to role play and were aware of the need to provide privacy, confidentiality and non-judgemental services to adolescents and youth, relatively few reported that adolescents and youth had approached them for sexual health matters; that the unmarried had approached them for information, counselling, supplies or services, or that they had served adolescents and youth of the opposite sex. This was particularly the case in community-based work but also in facility-based encounters with the young. These reports of a failure to develop communication skills and break down provider discomfort call for a reassessment of training methodologies.

In order that ARSH services are provided to all and AFHCs are optimally utilised, it is critical that the content of training is not restricted to raising awareness levels, but also sensitises providers about gender roles and the ways in which prevailing gender norms inhibit access to counselling and services among the unmarried, and among girls and young women. At the same time, training must focus far more on communication skills, on breaking down inhibitions, and enabling providers to overcome discomfort about responding to the information, counselling and service needs of all categories of adolescents and youth in open and non-threatening ways. It may not always be possible for MOs to counsel or treat same-sex adolescents and youth, and it is important that training of and guidelines for MOs enable them to overcome their own discomfort about interacting with opposite-sex adolescents and youth, and offer practical solutions such as the presence of a third person in situations requiring physical examinations of opposite-sex young clients. Ways must also be found of providing on-the-job support to providers, particularly frontline workers who interact with the young on a more frequent basis, to enable young people to feel comfortable about approaching them about personal health concerns.

The RKSK places considerable emphasis on capacity building, and there is a need to infuse within provider training programmes more interactive approaches that enable different cadres of health care providers to overcome traditional attitudes and lack of exposure to the special needs of adolescents and youth. They must also be sensitised to the different needs and constraints faced by girls versus boys, and the unmarried versus the married. Training programmes must be supplemented with audio-visual aids, frequently asked questions (FAQs) and case studies that providers may take away and consult in the course of their interactions with different categories of adolescents and youth.

Exploit available opportunities to reach girls and boys, the married and the unmarried

Findings have highlighted that health care providers are not necessarily sensitive about the different obstacles faced by girls and boys, and the married and the unmarried in realising their sexual and reproductive rights. Several are uncomfortable about providing contraceptive counselling and supplies to the unmarried, most overlook the limited freedom of movement and decision making authority accorded to married girls, and few have made inroads into counselling the newly married about delaying the first pregnancy or have encouraged marriage delay for girls. Approaches for different categories of adolescents and youth need to be different: for example, reaching married girls with counselling and supplies may require home visits and coordination with AFHCs, and the need to emphasise the benefits of delaying the first pregnancy and spacing the second; reaching adolescents and youth with condoms may require anonymous approaches such as placing condoms in spaces attended by them and inviting them to access condoms as required, and reaching the unmarried may require the participation of young intermediaries. The RKSK has recognised this need and has called for a cadre of peer educators to act as intermediaries between adolescents and youth on the one hand and ASHAs and ANMs on the other. It has also acknowledged the multiple and different priorities of different categories of adolescents and youth. The challenge, however, lies in making effective connections between these categories of adolescents and youth and the health system in terms of well qualified and credible peer educators. Aside from peer educators, efforts are needed that allow for seamless referrals and counselling through schools and frontline workers, as appropriate. Finally, much more needs to be done, through RKSK to inform different categories of adolescents and youth about the services to which they are entitled and the locations of these services.

Build awareness among adolescents and youth about the availability of AFHCs

Findings that AFHC services are under-utilised suggests that adolescents and youth may not be aware of the existence of AFHCs and their entitlement to use AFHC services on the one hand, and may find AFHCs an unacceptable or threatening facility from which to obtain services on the other. Health care providers must play a role in changing these perceptions. For one, community and school health activities should inform adolescents and youth about AFHCs and the chain of adolescent friendly services available to adolescents and youth at community, school and facility levels. Second, adolescents and youth must be informed that counselling, contraceptive supplies and treatment are available to all, that services are free of cost, as also about the timings and locations of available facilities, and the types of services that different cadres of health care providers and different levels of the health system can offer them.

