Silke Seco-Grutz to m Hide options Nov 29 (21 hours ago)

From: **Silke Seco-Grutz <S-Seco@dfid.gov.uk>**
To: **Shibani Goswami <dfidhhw@gmail.com>**
Date: **Nov 29, 2005 11:47 PM**
Subject: **RE: Proposal for Adolescent Health**

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Dear Shibani

Thanks for sending me the update proposal on adolescent health. Unfortunately I am having problems opening it - it doesn't seem to be a word or an adobe acrobat document. Could you please resend it?

I hope the discussions on the scheme with Sandhya and Shouvik are going well.

I am OK, trying to take some more rest.

Regards

Silke

Shibani Goswami to Silke Hide options 3:27 am (0 minutes ago)

From: **Shibani Goswami <dfidhhw@gmail.com>** Mailed-By: gmail.com
To: **Silke Seco <s-seco@dfid.gov.uk>**
Date: **Dec 1, 2005 3:27 AM**
Subject: **Proposal for adolescent health**

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Dear Silke,

Re-sending the proposal. With regard to issues on health component indicated by you, discussion was held with Souvik and Sandhya. The hard copy on seriating reply had been handed over to Souvik. Regarding community mobilisation we had some fruitful discussion, details you will come to know from Sandhya.

Happy to know that your health is progressing well.

With love.

Shibani

Shibani Goswami to Silke Hide options 4:12 am (3 minutes ago)

From: **Shibani Goswami <dfidhhw@gmail.com>** Mailed-By: **gmail.com**
To: **Silke Seco <s-seco@dfid.gov.uk>**
Date: **Nov 28, 2005 4:12 AM**
Subject: **Proposal for Adolescent Health**

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Dear Silke,

How are you ? I have received your mail dt. November, 25 along with the list of issues to be discussed as part of the KUSP - HHWs review during mid-term evaluation by DFID which has started today. I could get opportunity to discuss few of the issues with Sandhya & Souvik till now. A lot to be discussed day after tomorrow. I will send you issue-wise status shortly.

Now, with regard to proposal on Adolescent Health Care submitted by AIIH & PH, we had discussion during your last visit at Kolkata. Your points on the submitted proposal of Adolscent Care were discussed with Dr. Raut, AIIH & PH on couple of occassions, last meeting held on 25.10.05. Subsequent to that Dr. Raut has sent revised proposal along with budget estimate which is attached. You may kindly go through it. On receipt of your clearance on the matter I am to prepare and submit note to my Department for approval and sanction, so that we could start the implementation work in time.

Take care.

With love.

Shibani

Proposal_for_adolescent_health_AIIHPH(26.11.05)
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Date: Sat, 26 Nov 2005 09:36:47 +0530

From: "Dr.Deepak Raut" <drdkraut@vsnl.net> View Contact Details Add Mobile Alert

Subject: Revised proposal on Adolescent Health Programme under KUSP

To: "Shibani Goswami" <dfidhhw@yahoo.com>

Dear Dr. Shibani Goswami,

Kindly find revised proposal on Adolescent Health Programme attached with this for your perusal and needful.I appreciate your suggestions and comments on the proposal.I have tried to incorporate the changes in the content and budget components as suggested during our meeting on 25 Nov' 05 in your chamber. In case any thing is missed please let me know so that same can also be included in the proposal.
Hope this revised proposal is in tune with your earlier suggestions.

Thanks and Best Regards

Dr.D.K.Raut MBBS,MD,FIPHA
Professor & Head
Department of Epidemiology
All India Institute of Hygiene & Public Health
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E-Mail: drdkraut@vsnl.net, drdeepakraut@yahoo.com

Attachments

Attachment scanning provided by: AntiVirus 2005

Files:

Proposal_for_adolescent_health_AIIHPH.doc (165k) [Preview] Save to Computer - Save to Yahoo! Briefcase

4. HEALTH CARE NEEDS ASSESSMENT OF ADOLESCENTS:

A) Awareness of RTI's / STI's, HIV/AIDS, (KABP study)

i) Purpose:

The purpose of this study is to assess the current Knowledge, attitude and behavioural practices for HIV/AIDS/STD, sexual and reproductive health among adolescence population in Municipalities of Kolkata and to develop baseline measurements for behavioural indicators to be used in assessing changes in behaviour over time.

ii) Aim:

To positively influence adolescent sexual behaviours in order to reduce HIV/AIDS and sexually transmitted infection by improving correct knowledge and Behaviour change communication.

iii) Objective:

1. To study the knowledge, attitudes, behaviors and beliefs of HIV/AIDS among (15-19 years) adolescents in Kolkata (India) and assess gender bias.
2. To study the sources of information on HIV/STD infection.
3. To develop the key behavioral indicators predictor of high-risk behavior changes over the time for HIV/STD infection, sexual and reproductive health.
4. To develop, plan and implement the intervention programme for adolescents for adopting and developing positive life style, improving reproductive hygiene and healthy behavioral practices for prevention and control of HIV/STD infection.

iv) Methodology:

a) Design:

An epidemiological cross-sectional study design will be used. Sampling is based on randomized two stage sampling strategy. The target group of adolescents between 15-19 years will be included by complete enumeration method from the sampling sites. The quantitative research will be accompanied by qualitative research to enhance the interpretation of the findings. Interviews with the adolescence will be based on structured self administered, anonymous questionnaire. Questionnaires will include information on demographical, socio-economic, gender characteristics. Reproductive and sexual heath and HIV/AIDS related Knowledge, beliefs, attitudes and behaviour and information on mode of transmission, prevention and protective methods, misbelieves, risk factors and source of getting this information will also be included. The sample size of adolescent children will be decided on the basis of municipalities that would be

included in the programme. However around 150 adolescents would be selected on random basis from group of school going and school drop-out adolescents.

b) Sampling:

1. Select four municipalities' site out of 40 of Urban Local Bodies (ULB's) on the basis of sampling from each zone. Selection of ULB will also depend on availability of Lady Medical officer and lady second tier supervisor. There after from south, east and west zone four ULB's will be selected on population proportion basis.

2. Selection of adolescents (15-19 years) by complete enumeration method.
3. Carry out pre-test on KABP on HIV/STD/AIDS and behavioural indicator.
(i) Conduct session on health education and promotion on HIV/STD by different modes of communication, ex. Lectures, posters, audio-visual etc.

(ii) Carry out post-test on KABP on HIV/STD/AIDS for assessing enhancement of knowledge and change in the behavior and attitude for prevention of HIV/STD.

(iii) Carry out intervention programme as mentioned & as per guidelines.

(iv) Study the behavioural trends each year.

(v) Implement phase-II to cover other municipalities, and conduct similar behavioural surveys.

c) Investigation Team:

Field investigation team will be consisted of medical doctors/faculty members from AIIH&PH as field investigators who are trained and experienced in conducting qualitative and quantitative survey will supervise and coordinate study in the field that will be supported by junior medical doctors (postgraduate students). The team will also include social scientist dealing with social and psychological components of study. Principal investigator and experts will be overall supervisor of the study dealing with development of the protocol, planning, organisation, implementation and conduction of the study.

B. Assessment of health status of adolescents, treatment seeking behaviour and utilization of health care services

I. Objectives:

1. To assess the health status of the adolescents e.g. nutritional, sexual and reproductive health status, psychological and behavioural problems.
2. To study the treatment seeking behaviour of the adolescents.
3. To study the utilization of the health care services by adolescents

Methodology and sampling design will be followed as mentioned in above the component.

C. Assessment of status of health care facilities for provision of services for the adolescents

I. Objectives:

1. To assess the availability of trained manpower in the health care facilities for providing services for the adolescents.
2. To identify the type of services available for the adolescents referral services.
3. To study the availability of drugs and equipment and other facilities.
4. To find out laboratory facilities if any for diagnosis of RTI/STI.
5. To identify the obstacles in provision of health care services for adolescents and suggest measures for its solution.

II. Material and Methods:

1. Study area: Health facilities i.e. dispensaries/clinics under the municipalities of KUSP.
2. Sampling frame:
3. Method of data collection: The data will be collected -a) by actual observation and b) by interview with the person in charge of the health care facility on the day of the visit.
4. Tools: Pre-designed, pre-tested schedule containing both closed and open ended questions regarding availability of general facilities, services, staff pattern- their training status, IEC materials, medical examination facilities, drugs, equipment and laboratory facilities- their working condition, referral services etc.
5. Data analysis: Collected data will be analyzed using appropriate statistical methods.

III. *Time Frame:*

It is envisaged that around two month period would be necessary to conduct entire study. The actual study will start from the day when the funds will be released to AIIH&PH.

D. Training of health officers on/AHO. adolescent health

Doctors, nurses, health workers need a good knowledge of normal adolescent development and skills to diagnose and treat common conditions. They are to be trained on how to address the problem of adolescents and make their approach friendly. Technical skills and a sympathetic professional approach should be combined with non-judgemental approach. Communication with adolescents on sensitive issues like sexuality, reproduction, STDs, age of marriage and child bearing etc. requires good communication skills. A communication model is to be evolved for effective communication.

Health officers will also have to organize teachers training programme on adolescent health and development on a large scale. Similarly peer training programme and student to student approach can pay rich dividend.

Training of different categories of staff should be held separately. It is envisaged that trainers training of Health officers and Assistant Health officers

will be organised by AIIH&PH. These trained Health officers will subsequently train their Honorary Health Workers (HHW), Lady second tier supervisor (LSTS), FTS's, Female STS's at ULB levels. However all these training programmes will be organised and conducted under overall supervision of CMU. AIIHPH would provide time to time technical guidance, supervision and monitoring of all the activities of adolescent health programme under KUSP.

1. **Participants**: Total 30 Health officers and Assistant Health officers belonging to pilot 10 ULB's would be trained in two batches. Around 15 participants are expected to attend training programme on adolescent health.

2. **Training duration**: Training would be conducted for three days duration.

3. **Time frame**: Around one month period will be necessary to plan and organise these training programmes.

4. **Training of Honorary Health Workers**: Health officers and assistant Health officers who will be trained in earlier training programme will be key trainers for the training of honorary health workers. Facilitator guide and training manual for HHW will be developed by AIIH&PH, which will be used for the training of HHW and other paramedical workers.

BUDGET:

SUMMERY OF BUDGET

I	**Adolescent Health care need assessment (Rs.144,480 X 4 ULB)**	**577,920**
II	**Training of Trainers (Rs. 217,000 X 2 Training Programmes)**	**434,000**
III	**Preparation of Training Module for HHW**	**95,000**
IV	**Monitoring & Supervision of HHW Training by AIIHPH (10 Programmes)**	**56,000**
	GRAND TOTAL	**1,162,920**

Sr.No.	Details				
I	**Adolescent Health care need assessment**	**Rate(Rs.)**	**No.**	**Days**	**Total**
A.	***Field expenses :***				
A1	**Per diem**				
A1.1	Principal Investigator/Experts	1500	2	6	18,000
A1.2	Field investigator (Medical Faculty)	800	2	6	9,600
A1.3	Research associates (PGTs)	500	2	6	6,000
A1.4	Social scientist	500	2	6	6,000
A1.5	Paramedical workers & Local guide	300	2	6	3,600
A2	Hiring of local transportation	800	2	6	9,600
A3	Consultancy and coordination	2000	1	6	12,000
A5	Contingency expenses	1000	2	6	12,000
	Sub-Total				76,800
B	***Office expenses***				
B1	Printing of Schedule				5,000

B2		Data entry and analysis				10,000
B3		Secretarial assistance				5,000
B4		Stationaries				5,000
B5		Computer software, mobile phone	20000	1	1	20,000
B6		Final Report Writing & Printing				10,000
B7		Contingency expenses				5,000
B8		Institutional charges (DOE & Adm. Exp.)				7,680
		Sub-Total				67,680
		Total				**144,480**
		Grand Total (four Urban Local Bodies)		4		**577,920**
II		**Training of Trainers**				
	1	Per diem for Experts/Resource Persons	1000	5	3	15,000
	2	Honorariums to facilitators	500	1	6	3,000
	3	Traveling expenses for outside experts	7000	2	2	28,000
	4	TA/DA for Participants	500	15	3	22,500
	5	Secretarial assistance	1000	2	10	20,000
	6	Training materials (file, folder, bags etc.)	500	25	1	12,500
	7	Banner, decoration	1000	1	1	1,000
	8	Lunch, tea, coffee & Hall	700	30	3	63,000
	9	Audio-visual aid	1000	1	3	3,000
	10	Travel expenses for field visit	2000	2	1	4,000
	11	Consultancy & Coordinator	2000	1	10	20,000
	12	Report writing and Publication	5000	1	1	5,000
	13	Institutional overhead charges				10,000
	14	Contingencies				10,000
		Total				**217,000**
		Grand Total (Two Programmes)				**434,000**
III		**Preparation of Training Module for HHW**				
	1	Honorariums to Specialist for writing	5000	5		25,000
	2	DTP	5000	2		10,000
	3	Photographs, sketches & artistic work	10000	1		10,000
	4	Consultation meeting for draft module	25000	1		25,000
	5	Printing and Publishing of Module	25000	1		25,000
		Total				**95,000**
IV		**Monitoring and Supervision of HHW Training by AIIHPH**				
	1	Per diem	1000	2	10	20,000
	2	Travel	800	2	10	16,000
	3	Consultancy and Coordination	1000	1	10	10,000
	4	Contingencies	1000	1	10	10,000
		Total (ten programmes)				**56,000**

Adolescent Health Care Services Project for KUSP

1 INTRODUCTION

2 ADOLESCENTS

3 IMPORTANCE OF ADOLESCENT HEALTH CARE PROGRAMME

3.1 Adolescents Health Problems

3.2 Why health care services for adolescents

3.2 Why health care services for adolescents

4. ADOLESCENT HEALTH CARE SCHEME

4.1 Need Assessment
4.2 Preparation of training module
4.3 Trainers training
4.4 Training of grass root level workers
4.5 Intervention measures to improve the adolescent health
4.6 Modalities for intervention measures

Department of Epidemiology

All India Institute of Hygiene & Public Health

110 C. R. Av., Kolkata-700 073

1 INTRODUCTION:

Adolescents complete their physical, emotional and psychological journey to adulthood in a changing world that contains both opportunities and dangers. Most adolescents are full of optimism and represent a positive force in society, an asset now and for the future as they grow and develop into adults. When supported, they can be resilient in absorbing setbacks and overcoming problems. However, adolescents are exposed to risks and pressures on a scale that their parents did not face. Modernization has accelerated change while the structures that protected previous generations of young people are being eroded. Adolescents receive contradictory messages on how to address the daily choices, which have lifelong consequences for healthy development. Millions are denied the essential support they need to become knowledgeable, confident and skilled adults. They miss out on schooling mostly for economic reasons. There are fortunate few young people have loving families who protect and care for them, many grow up with no adults committed to their welfare or where the ability of caring adults to support them has been damaged. Adolescents are at risk of early and unwanted pregnancy, of sexually transmitted infections (STIs) including HIV and AIDS, and vulnerable to the dangers of tobacco use, alcohol and other drugs. Many are exposed to violence and fear on a daily basis. Some of the pressures adolescents are under, or the choices they make, can change the course of their young lives, or even end them. These outcomes represent personal tragedies for young people and their families.

They are also unacceptable losses that put the health and prosperity of society at risk. Addressing the needs of adolescents is a challenge that goes well beyond the role of health services alone. The legal framework, social policy, the safety of communities and opportunities for education and recreation are just some of the factors of civil society that are key to adolescent development. However, within an integrated approach, health services can play an important role in helping adolescents to stay healthy and to complete their journey to adulthood; supporting young people who are looking for a route to good health, treating those who are ill, injured or troubled and reaching out to those who are at risk.

Effective health services reach adolescents who are growing up in difficult circumstances as well as those who are well protected by their communities. Health services need to link with the other key services for adolescents, so that they become part of a supportive structure that protects young people against dangers, and helps them to build knowledge, skills and confidence. This is far from being the case in many countries. Health services often regard adolescents as a healthy group who do not need priority action, and so provide a minimum subset of adult or paediatric services with no adjustments for their special needs. There is evidence that many young people regard such health services as irrelevant to their needs and distrust them. They avoid such services altogether, or seek help from them only when they are desperate.
'Adolescent friendly' health services meet the needs of young people in this age range sensitively and effectively and are inclusive of all adolescents. Such services deliver on the rights of young people and represent an efficient use of precious health resources.

Objective

The health services for Adolescent Health aim to provide quality health care for young people and promote healthy adolescent development. Services take into account the wide range of family, school, peer and individual issues that can affect young people's health. Adolescents' services shall be sensitive to the importance of cultural background, religion and spirituality, gender, and sexuality in a young person's life. The adolescent health services provides the package of preventive, promotive and curative services for overall development of adolescents health.

2 ADOLESCENTS:

The World Health Organization defines adolescents as young people aged 10-19 years. There are about 1.2 billion adolescents, a fifth of the world's population, and their numbers are increasing. Four out of five live in developing countries.
Adolescence is a journey from the world of the child to the world of the adult. It is a time of physical and emotional change as the body matures and the mind becomes more questioning and independent. During adolescence, growth spurt occur and about 35% gain of adult weight and 11% of adult height are acquired- so achievement of optimum growth and development during this period is of utmost important in maintaining good health thereafter.

Adolescents are no longer children, but not yet adults, and this period of change is full of paradox. Adolescents can seem old beyond their years, but need adult support. They can put themselves at risk without thinking through the consequences; display optimism and curiosity, quickly followed by dismay and depression. Biologically, they can become mothers and fathers, without being ready for the responsibility. They feel a growing sense of independence, but depend on adults for their material needs. And as they change, so their needs change with them.
_ Early adolescence (10-13) is characterized by a spurt of growth, and the beginnings of sexual maturation. Young people start to think abstractly.
_ In mid-adolescence (14-15) the main physical changes are completed, while the individual develops a stronger sense of identity, and relates more strongly to his or her peer group, although families usually remain important. Thinking becomes more reflective.
_ In later adolescence (16-19) the body fills out and takes its adult form, while the individual now has a distinct identity and more settled ideas and opinions.
These changes take place at a different rate for each individual and can be a period of anxiety as well as pried.

Part of challenges for health services is to recognize that adolescents have a range of needs based on individual circumstances. Those who are especially vulnerable and hard to reach include young people who:
_ are denied the opportunity to complete their education;
_ have no stable homes or support, living rough in towns and cities, exposed to risks of malnutrition, abuse, violence and disease;
_ are vulnerable to sexual abuse or violence, or are sexually exploited by people who are older and more powerful;
_ Work long hours for little pay, exposed to hazardous work processes;

_ live as young wives in families who oppress and abuse them;
_ live as ethnic minorities in a land where they and their parents are rejected by mainstream culture;
_ are among the 1 in 10 young people affected by a disability, and denied the same opportunities for development as their peers.

3 IMPORTANCE OF ADOLESCENT HEALTH CARE PROGRAMME

Adolescents are generally believed to be healthy because death rates for this age group are lower than for children or for elderly people. However, death rates are an extreme measure of health status and tell only part of the story. There are many interrelated reasons why we need to pay attention to the health of adolescents: for this age group, for later life and for the next generation.

1 To reduce death and disease in adolescents now

An estimated 1.7 million young people aged from 10 to 19 die each year world wide – mainly from accidents, violence, pregnancy related problems or illnesses that are either preventable or treatable. Many more develop chronic illness that damages their chances of personal fulfillment.

2 To reduce the burden of disease in later life

Malnutrition in childhood and in adolescence can cause lifelong health problems, while failure to care for the health needs of young pregnant women can damage their own health and that of their babies. This is the age when sexual habits and decisions about risk and protection are formed. Some of the highest infection rates for sexually transmitted infections are in adolescents. The HIV/AIDS pandemic alone is sufficient reason to look anew at how health services address the needs of adolescents.