Build closer linkages between school health programmes and AFHCs

The school health programme operates in every primary and secondary school; it not only screens students for a range of health problems, but is also expected to convey health-promoting information to students and provide referrals for counselling and services. At the same time, the Adolescence Education Programme is implemented at secondary and higher secondary school levels and is intended to inform adolescents about sexual and reproductive health matters along with other health- and gender-related concerns associated with adolescence. These programmes are implemented, respectively, by health care providers and teachers, yet neither of these opportunities are used to inform adolescents and youth about AFHCs, the kinds of services to which adolescents and youth are entitled, and their right to confidential services free of cost. These opportunities must be exploited; health care providers and teachers alike must be held responsible for informing school-going adolescents about AFHCs, the services available at these clinics and their entitlement to use them, as well as for supporting them in overcoming obstacles that inhibit them from accessing these services.

Improve the quality of service delivery at AFHCs

Findings call for increased efforts to improve the quality of service provision at AFHCs. Efforts are needed to make the AFHCs one-stop clinics for meeting the needs of adolescents and youth. Comprehensive information and services should be made available to adolescents and youth who seek services at AFHCs. Findings that young people's right to privacy and confidential and non-judgemental services are not always respected call for improving the quality of facilities designated as AFHCs to ensure privacy for services as well as sensitising and strengthening further the

skills of the health care providers working in or associated with AFHCs to provide services in non-judgemental and sensitive ways.

Overcome facility-level barriers

The health care providers in our study expressed many facility-level barriers that compromise their ability to serve young clients and restrict the facilities in which they work from appearing to be welcoming of young clients. Barriers included limited auditory and visual privacy, competing time pressures from general responsibilities and inability of providers to spend sufficient time with young clients, insufficient support from supervisory staff and higher-level providers, and even limited availability of supplies. Efforts must be made to make facilities more inviting and less threatening, ensure that providers have dedicated time for addressing the needs of young clients, and that essential supplies, such as condoms, oral contraceptives, pregnancy testing kits and sanitary pads, are routinely available both for frontline workers and at facility level.

Make health of adolescents and youth a priority among health care providers

Narratives have suggested that health care providers tend to give less priority to addressing the needs of adolescents and youth than they do to their other responsibilities. For example, several providers noted that they had not dealt with young clients in the recent past, or had only addressed the contraceptive- and pregnancy-related needs of married girls. Several ANMs suggested that counselling and provision of information to adolescents and youth at the community level was the responsibility of ASHAs and other frontline workers, and several MOs perceived that their role was to address only difficult cases and those that require specialised training. Efforts must be made to apprise all categories of providers about the importance of and rationale for addressing the needs of adolescents and youth, including their right to access information and services irrespective of their marital status, and the role of good health in adolescence in defining the health of individuals in adulthood.