Many diseases of late middle age, such as lung cancer, bronchitis and heart disease, are strongly associated with a smoking habit that begins in adolescence.

3 To invest in health – today and tomorrow

Healthy and unhealthy practices adopted today may last a lifetime. Today's adolescents are tomorrow's parents, teachers and community leaders. What they learn they will teach to their own children. Adolescence is a period of curiosity, when young people are receptive to information about themselves and their bodies, and when they begin to take an active part in decision making.

4 To deliver on human rights

The Convention on the Rights of the Child (CRC) says that young people have a right to life, development, and (Article 24) "the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health". The CRC gives young people the right to preventive health care, and calls for specific protection for those in exceptionally difficult conditions or living with disabilities. Under the CRC, Governments not only have a duty to ensure services for good health care, but also have a duty to ensure that young people can express themselves and that their views are given weight according to their age and maturity.

5 To protect human capital

In some societies two out of three adolescents are involved in productive work, while many young women below the age of 20 are already mothers. If they are no longer able to fulfill these roles because of injury, illness or psychological damage, the cost is primarily a

human one, but there is also a cost to society. Economic development, as well as personal fulfillment, is strongly related to the health and education levels of the population.
We need to pay attention to the health needs of adolescents to:
_ reduce death and disease, now and during their future lives.
_ deliver on the rights of adolescents to health care, especially reproductive health care;
_ ensure that this generation of adolescents will, in turn, safeguard the health of their own children.
But, health of the adolescent population are relatively neglected both at the family and at the health provider level. There is a relative gap in the health care of the adolescents, resulting in occurrence of preventable morbidities and mortalities affecting the potential workforce of the country. The intrinsic vulnerability of the adolescent people who form a heterogeneous group is aggravated by their risk taking attitude, strong peer influence, inaccess to information and traditional gender disparities in the society. So it is important that diverse health needs of adolescents like physical, psychological and social health needs are given due consideration by the health providers. Programmes on adolescent health while putting due stress on reproductive health, should work on a wider perspective, considering the adolescents physical and emotional needs as well.

Adolescents do not appreciate the importance of seeking treatment when they are unwell and often underestimate the severity of their condition. Even when they choose to seek care, there may be important barriers preventing their access to such care. The health services may not be available, accessible or acceptable to the adolescent people. Cultural reason, physical distance, time disparity, fear of being recognized, lack of confidentiality, natural aversion to be in a clinic or treatment centre and rude or judgemental health workers may act as obstacles in utilization of health care services by the adolescent individuals.

National Population Policy 2000 has identified adolescents as under-served population group. Govt. of India intends to improve the services for this vulnerable group of population who have till now been effectively left out of planning process. KUSP like to introduce the service of adolescent care in their health component and start it as pilot project in 4 urban local bodies. As mentioned, this vulnerable group of population may suffer from various health problems, so far effective implementation of adolescent health programme in the municipalities under KUSP, it is essential to assess the health status and needs of the adolescents of the area, facilities available and suggest measures for intervention.

3.1 Adolescents Health Problems

Adolescents represent about of a fifth of country's population but the health needs of adolescents have seldom been addressed. They face a number of health problems like general health problems, menstrual problems, mental health problems, early and unprotected sex, sexual abuse, accidents and violence, addictive behaviors like alcoholism and drug addiction etc. National Family Health Survey data revealed that over 50% of girls marry below the age of 18. Teen age pregnancies being high risk pregnancies result in unsafe abortion, low birth weight and high maternal morbidity and mortality. The age group 15 - 19 contributes 19% of total fertility in India. Highest unmet needs for contraception have been reported in the age group 15 - 19 years. Around 30% of

adolescent's girls and 18% of boys suffer from malnutrition. As the adolescents undergo sexual development, they are curious to know about it. Several studies show varying levels of pre-marital sex among male and female adolescents. The median age of initiation of sexual debut is 15 - 16years.

The combination of growing physical maturity, hormonal changes, emotional immaturity and lack of information makes adolescents specially vulnerable to certain types of health events, the effect of which may be serious and permanent e.g. sexually transmitted infections including HIV/AIDS, unwanted teenage pregnancy, unsafe abortions and resultant pelvic infection, drug addiction, alcoholism etc. Around 40% of HIV infections are centred on teenagers. Adolescents are also very often under psychological stress, as they become more independent and assertive leading to confusion, tension, frustration, feeling of insecurity and depression.

Adolescents are subject to many of the same diseases as children and adults. There are also some health risks that are especially connected with puberty. Adolescents have different health risks and needs according to their age, sex and living circumstances. Adolescents may not appreciate the importance of seeking treatment when they are unwell, and often underestimate the severity of their condition.

Adolescents are vulnerable to harmful consequences of health risks. Some, like depression or interpersonal violence, have immediate effects, while others such as sexually transmitted infections or smoking have harmful or fatal effects in the medium or long term. Adolescents, especially girls, are vulnerable to sexual abuse. The common health problems adolescents usually suffer are grouped as follows.

1. Malnutrition
2. General health problems
3. Menstrual problems
4. Early unprotected sex
5. Addictive behaviors
6. Accidents and violence
7. Sexual abuse
8. Mental health problems-depression and suicide
9. Reproductive tract infections, sexually transmitted diseases, HIV/AIDS, etc.

3.2 *Why health care services for adolescents*

- One fifth of the population is between 10-19 years of age
- 22.8% of the Indian population is adolescent
- 83.5% of the world's young people lives in developing countries;
- Sexual activity among adolescents is up to 30%
- Malnutrition is found to be around 45% in girls and 20% among boys
- Married female's adolescents are 26-54% of 15-18 years
- 36-64% of married teenagers(13-19 years) are either pregnant or mothers
- Around 5% teenagers use *DRUGS*

Level of Awareness

- Misconception about AIDS- 70-80 %
- Awareness about how AIDS spreads- 45- 60%
- Awareness about STDs/ RTIs - 32%
- Source of knowledge comes 78% from peers
- Married teenagers(15-18 yrs)

Use of contraception : 8%
Inability to take decision about health: 83%

Outcomes:

- Reduction of births to teens ages 15-17.
- Promotion and provision of health care, and access to health care for the adolescent population.
- Promotion and implementation of strategies that will reduce the risk-taking behaviours of adolescents.
- Involvement of communities in adolescent issues.
- Provision of coordinated efforts that will reduce morbidity and mortality during adolescence.

Package of services to be made available at each level of care need to be clearly defined. Though there is a strategy of government for providing ARSH services, the strategies proposed should be revisited in light of suggested national strategies. There is needed to be more clarity on suggested immunization for adolescents, growth monitoring, and access to STI services. Similarly we need to provide sufficient details as who will provide counselling services and at what level? How we plan to develop favorable attitudes amongst the stakeholders and gatekeepers on need for services to adolescents. What are additional infrastructure and supplies?

4. ADOLESCENT HEALTH CARE SERVICES SCHEME UNDER HEALTH COMPONENT OF KUSP :

4.1. Health Care need assessment of Adolescents by AIIH & PH

- Out of 40 ULBs, 10 ULBs will be selected for need assessment study
- Awareness of RTI/STIs, HIV/AIDS, etc (KABP study)
- Treatment seeking behaviour
- Assess the health status of the adolescents- e.g. nutritional, sexual and reproductive health status, psychological and behavioral problems etc.
- Utilisation of Health care services by adolescents
- Target date for submission of final report – end of December, 2005

4.2 Preparation of training module for the trainers in English and modules for grass root level workers in Bengali by AIIH & PH – by end of January, 2006.

4.3 Trainers training by AIIH & PH

- 30 participants out of 10 pilot ULBs
- In two batches, each batch of 15 participants
- Duration of training – 3 days
- Time frame – by February, 2006

4.4 Training of HHWs, FTSs and Female STSs at ULB level by the trainers – to be organised by CMU with ULBs

- Duration of training – 2 days
- Each batch consisting of 30 participants
- Time to time monitoring & supervision of the training sessions conducted by the trainers for the grass root level workers by AIIH & PH
- Time frame – by March, 2006

4.5 Intervention measures to improve the Adolescents Health by the ULB and monitored by CMU

- Preventive & Promotive :

Mostly awareness generation on normal physiological & Psychological changes during adolescents, motherhood, age of marriage, age of first pregnancy, STD, HIV / AIDS, Personnel Hygiene during menstruation, Sex behaviour, Nutrition etc.

- Curative Services :

Detection & correction of Anaemia, detection & treatment of RTI and any other specific diseases.

- Time frame – by April, 2006

4.6 Modalities for intervention measures to improve the Adolescents Health

A) Building up of Awareness amongst the Adolescent :

Awareness Programme at Health Administrative Unit (HAU) level / community level by the trainers for the Adolescents. 20 participants in a group, two hours session, pre & post evaluation to be conducted.

B) Clinical Part :

- One adolescent clinic per HAU per month
- Three such clinics per ULB per month
- Thirty such clinics for 10 ULBs per month
- The clinic will be conducted by lady Medical Professional assisted by HHW, FTS, lady STS.

Date: Thu, 17 Nov 2005 23:50:14 +0530

From: "Dr.Deepak Raut" <drdkraut@vsnl.net> View Contact Details Add Mobile Alert

Subject: Proposal on Adolescent Health

To: "Shibani Goswami" <dfidhhw@yahoo.com>

Dear Dr. Shibani Goswami,

Greetings from AIIH&PH

Kindly accept my apology for inadvertent delay in sending the proposal which was due to festival season. As per your suggestions and of Ms. Silke, I have modified the proposal.Please find the detail proposal along with budget estimates for all four components of the study and training,attached to this mail for your perusal and needful action.

Please let me know in case of any doubts or any suggestions for modification that can be again incorporated.If required we can meet on Friday in case you are free at around 4.00PM.

Thank you very much and Best regards

Dr.D.K.Raut MBBS,MD,FIPHA
Professor & Head
Department of Epidemiology
All India Institute of Hygiene & Public Health
110 C.R. Av., Kolkata-700 073 (W.B.) INDIA
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E-Mail: drdkraut@vsnl.net, drdeepakraut@yahoo.com

Attachments

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Files:

Proposal_for_adolescent_health_AIIHPH.doc

PROPOSAL FOR IMPLEMENTATION OF ADOLOSCENT HEALTH PROGRAMME UNDER -KUSP

PRINCIPLE INVESTIGATOR: DR. D.K.RAUT, PROF. & HEAD

CO-INVESTIGATORS:
1. DR. D. PAL, ASST. PROFESSOR
2. DR. R. N. SINHA, ASST. PROFESSOR
   DEPT. OF MCH

DEPARTMENT OF EPIDEMIOLOGY
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PROPOSAL FOR IMPLEMENTATION OF ADOLOSCENT HEALTH PROGRAMME UNDER -KUSP

Adolescence is a fascinating period of life that marks the transition from being a dependent child to becoming an independently functioning adult. It is the period of life between age 10 - 19 years- a crucial phase of growth and development, when there occur physical and physiological changes along with emotional instability.

Changes during adolescence:
The changes that occur are - biological development (body size and shape), cognitive development, self-concepts and self-esteem, sexuality and morality, relationships with family, peers and society. These changes occur due to hormonal changes in conjunction with social structure. In this period the close and dependent relationships with parents and older family members begin to give way to more intense relationships with peers and other adults. It is also a time when physiologically adolescents begin to reach their adult size, their bodies become more sexually define and reproductive capacity is established. They have different needs according to their stage of development and personal circumstances.

During adolescence, growth spurt occur and about 35% gain of adult weight and 11% of adult height are acquired- so achievement of optimum growth and development during this period is of utmost important in maintaining good health thereafter.

Health problems of adolescence:
Adolescents represent about of a fifth of country's population but the health needs of adolescents have seldom been addressed. They face a number of health problems like general health problems, menstrual problems, mental health problems, early and unprotected sex, sexual abuse, accidents and violence, addictive behaviors like alcoholism and drug addiction etc. National Family Health Survey data revealed that over 50% of girls marry below the age of 18. Teen age pregnancies being high risk pregnancies result in unsafe abortion, low birth weight and high maternal morbidity and mortality. The age group 15 - 19 contributes 19% of total fertility in India. Highest unmet needs for contraception have been reported in the age group 15 - 19 years. Around 30% of adolescent's girls and 18% of boys suffer from malnutrition. As the adolescents undergo sexual development, they are curious to know about it. Several studies show varying levels of pre-marital sex among male and female adolescents. The median age of initiation of sexual debut is 15 - 16years.

The combination of growing physical maturity, hormonal changes, emotional immaturity and lack of information makes adolescents specially vulnerable to certain types of health events, the effect of which may be serious and permanent e.g. sexually transmitted infections including HIV/AIDS, unwanted teenage

pregnancy, unsafe abortions and resultant pelvic infection, drug addiction, alcoholism etc. Around 40% of HIV infections are centered on teenagers. Adolescents are also very often under psychological stress, as they become more independent and assertive leading to confusion, tension, frustration, feeling of insecurity and depression.

But, health of the adolescent population are relatively neglected both at the family and at the health provider level. There is a relative gap in the health care of the adolescents, resulting in occurrence of preventable morbidities and mortalities affecting the potential workforce of the country. The intrinsic vulnerability of the adolescent people who form a heterogeneous group is aggravated by their risk taking attitude, strong peer influence, inaccess to information and traditional gender disparities in the society. So it is important that diverse health needs of adolescents like physical, psychological and social health needs are given due consideration by the health providers. Programmes on adolescent health while putting due stress on reproductive health, should work on a wider perspective, considering the adolescents physical and emotional needs as well.

Adolescents do not appreciate the importance of seeking treatment when they are unwell and often underestimate the severity of their condition. Even when they choose to seek care, there may be important barriers preventing their access to such care. The health services may not be available, accessible or acceptable to the adolescent people. Cultural reason, physical distance, time disparity, fear of being recognized, lack of confidentiality, natural aversion to be in a clinic or treatment centre and rude or judgemental health workers may act as obstacles in utilization of health care services by the adolescent individuals.

National Population Policy 2000 has identified adolescents as under-served population group. Govt. of India intend to improve the services for this vulnerable group of population who have till now been effectively left out of planning process. KUSP like to introduce the service of adolescent care in their health component and start it as pilot project in 4 urban local bodies. As mentioned, this vulnerable group of population may suffer from various health problems, so far effective implementation of adolescent health programme in the municipalities under KUSP, it is essential to assess the health status and needs of the adolescents of the area, facilities available and suggest measures for intervention.

Therefore, **a study** should be undertaken among the adolescents of the municipalities under KUSP with the **following objectives**:

1. To assess the health status of the adolescents- e.g. nutritional, sexual and reproductive health status, psychological and behavioral problems etc.
2. To know about their awareness of general health, reproductive health, unprotected sex, STDs, RTIs, HIV/AIDS, contraception etc. and their needs.

3. To study the status of health care facilities about provision of services for the adolescents.
4. To suggest measures of intervention in conformity with the needs of the adolescents as revealed by the survey.

Materials and Methods:

It will be a cross-sectional study among the adolescents of the municipalities under KUSP. The study will be carried out among a number of adolescents (size determined by appropriate statistical method) selected by random sampling.

Method of data collection will be by personal interview using a pre-tested, semi-structured questionnaire, general health examination and observation.

A survey of existing health facilities about provision of services for the adolescents and service providers will also be carried out.

From the collected data, the health status of the adolescent individuals, their health awareness and information gaps, needs and expectations regarding "Adolescent friendly" services will be ascertained and appropriate intervention measures will be suggested.

Suggested Interventions:

Adolescent friendly health services should have high clinical standards and qualities that young people seek. It should be accessible, acceptable, equitable, comprehensive and appropriate- in the right place at the right time and affordable and to be delivered by competent and motivated providers.

The interventional approaches can be at **three levels**- a) Community level, b) Family level and c) Individual level.

a) **Community level**- Most effective way of reaching the adolescents and influencing them is through schools and colleges. Problems of adolescents can be included in the school and college curriculum. Health sector should select a few things such as, prevention of anaemia and malnutrition, reproductive cycle, menstrual cycle and hygiene, age of marriage and child birth, risk of teenage pregnancies, prevention/control of RTI/STD including HIV/AIDS, voluntary blood donation, contraception, unsafe sex and unsafe abortion etc. for effective coverage in the schools of their jurisdiction through health programme. This should be done in consultation of school teachers and parents. Teachers should be given training in problem of adolescence so that they can detect the problems early and start intervention.

b) Adolescents out of school can be reached through non-formal education system in consultation with local municipalities and panchayets and with the help of NGOs.

Health education programmes as lectures/demonstrations including Audio-visuals can play important role. Area specific material on IEC in local languages needs to be developed for effective communication.

Another effective way of reaching the adolescents is through **Peer Education** programme- a programme that is at least in part devised and delivered by young people for young people. Young people are often more comfortable talking to peers than parents and teachers. Most often these programmes produce a change in knowledge as well as behavior than adult programmes.

Family level- Family oriented programmes including parental guidance/ education can play an important role. Parents' Day can be organized in schools and clinics to train the parents regarding the problems of adolescents and to help them to tackle it. Family factors and inadequate social support play an important role in juvenile delinquency. Adequate social support of parents is important. Health workers during their weekly to monthly home visits should provide information to the parents and emotional support for solving the problems of adolescents.

Individual level- Many problems of adolescents can be solved through inter-personal communication at clinics by physicians/health workers, by counselling and also during home visit.

Up gradation of facility at Health Centres:
Health centres and clinics are to be strengthened in terms of educational material and services for the adolescents according to their needs. Clinics should be accessible i.e. it should be held in places where adolescents go and timing should be suitable for them. Adolescents are to be assured of privacy during a consultation and confidentiality afterwards. Trained health officers and workers are to be posted so that they can address the problems of adolescents. They should have good communication skills and there should be arrangements for counselling of adolescents in different issues and a counsellor is to be posted at the clinic. A psychologist is also to be posted for tackling the psychological and behavioural problems of adolescents. Training alone will not resolve quality issues. Structural problems must be addressed so that equipment, medicines and supplies are available when and where needed.

Services to be provided are preventive, promotive and curative services.

Preventive services- Immunization with tetanus toxoid, hepatitis B vaccine and for adolescent girl's rubella vaccine. Education about prevention of anaemia, malnutrition, STD,s/RTIs, HIV/AIDS and contraception etc.

Promotive services- Nutritional education, nutritional supplementation, provision of iron and folic acid tablets, improving menstrual hygiene, health education, life style and behaviour changes.

Curative services- Apart from treatment of common illnesses there should be facilities for treatment of STDs/RTIs, scope of doing MTPs, and management of its complication, treatment of behavioral and psychological problems and referral services.

Adolescents are to be involved in planning and monitoring and community support is needed to ensure that services are acceptable and used.
Finally, improvements in adolescent health services will act as a catalyst to improve health services for everyone, as staff attitudes change and people's expectations rise. Adolescents are on the verge of adulthood and will continue to demand services that match their needs. Adolescent friendly health services can pioneer change for the whole population.

A. HEALTH CARE NEEDS ASSESSMENT OF ADOLESCENTS
Awareness of RTI's/ STI's, HIV/AIDS, (KABP study)

I. Purpose:

The purpose of this study is to assess the current Knowledge, attitude and behavioural practices for HIV/AIDS/STD, sexual and reproductive health among adolescence population in Municipalities of Kolkata and to develop baseline measurements for behavioural indicators to be used in assessing changes in behaviour over time.

II. Aim:

To positively influence adolescent sexual behaviours in order to reduce HIV/AIDS and sexually transmitted infection by improving correct knowledge and Behaviour change communication.