References

- Boyce, C and P. Neale. 2006. *Conducting In-Depth Interviews: A Guide for Designing and Conducting In-Depth Interviews for Evaluation Input*, Monitoring and Evaluation- 2. USA: Pathfinder International.
- Center for Operations Research and Training (CORT). 2009. *Assessment of Adolescent Reproductive and Sexual Health (ARSH) Centers in Gujarat*. CORT: Vadodara.
- Dick, B., J. Ferguson, V. Chandra-Mouli et al. 2006. Review of the evidence for interventions to increase young people's use of health services in developing countries. In: Ross DA, Dick B, Ferguson J, eds. *Preventing HIV/AIDS in young people: A systematic review of the evidence from developing countries*. Geneva: World Health Organization.
- International Institute for Population Sciences (IIPS) and Population Council. 2010. *Youth in India: Situation and Needs 2006–2007*. Mumbai: IIPS.
- International Institute for Population Sciences (IIPS). 2010. *District Level Household and Facility Survey (DLHS-3), 2007–08: India*. Mumbai: IIPS.
- International Institute of Health Management Research (IIHMR). 2010. *Evaluation study on Adolescent Friendly Health Clinics in Maharashtra*. IIHMR: Jaipur.
- Kumar, R. 2014. *Overview of Rashtriya Kishor Swasthya Karyakram*. Presentation made at the launch of Rashtriya Kishor Swasthya Karyakarm and National Consultation on Adolescent Health, New Delhi, January 2014.
- Ministry of Health and Family Welfare (MOHFW). 2006a. *Implementation Guide on RCH II Adolescent Reproductive Sexual Health Strategy for State and District Programme Managers*, New Delhi: MOHFW, Government of India.
- Ministry of Health and Family Welfare (MOHFW). 2006b. *Orientation Programme for Medical Officers to Provide Adolescent-Friendly Reproductive and Sexual Health Services: Facilitator's Guide*. New Delhi: MOHFW, Government of India.
- Ministry of Health and Family Welfare (MOHFW). 2006c. *Orientation Programme for ANMs/LHVs to Provide Adolescent-Friendly Reproductive and Sexual Health Services: Facilitator's Guide*. New Delhi: MOHFW, Government of India.
- Ministry of Health and Family Welfare (MOHFW). 2006d. *Reading material for ASHA, Book # 3, Family planning, RTI/STIs and HIV/AIDS and ARSH*. Accessed on July 4, 2011 at http://www.mohfw.nic.in/NRHM/Documents/ASHA_Book_No_3.pdf.
- Ministry of Health and Family Welfare (MOHFW). 2009. *National Rural Health Mission, Reproductive and Child Health Program Phase 2, 6th Joint Review Mission Aide Memoire*. New Delhi: MOHFW, Government of India.
- Ministry of Health and Family Welfare (MOHFW). 2012. *Update on the ASHA Programme*. New Delhi: MOHFW, Government of India.
- Ministry of Health and Family Welfare (MOHFW). 2014. *Rashtriya Kishor Swasthya Karyakram Strategy Handbook*. New Delhi: MOHFW, Government of India.
- Ministry of Statistics and Programme Implementation (MOSPI). 2008. *New Series (1999–2000) Statement: Gross State Domestic Product at Current Prices*. New Delhi: Ministry of Statistics and Programme Implementation, Government of India. Accessed on 27 March 2008 at www.mospi.nic.in/6_gsdp_cur_9394ser.htm.
- Office of the Registrar General and Census Commissioner, India. 2011. *Provisional Population Totals, Paper I of 2011: Census of India 2011, Series I-India*. New Delhi: Office of the Registrar General, India.
- Planning Commission. 2011. *Mid-term appraisal: Eleventh Five Year Plan 2007–2012*. New Delhi: Planning Commission.
- Santhya, K.G., S. J. Jejeebhoy and S. Ghosh. 2007. *Addressing the sexual and reproductive health needs of young people: Perspectives and experiences of stakeholders from the health and non-health sectors*. New Delhi: Population Council.
- Santhya, K.G., S.J. Jejeebhoy and A. J. Francis Xavier. 2011. *Implementing the Janani Suraksha Yojana: Perspectives and Experiences of Accredited Social Health Activists in Rajasthan*. New Delhi: Population Council.
- Santhya, K.G., S.J. Jejeebhoy, R. Acharya et al. 2011. *Effects of the Janani Suraksha Yojana on Maternal and Newborn Care Practices: Women's Experience in Rajasthan*. New Delhi: Population Council.
- Santhya, K.G., R. Prakash, S.J. Jejeebhoy et al. 2014. *Assessing Adolescent Friendly Health Clinics in India: The perspectives of adolescents and youth*. New Delhi: Population Council.

Authors

Shireen J. Jejeebhoy, Senior Associate, Population Council, New Delhi

K G Santhya, Associate II, Population Council, New Delhi

Santosh Kumar Singh, Assistant Programme Officer, Population Council, Patna, Bihar

Shilpi Rampal, Research Assistant, Population Council, New Delhi

Komal Saxena, Programme Administrator, Population Council, New Delhi

List of investigators

Babita Bansod
Rajesh Manik Bhivsene
Kalyani D Bhure
Pankaj Bhuyar
Rahul Chaudhari
Pawan Chaudhari
Sarita Ramdas Deshbhratar
Md. Tasnim Faruque
Neeta Bhanudas Fulzele
Komal Pyarelal Gupta
Reena Pyarelal Gupta
Anju Abhay Karketa
Nasim Kousar
Brajesh Kumar
Deepak Kumar
Kamlesh Kumar
Pratibha Kumari
Shailender Kumar
Yashoda Kumari
Prerana Hiranmanji Malwe
Mariam Minz
Hrishikesh Pandey
Anil Phapale
Ashish Ranjan
Rajeshri Keshavrao Rathod
Rajnikant
Brahmanand Saraswati
Md. Shakil
Ismail Sharif
Meena Shinde
Munni Tigga
Jai Shankar Tiwari
Dinesh Uke

Printed at :
systemsvision@gmail.com



**POPULATION
COUNCIL**

Ideas. Evidence. Impact.

Zone 5A, Ground Floor
India Habitat Centre, Lodi Road
New Delhi, India 110003
Phone: 91-11-24642901
Email: info.india@popcouncil.org

popcouncil.org