III. Objective:

1. To study the knowledge, attitudes, behaviors and beliefs of HIV/AIDS among (15-19 years) adolescents in Kolkata (India) and assess gender bias.
2. To study the sources of information on HIV/STD infection.
3. To develop the key behavioral indicators predictor of high-risk behavior changes over the time for HIV/STD infection, sexual and reproductive health.
4. To develop, plan and implement the intervention programme for adolescents for adopting and developing positive life style, improving reproductive hygiene and healthy behavioral practices for prevention and control of HIV/STD infection.

Time

Time Frame :- 2 months after the start of the activity.

IV. Methodology:

A. Design:

An epidemiological cross-sectional study design will be used. Sampling is based on randomized two stage sampling strategy. The target group of adolescents between 15-19 years will be included by complete enumeration method from the sampling sites. The quantitative research will be accompanied by qualitative research to enhance the interpretation of the findings. Interviews with the adolescence will be based on structured self administered, anonymous questionnaire. Questionnaires will include information on demographical, socio-economic, gender characteristics. Reproductive and sexual heath and HIV/AIDS related Knowledge, beliefs, attitudes and behaviour and information on mode of transmission, prevention and protective methods, misbelieves, risk factors and source of getting this information will also be included. The sample size of adolescent children will be decided on the basis of municipalities that would be included in the programme.

B. Sampling:

1. Select four municipalities' site out of 40 of Urban Local Bodies (ULB's) on the basis of sampling from each zone. Selection of ULB will also depend on availability of Lady Medical officer and lady second tier supervisor. There after from south, east and west zone four ULB's will be selected on population proportion basis.

2. Selection of adolescents (15-19 years) by complete enumeration method.
3. Carry out pre-test on KABP on HIV/STD/AIDS and behavioural indicator.

(i) Conduct session on health education and promotion on HIV/STD by different modes of communication, ex. Lectures, posters, audio-visual etc.

(ii) Carry out post-test on KABP on HIV/STD/AIDS for assessing enhancement of knowledge and change in the behavior and attitude for prevention of HIV/STD.

(iii) Carry out intervention programme as mentioned & as per guidelines.

(iv) Study the behavioural trends each year.

(v) Implement phase-II to cover other municipalities, and conduct similar behavioural surveys.

B. Assessment of Health Status of Adolescents, Their Treatment Seeking Behaviour and Utilization of Health Care Services

I. Objectives:

1. To assess the health status of the adolescents e.g. nutritional, sexual and reproductive health status, psychological and behavioural problems.
2. To study the treatment seeking behaviour of the adolescents.
3. To study the utilization of the health care services by adolescents

C. ASSESSMENT OF STATUS OF HEALTH CARE FACILITIES FOR PROVISION OF SERVICES FOR THE ADOLESCENTS

I. Objectives:

1. To assess the availability of trained manpower in the health care facilities for providing services for the adolescents.
2. To identify the type of services available for the adolescents referral services.
3. To study the availability of drugs and equipment and other facilities.
4. To find out laboratory facilities if any for diagnosis of RTI/STI.
5. To identify the obstacles in provision of health care services for adolescents and suggest measures for its solution.

II. Material and Methods:

1. Study area: Health facilities i.e. dispensaries/clinics under the municipalities of KUSP.
2. Sampling frame:
3. Method of data collection: The data will be collected -a) by actual observation and b) by interview with the person in charge of the health care facility on the day of the visit.
4. Duration of study: One month.
5. Tools: Pre-designed, pre-tested schedule containing both closed and open ended questions regarding availability of general facilities, services, staff pattern- their training status, IEC materials, medical examination facilities, drugs, equipment and laboratory facilities- their working condition, referral services etc.
6. Data analysis: Collected data will be analyzed using appropriate statistical methods.

D. TRAINING OF HEALTH OFFICERS & HONOURARY HEALTH WORKERS

Doctors, nurses, health workers need a good knowledge of normal adolescent development and skills to diagnose and treat common conditions. They are to be trained on how to address the problem of adolescents and make their approach friendly. Technical skills and a sympathetic professional approach should be combined with non-judgemental approach. Communication with adolescents on sensitive issues like sexuality, reproduction, STDs, age of marriage and child bearing etc. requires good communication skills. A communication model is to be evolved for effective communication.

Health officers will also have to organize teachers training programme on adolescent health and development on a large scale. Similarly peer training programme and student to student approach can pay rich dividend.

Training of different categories of staff should be held separately. It is envisaged that trainers training of Health officers will be organised by AIIH&PH. These trained Health officers will subsequently train their Assistant Health Officers and

Honorary Health Workers (HHW), Lady second tier supervisor (LSTS), FTS's, Female STS's at ULB levels. However all these training programmes will be organised and conducted under the supervision of Dr. Shibani Goswami, Health Expert. AIIHPH would provide time to time technical guidance, supervision and monitoring of all the activities of adolescent health programme under KUSP.

BUDGET:

SUMMERY OF BUDGET

I	**Adolescent Health care need assessment (Rs.218760 X 4 ULB)**	**875,040**
II	**Training of Trainers (Rs. 273000 X 2 Training Programmes)**	**546,000**
III	**Preparation of Training Module for HHW**	**95,000**
IV	**Monitoring and Supervision of HHW Training by AIIHPH (10 Programmes)**	**80,000**
	GRAND TOTAL	**1,596,040**

Sr. No.	Details	Rate(Rs.)	No.	Days	Total
I	**Adolescent Health care need assessment**				
A.	***Field expenses :***				
A1	**Per diem**				
A1.1	Principal Investigator/Experts	1500	2	6	18,000
A1.2	Field investigator (Medical Faculty)	800	2	6	9,600
A1.3	Research associates (PGTs)	500	2	6	6,000
A1.4	Social scientist	500	2	6	6,000
A1.5	Paramedical workers & Local guide	300	2	6	3,600
A2	**Travelling expenses**				
A2.1	F.I.,R.A.&SS	600	6	2	7,200
A2.2	Principal Investigator/Experts	1000	2	2	4,000
A2.3	Paramedical workers & Local guide	300	2	2	1,200
A2.4	Hiring of local transportation	500	2	6	6,000
A2.5	POL for local transport	500	2	6	6,000
A3	Consultancy and coordination	2000	1	6	12,000
A4	Lodging and Boarding	500	10	6	30,000
A5	Contingency expenses	1000	2	6	12,000
	Sub-Total				121,600
B	***Office expenses***				
B.1	Printing of Schedule				10,000
B.2	Data entry and analysis				10,000
B.3	Secretarial assistance				5,000
B.4	Stationeries				10,000
B.5	Computer, Software & Phone	30000	1	1	30,000
B.6	Final Report Writing & Printing				10,000
B.7	Contingency expenses				10,000
B.8	Institutional charges (DOE & Adm. Exp.)				12,160
B.9	Sub-Total				97,160
	Total				**218,760**
	Grand Total (four Urban Local Bodies)		4		875,040

II	**Training of Trainers**				
1	Per diem for Experts/Resource Persons	1000	5	3	15,000
2	Honorarium to facilitators	500	1	6	3,000
3	Travelling expenses for outside experts	7000	2	2	28,000
4	Per diem for Participants	500	20	3	30,000
5	Travelling expenses for Participants	500	20	2	20,000
6	Secretarial assistance	1000	2	10	20,000
7	Training materials (file, folder, bags etc.)	500	30	1	15,000
8	Banner, decoration	1000	2	1	2,000
9	Lunch, tea, coffee & Hall	700	30	3	63,000
10	Audio-visual aid	1000	1	3	3,000
11	Travel expenses for field visit	2000	2	1	4,000
12	Consultancy & Coordinator	2000	1	10	20,000
13	Report writing and Publication	10000	1	1	10,000
15	Institutional overhead charges				20,000
16	Contingencies				20,000
	Total				273,000
	Grand Total (Two Programmes)				**546,000**
III	**Preparation of Training Module for HHW**				
1	Honorarium to Specialist for writing	5000	5		25,000
2	DTP	5000	2		10,000
3	Photographs, sketches & artistic work	10000	1		10,000
4	Consultation meeting for draft module	25000	1		25,000
5	Printing and Publishing of Module	25000	1		25,000
	Total				**95,000**
IV	**Monitoring and Supervision of HHW Training by AIIHPH**				
1	Per diem	1000	2	10	20,000
2	Travel	1000	2	10	20,000
3	Lodging and Boarding	1000	1	10	10,000
4	Consultancy and Coordination	2000	1	10	20,000
5	Contingencies	1000	1	10	10,000
	Total (ten programmes)				**80,000**

****

Adolescent clinic –

silke seco <silkeseco1@yahoo.com> to me, a-kennin Hide options 10:20 pm (10 minutes

From: **silke seco <silkeseco1@yahoo.com>** Signed-By: **yahoo.com** | Mailed-By: **yahoo.cor**
To: **dfidhhw@gmail.com, a-kenningham@dfid.gov.uk, s-seco@dfid.gov.uk**
Date: **Oct 27, 2005 10:20 PM**
Subject: **adolescent proposal**

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Dear Dr. Goswami

As agreed, I am sending you some comments on the adolescent health services proposal that was drafted by the AIIMS. I am currently on leave and do not have Dr. Kraul email address. Please feel free to pass these comments to him.

I am very pleased to see action regarding this component since adolescents are a vulnerable and neglected age group in India, and addressing their health needs is imperative. The justification for introducing adolescent health services within the Honorary Health Workers' scheme and the key adolescent health issues to address ar well laid out in the proposal. Moreover, I support the pilot approach and therefore the selection of a small number of ULBs to begin with, since this is a new intervention.

Notwithstanding the above, the proposal could be strengthened by:

a. Expanding on the methodology section, including:

- Criteria for selection of the pilot ULBs, and appropriate number
- Expected length of the pilot phase
- Content of the training and specification of who will be selected/on what basis

a. In addition to training in adolescent health needs, I think it is important to explai how it is proposed to make the existing health services adolescent-friendly and accessible. This could include for example, dedicated timings and /or days for adolescents, ensuring privacy and confidentiality, etc.
b. I would also strongly recommend to take a holistic approach to adolescent healt and include mental and physical well-being – if not immediately, at a later stage In this respect, it will also be important to think of inter-sectoral linkages with otl adolescent programmes and departments which deal with this group. The HHW should be equipped to act as referral points for further services, such as counseling.
c. An Information, Communication and Education component to ensure that adolescents in the ULBs are aware of these services should be developed. I ha seen successful initiatives elsewhere by using peer educators as a strategy (i.e adolescents becoming "health promoters" among their peers) and I believe this strategy has been proposed by GoI in the National Youth Policy 2003.
d. Lastly, a budget needs to be added to the proposal.

I would like to revise the full proposal and discuss the issue of adolescents furth – perhaps during my next visit to Kolkata, but I support the idea of getting the AIIMS involved, at least during the first phase. I believe there is potentially scop to do more and we should discuss possibilities as we go along.

Hope you find these comments helpful.

From: **Silke Seco <S-Seco@dfid.gov.uk>**
To: **drdkraut@vsnl.net, Shibani Goswami <dfidhhw@gmail.com>**
Date: **Nov 8, 2005 8:07 PM**
Subject: **RE: adolescent proposal**

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Dear Dr. Raut,

Thanks for confirming that you received my comments on the adolescent proposal and for agreeing to address them in the final version.

I am planning to spend 2/3 days in Kolkata during the week of November 21st. If you are available, it would be good to try and meet to discuss this issue further.

Please let me know your availability during this week and I will try to arrange my trip accordingly. Please Shibani, let me know your availability as well.

Silke

From: drdkraut@vsnl.net
[mailto:drdkraut@vsnl.net]
Sent: 05 November 2005 19:57
To: Shibani Goswami; Silke Seco
Subject: Re: adolescent proposal

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Dr.Deepak Raut to me, Silke Hide options Nov 5 (1 day ago)

From: **Dr.Deepak Raut <drdkraut@vsnl.net>** Mailed-By: **vsnl.net**
To: **Shibani Goswami <dfidhhw@gmail.com>, Silke Seco <s-seco@dfid.gov.uk>**
Date: **Nov 5, 2005 6:26 AM**
Subject: **Re: adolescent proposal**

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Dear Dr. Shibani Goswami and Silke,

I am happy to know that you principally agrees to the proposal on adolescent Health.I have noted down the suggestions of Ms. Silke and would be incorporating it in the final proposal. Yes we need to make services adolescent friendly and also suggested to include peer group members who can act as facilitators and also coordinators.The budget will also be included in the final proposal.

We need to discus all these issues as per your convenience.

Thanks and regards

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E-Mail: drdkraut@vsnl.net, drdeepakraut@yahoo.com

Silke Seco to me, An Hide options Oct 4 (2 days ago)

From: **Silke Seco <S-Seco@dfid.gov.uk>**
To: **dfidhhw@gmail.com**
Cc: **Andrew Kenningham <A-Kenningham@dfid.gov.uk>**
Date: **Oct 4, 2005 1:03 AM**
Subject: **RE: Back to Office Report**

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Dear Shibani

Thank you for keeping me updated with some of the issues that we discussed during my last visit to Kolkata. I am attaching my BTOR with the additions and changes you have suggested.

Andrew Kenningham, DFID economics adviser and new KUSP team leader and I are planning a visit to Kolkata to discuss the HHW scheme and visit another municipality in the near future. We will keep you informed of possible dates and of the issues we would like to discuss.

I also look forward to hearing on the adolescent care proposal.

Best wishes

Silke

Dr.Deepak Raut to r More options Sep 28 (6 days ago)

Dear Dr. Shibani
We will discus adolescent Health Program as schedule on 4th Oct.Then the things will be more clear.
I agree for the program on Vector born disease control and we will also discus modalities during our discussion.

Thanks and Best regards

Dr.D.K.Raut MBBS,MD,FIPHA
Professor & Head
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Adolescent Health Care Services Project for KUSP

1 INTRODUCTION

2 ADOLESCENTS

3 IMPORTANCE OF ADOLESCENT HEALTH CARE PROGRAMME

3.1 Adolescents Health Problems

3.2 Why health care services for adolescents

3.2 Why health care services for adolescents

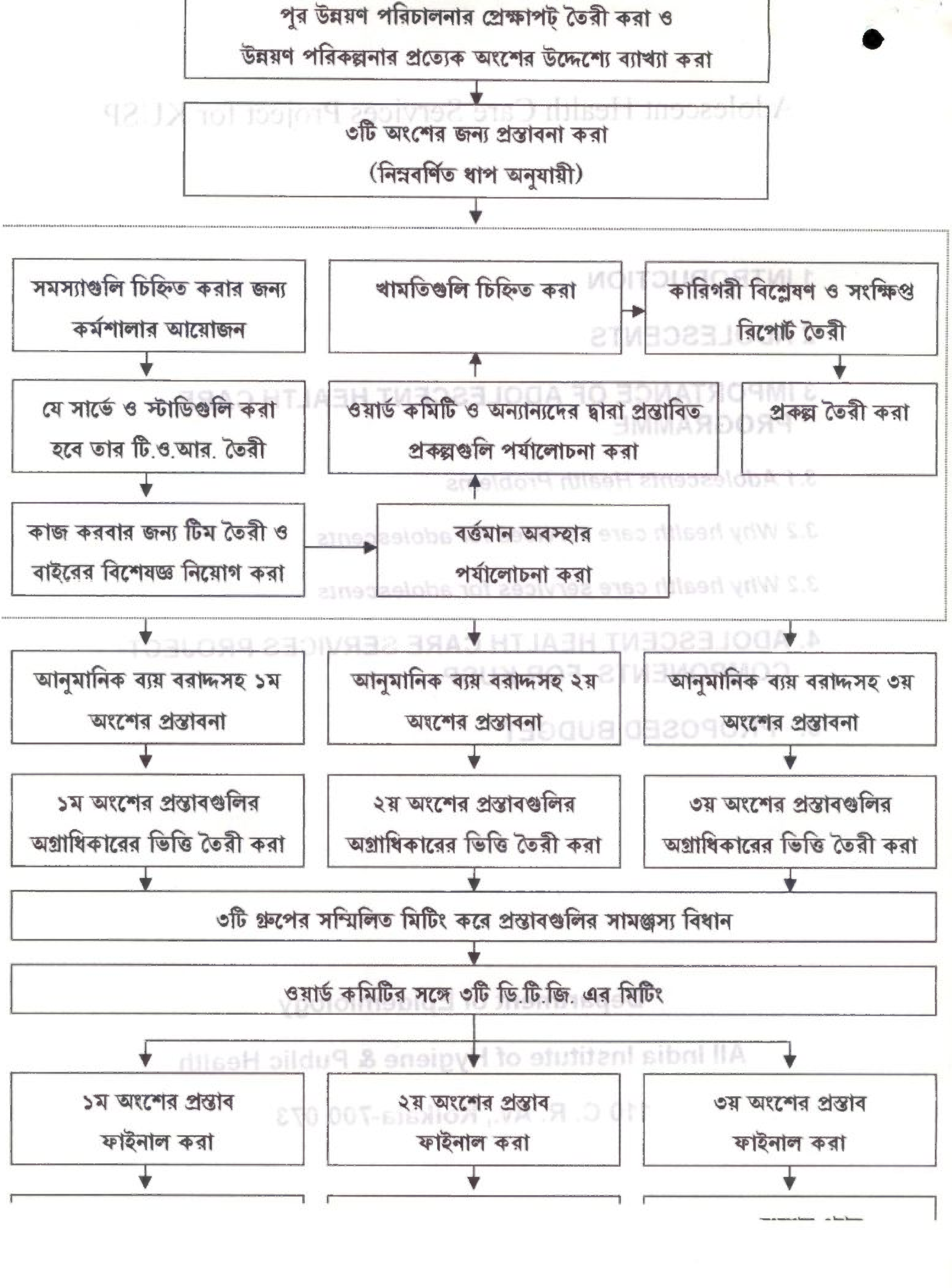
4. ADOLESCENT HEALTH CARE SERVICES PROJECT COMPONENTS FOR KUSP

5. PROPOSED BUDGET

Department of Epidemiology

All India Institute of Hygiene & Public Health

110 C. R. Av., Kolkata-700 073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উন্নয়ণ পরিকল্পনার প্রত্যেক অংশের উদ্দেশ্যে ব্যাখ্যা করা
৩টি অংশের জন্য প্রস্তাবনা করা
(নিম্নবর্ণিত ধাপ অনুযায়ী)
সমস্যাগুলি চিহ্নিত করার জন্য কর্মশালার আয়োজন
খামতিগুলি চিহ্নিত করা
কারিগরী বিশ্লেষণ ও সংক্ষিপ্ত রিপোর্ট তৈরী
যে সার্ভে ও স্টাডিগুলি করা হবে তার টি.ও.আর. তৈরী
ওয়ার্ড কমিটি ও অন্যান্যদের দ্বারা প্রস্তাবিত প্রকল্পগুলি পর্যালোচনা করা
প্রকল্প তৈরী করা
কাজ করবার জন্য টিম তৈরী ও বাইরের বিশেষজ্ঞ নিয়োগ করা
বর্তমান অবস্থার পর্যালোচনা করা
আনুমানিক ব্যয় বরাদ্দসহ ১ম অংশের প্রস্তাবনা
আনুমানিক ব্যয় বরাদ্দসহ ২য় অংশের প্রস্তাবনা
আনুমানিক ব্যয় বরাদ্দসহ ৩য় অংশের প্রস্তাবনা
১ম অংশের প্রস্তাবগুলির অগ্রাধিকারের ভিত্তি তৈরী করা
২য় অংশের প্রস্তাবগুলির অগ্রাধিকারের ভিত্তি তৈরী করা
৩য় অংশের প্রস্তাবগুলির অগ্রাধিকারের ভিত্তি তৈরী করা
৩টি গ্রুপের সম্মিলিত মিটিং করে প্রস্তাবগুলির সামঞ্জস্য বিধান
ওয়ার্ড কমিটির সঙ্গে ৩টি ডি.টি.জি. এর মিটিং
১ম অংশের প্রস্তাব ফাইনাল করা
২য় অংশের প্রস্তাব ফাইনাল করা
৩য় অংশের প্রস্তাব ফাইনাল করা

1 INTRODUCTION:

Adolescents complete their physical, emotional and psychological journey to adulthood in a changing world that contains both opportunities and dangers. Most adolescents are full of optimism and represent a positive force in society, an asset now and for the future as they grow and develop into adults. When supported, they can be resilient in absorbing setbacks and overcoming problems. However, adolescents are exposed to risks and pressures on a scale that their parents did not face. Modernization has accelerated change while the structures that protected previous generations of young people are being eroded. Adolescents receive contradictory messages on how to address the daily choices, which have lifelong consequences for healthy development. Millions are denied the essential support they need to become knowledgeable, confident and skilled adults. They miss out on schooling mostly for economic reasons. There are fortunate few young people have loving families who protect and care for them, many grow up with no adults committed to their welfare or where the ability of caring adults to support them has been damaged. Adolescents are at risk of early and unwanted pregnancy, of sexually transmitted infections (STIs) including HIV and AIDS, and vulnerable to the dangers of tobacco use, alcohol and other drugs. Many are exposed to violence and fear on a daily basis. Some of the pressures adolescents are under, or the choices they make, can change the course of their young lives, or even end them. These outcomes represent personal tragedies for young people and their families.

They are also unacceptable losses that put the health and prosperity of society at risk. Addressing the needs of adolescents is a challenge that goes well beyond the role of health services alone. The legal framework, social policy, the safety of communities and opportunities for education and recreation are just some of the factors of civil society that are key to adolescent development. However, within an integrated approach, health services can play an important role in helping adolescents to stay healthy and to complete their journey to adulthood; supporting young people who are looking for a route to good health, treating those who are ill, injured or troubled and reaching out to those who are at risk.

Effective health services reach adolescents who are growing up in difficult circumstances as well as those who are well protected by their communities. Health services need to link with the other key services for adolescents, so that they become part of a supportive structure that protects young people against dangers, and helps them to build knowledge, skills and confidence. This is far from being the case in many countries. Health services often regard adolescents as a healthy group who do not need priority action, and so provide a minimum subset of adult or paediatric services with no adjustments for their special needs. There is evidence that many young people regard such health services as

KOLKATA URBAN SERVICES FOR THE POOR

CHANGE MANAGEMENT UNIT

Memo No. CMU-94/2003(Pt. II)/ Dt .. 30.06.2005

From : Arnab Roy
Project Director, CMU

To : The Chairman

.... Municipality

Sub : Training of Health Officer & Assist. Health Officer in Public Health under Health Component of KUSP.

Sir,

You may be aware that DFID has approved re-training of all Health functionaries. For the purpose, a comprehensive training for the Health Officer and Asstt. Health Officer of 40 KMA ULBs (except KMC) in public health, planning & management is being organised in batches by CMU through All India Institute of Hygiene & Public Health, Kolkata. Therefore, you are requested to forward the names of Health Officer & Asstt. Health Officer only by 07.07.2005 through FAX positively.

The 3rd (final) batch of training will be held at Bangalore during August 29, 2005 to September 02, 2005. As such the participant/s is to reach Bangalore by evening of August 28, 2005 positively. Railway ticket for to and fro journey of the participants preferably in AC III Tier may kindly be arranged from your end. A feed back on railway reservation may be please be forwarded to Health Expert, CMU.

Expenses for the cost of railway ticket etc. and daily allowance @ Rs. 230/- per diem per participant is to be incurred from the KUSP fund already placed to you. The expenditure is to be booked under "Health Component - Training of HOs & AHOs". The Statement of Expenditure (SOE) and Utilisation Certificate (U.C.) within 1 month after completion of the training through the Accounting Support Agency.

Yours faithfully,

Project Director, CMU

C:\Dr. Goswami\KUSP\KUSP\Letter Head ULBs.doc

ILGUS BHAVAN, HC BLOCK, SECTOR 3, BIDHANNAGAR, KOLKATA 700 106
PH. : 033-2337 8723, 2337 7315, 2358 6403 / 5767, FAX : 033-2337 7318 / 2358 5800
email : kuspcmu@vsnl.net, website : www.changekolkata.org

irrelevant to their needs and distrust them. They avoid such services altogether, or seek help from them only when they are desperate.
'Adolescent friendly' health services meet the needs of young people in this age range sensitively and effectively and are inclusive of all adolescents. Such services deliver on the rights of young people and represent an efficient use of precious health resources.

Objective

The health services for Adolescent Health aim to provide quality health care for young people and promote healthy adolescent development. Services take into account the wide range of family, school, peer and individual issues that can affect young people's health. Adolescents' services shall be sensitive to the importance of cultural background, religion and spirituality, gender, and sexuality in a young person's life. The adolescent health services provides the package of preventive, promotive and curative services for overall development of adolescents health.

2 ADOLESCENTS:

The World Health Organization defines adolescents as young people aged 10-19 years. There are about 1.2 billion adolescents, a fifth of the world's population, and their numbers are increasing. Four out of five live in developing countries.
Adolescence is a journey from the world of the child to the world of the adult. It is a time of physical and emotional change as the body matures and the mind becomes more questioning and independent. During adolescence, growth spurt occur and about 35% gain of adult weight and 11% of adult height are acquired- so achievement of optimum growth and development during this period is of utmost important in maintaining good health thereafter.

Adolescents are no longer children, but not yet adults, and this period of change is full of paradox. Adolescents can seem old beyond their years, but need adult support. They can put themselves at risk without thinking through the consequences; display optimism and curiosity, quickly followed by dismay and depression. Biologically, they can become mothers and fathers, without being ready for the responsibility. They feel a growing sense of independence, but depend on adults for their material needs. And as they change, so their needs change with them.
_ Early adolescence (10-13) is characterized by a spurt of growth, and the beginnings of sexual maturation. Young people start to think abstractly.
_ In mid-adolescence (14-15) the main physical changes are completed, while the individual develops a stronger sense of identity, and relates more strongly to his or her peer group, although families usually remain important. Thinking becomes more reflective.
_ In later adolescence (16-19) the body fills out and takes its adult form, while the individual now has a distinct identity and more settled ideas and opinions.

মজুরী ভিত্তিক কর্মসংস্থান কর্মসূচি

- বৃহত্তর কলকাতা এলাকার বাইরে বেশ কিছু পৌর এলাকা বিশেষ করে সামপ্রতিককালে গঠিত পৌরএলাকায় মৌল পরিষেবার পরিকাঠামো উন্নয়নের প্রয়োজন আছে। এই সব পৌর এলাকার পরিকাঠামো উন্নয়নের জন্য ২০০৫ - ০৬ আর্থিক বছরে রাজ্য বাজেটে ৫০ কোটি টাকা বরাদ্দ আছে।
- পরিকাঠামো উন্নয়নের প্রকল্প রূপায়ণ করতে হবে **মজুরী ভিত্তিক কর্মসংস্থান কর্মসূচির** মাধ্যমে।

কর্মসূচির উদ্দেশ্য

- এই কর্মসূচির মাধ্যমে একদিকে যেমন মৌল পরিষেবা পরিকাঠামো উন্নয়নের মাধ্যমে নাগরিকদের কাছে উন্নততর পরিষেবা পৌঁছে দেওয়া যাবে, সেইরকমভাবে এলাকার দরিদ্র শহরবাসীর কর্মসংস্থানের সুযোগ হবে।

প্রকল্প রূপায়ণ

- পৌরসভাকে প্রকল্পগুলি রূপায়ণ করতে হবে ওয়ার্ড কমিটি অথবা সমষ্টি উন্নয়ন সমিতির মাধ্যমে। সামগ্রিক নজরদারি করবে পৌরসভা।
- প্রকল্প চিহ্নিত করবে ওয়ার্ড কমিটি প্রস্তাবিত আয়-ব্যয়ের হিসাব ভেট করাতে হবে পুরসভার সাব-অ্যাসিস্ট্যান্ট

These changes take place at a different rate for each individual and can be a period of anxiety as well as pried.

Part of challenges for health services is to recognize that adolescents have a range of needs based on individual circumstances. Those who are especially vulnerable and hard to reach include young people who:
_ are denied the opportunity to complete their education;
_ have no stable homes or support, living rough in towns and cities, exposed to risks of malnutrition, abuse, violence and disease;
_ are vulnerable to sexual abuse or violence, or are sexually exploited by people who are older and more powerful;
_ Work long hours for little pay, exposed to hazardous work processes;
_ live as young wives in families who oppress and abuse them;
_ live as ethnic minorities in a land where they and their parents are rejected by mainstream culture;
_ are among the 1 in 10 young people affected by a disability, and denied the same opportunities for development as their peers.

3 IMPORTANCE OF ADOLESCENT HEALTH CARE PROGRAMME

Adolescents are generally believed to be healthy because death rates for this age group are lower than for children or for elderly people. However, death rates are an extreme measure of health status and tell only part of the story. There are many interrelated reasons why we need to pay attention to the health of adolescents: for this age group, for later life and for the next generation.

1 To reduce death and disease in adolescents now

An estimated 1.7 million young people aged from 10 to 19 die each year world wide — mainly from accidents, violence, pregnancy related problems or illnesses that are either preventable or treatable. Many more develop chronic illness that damages their chances of personal fulfillment.

2 To reduce the burden of disease in later life

Malnutrition in childhood and in adolescence can cause lifelong health problems, while failure to care for the health needs of young pregnant women can damage their own health and that of their babies. This is the age when sexual habits and decisions about risk and protection are formed. Some of the highest infection rates for sexually transmitted infections are in adolescents. The HIV/AIDS pandemic alone is sufficient reason to look anew at how health services address the needs of adolescents.
Many diseases of late middle age, such as lung cancer, bronchitis and heart disease, are strongly associated with a smoking habit that begins in adolescence.

3 To invest in health — today and tomorrow

Healthy and unhealthy practices adopted today may last a lifetime. Today's adolescents are tomorrow's parents, teachers and community leaders. What they

ক্রমিক সংখ্যা	প্রশ্ন	সঠিক উত্তরে টিক (√) দিন ও যথাযথ জায়গায় উত্তর লিখুন	প্রশ্নের মান
৯।	শিশুর সর্দি কাশি হলে কোন তিনটি বিপদের লক্ষনগুলির প্রতি লক্ষ্য রাখতে হবে ?		২
১০।	গর্ভনিরোধের বড়ি খাওয়ানোর পদ্ধতিটি কি ?		২
১১।	কপার টি কাকে দেবেন না ?		১
১২।	যক্ষা রোগ কি ভাবে ছড়ায় ?		২
১৩।	মাতৃ মৃত্যুহার নির্ণয় সূত্রটি কি ?		২
১৪।	কোনো এক এলাকায় জনসংখ্যা ৩,৫৫০, একবছরে জীবিত শিশুর জন্ম সংখ্যা ৫০, মোট মৃতের সংখ্যা ১৩, ১ বছরের নীচে শিশু মৃত্যুর সংখ্যা ২ এবং ৫ বছরের নীচে বাচ্চার মৃত্যুর সংখ্যা ৫ হলে সেই এলাকায় ঐ বছরে শিশু মৃত্যুর হার কত?		২
১৫।	কোনো এলাকায় ৩০০ জন প্রজননশীল দম্পতির মধ্যে নির্দিষ্ট বছরে ১০ জন মহিলা লাইগেশন করিয়েছে, ২ জন পুরুষ ভ্যাসেকটোমি করিয়েছে, ২০ জন ওরাল পিল খান, ৪ জন আই.ইউ.ডি. এবং ১৪ জন কন্ডোম ব্যবহার করেন - এক্ষেত্রে প্রজননশীল দম্পতির সুরক্ষা হার কত ?	১৬.৬ / ১৭.৬ / ১৪.৬	২
	মোট		৩০

প্রথম সারির পরিদর্শিকার নাম ঃ

এস. এইচ. পি. নং ঃ   তারিখ ঃ

learn they will teach to their own children. Adolescence is a period of curiosity, when young people are receptive to information about themselves and their bodies, and when they begin to take an active part in decision making.

4 To deliver on human rights

The Convention on the Rights of the Child (CRC) says that young people have a right to life, development, and (Article 24) "the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health". The CRC gives young people the right to preventive health care, and calls for specific protection for those in exceptionally difficult conditions or living with disabilities. Under the CRC, Governments not only have a duty to ensure services for good health care, but also have a duty to ensure that young people can express themselves and that their views are given weight according to their age and maturity.

5 **To protect human capital**

In some societies two out of three adolescents are involved in productive work, while many young women below the age of 20 are already mothers. If they are no longer able to fulfill these roles because of injury, illness or psychological damage, the cost is primarily a human one, but there is also a cost to society. Economic development, as well as personal fulfillment, is strongly related to the health and education levels of the population.

We need to pay attention to the health needs of adolescents to:

_ reduce death and disease, now and during their future lives.

_ deliver on the rights of adolescents to health care, especially reproductive health care;

_ ensure that this generation of adolescents will, in turn, safeguard the health of their own children.

But, health of the adolescent population are relatively neglected both at the family and at the health provider level. There is a relative gap in the health care of the adolescents, resulting in occurrence of preventable morbidities and mortalities affecting the potential workforce of the country. The intrinsic vulnerability of the adolescent people who form a heterogeneous group is aggravated by their risk taking attitude, strong peer influence, inaccess to information and traditional gender disparities in the society. So it is important that diverse health needs of adolescents like physical, psychological and social health needs are given due consideration by the health providers. Programmes on adolescent health while putting due stress on reproductive health, should work on a wider perspective, considering the adolescents physical and emotional needs as well.

Adolescents do not appreciate the importance of seeking treatment when they are unwell and often underestimate the severity of their condition. Even when they choose to seek care, there may be important barriers preventing their access to such care. The health services may not be available, accessible or acceptable to the adolescent people. Cultural reason, physical distance, time disparity, fear of being recognized, lack of confidentiality, natural aversion to be

ডি.এফ.আই.ডির সহায়তায় স্বেচ্ছাসেবী স্বাস্থ্যকর্মীর এই স্কীমটি বৃহত্তর কলকাতা এলাকার বাইরে ১১ টি পৌরসভায় যথা ঃ বহরমপুর, জঙ্গিপুর, কোচবিহার, সিউড়ি, বোলপুর, বাঁকুড়া, বিষ্ণুপুর, পুরুলিয়া, কালনা, কৃষ্ণনগর ও মেদিনীপুর -এ ১লা ফেব্রুয়ারী, ২০০৪ থেকে লাগু হয়েছে।

স্কীমের আওতায় থাকবেন শহর এলাকার দরিদ্র ও পিছিয়ে পড়া মানুষজন, বিশেষ করে মা ও পাঁচ বছর পর্যন্ত শিশুরা ও কিশোর-কিশোরীরা।

in a clinic or treatment centre and rude or judgemental health workers may act as obstacles in utilization of health care services by the adolescent individuals.

National Population Policy 2000 has identified adolescents as under-served population group. Govt. of India intends to improve the services for this vulnerable group of population who have till now been effectively left out of planning process. KUSP like to introduce the service of adolescent care in their health component and start it as pilot project in 4 urban local bodies. As mentioned, this vulnerable group of population may suffer from various health problems, so far effective implementation of adolescent health programme in the municipalities under KUSP, it is essential to assess the health status and needs of the adolescents of the area, facilities available and suggest measures for intervention.

3.1 Adolescents Health Problems

Adolescents represent about of a fifth of country's population but the health needs of adolescents have seldom been addressed. They face a number of health problems like general health problems, menstrual problems, mental health problems, early and unprotected sex, sexual abuse, accidents and violence, addictive behaviors like alcoholism and drug addiction etc. National Family Health Survey data revealed that over 50% of girls marry below the age of 18. Teen age pregnancies being high risk pregnancies result in unsafe abortion, low birth weight and high maternal morbidity and mortality. The age group 15 - 19 contributes 19% of total fertility in India. Highest unmet needs for contraception have been reported in the age group 15 - 19 years. Around 30% of adolescent's girls and 18% of boys suffer from malnutrition. As the adolescents undergo sexual development, they are curious to know about it. Several studies show varying levels of pre-marital sex among male and female adolescents. The median age of initiation of sexual debut is 15 - 16years.

The combination of growing physical maturity, hormonal changes, emotional immaturity and lack of information makes adolescents specially vulnerable to certain types of health events, the effect of which may be serious and permanent e.g. sexually transmitted infections including HIV/AIDS, unwanted teenage pregnancy, unsafe abortions and resultant pelvic infection, drug addiction, alcoholism etc. Around 40% of HIV infections are centred on teenagers. Adolescents are also very often under psychological stress, as they become more independent and assertive leading to confusion, tension, frustration, feeling of insecurity and depression.

Adolescents are subject to many of the same diseases as children and adults. There are also some health risks that are especially connected with puberty. Adolescents have different health risks and needs according to their age, sex and living circumstances. Adolescents may not appreciate the importance of seeking treatment when they are unwell, and often underestimate the severity of their condition.

পাঁচ বছর পর্যন্ত বয়সের বাচ্চাদের ওজনের গতিরেখা মাপার (Growth Monitoring) ক্লিনিক

- প্রতি ব্লকে ৫ বছর পর্যন্ত বয়সের বাচ্চাদের লিষ্ট তৈরী করা।
- ঐ বাচ্চাদের নিয়মিত সময়ের ব্যবধানে ওজন করা ও **Growth Monitoring Card** এ ওজন লিপিবদ্ধ করা।
- যে সব বাচ্চার ওজন স্বাভাবিক গতিরেখায় থাকবে তাদের ২ মাস অন্তর ওজন নেওয়া।
- যে সব বাচ্চার ওজনের গতিরেখা স্বাভাবিক থেকে কম হবে, তাদের প্রতি মাসে ওজন নিতে হবে।
- **Grade I, II & III** - র অপুষ্ট বাচ্চার মা ও পরিবারের অন্যান্য সদস্যদের ঐ বাচ্চার পুষ্টি বাড়ানোর জন্য পরামর্শ দেওয়া।
- **Grade IV** র গতিরেখা সম্পন্ন বাচ্চাদের হাসপাতালে পাঠিয়ে উপযুক্ত চিকিৎসার ব্যবস্থা করা।

সাব-হেল্থ পোষ্টে রেজিষ্টার রক্ষণাবেক্ষন

সাব-হেল্থ পোষ্ট থেকে বিভিন্ন স্বাস্থ্য পরিষেবা দেওয়া হয়। পরিষেবাপ্রাপ্ত জনগণ বিশেষত মা ও শিশুদের বিভিন্ন তথ্য লিপিবদ্ধ করার জন্য প্রত্যেক পরিষেবার জন্য সাব-হেল্থ পোষ্ট ইত্যাদি আলাদা আলাদা রেজিষ্টার কার্ড রাখা হয়। এই সব মূল্যবান তথ্য সাব-হেল্থ পোষ্টের কাজের মূল্যায়ণে ব্যবহার করা হবে এবং পরিসংখ্যান তৈরী ও আরও উন্নততর পরিষেবা দেওয়ার সাহায্য করবে।

ক) নিম্নলিখিত রেজিষ্টার (Register) / কার্ড সাব-হেল্থ পোষ্টে রাখতে হবে ঃ

(১) স্বেচ্ছাসেবী স্বাস্থ্যকর্মীর **(HHW)** হাজিরা খাতা।

(২) ANC / PNC রেজিষ্টার এবং কার্ড **(ANC / PNC Register & Card)**

(৩) ইমুনাইজেশন রেজিষ্টার এবং কার্ড **(Immunisation Register & Card)**

(৪) ৫ বছর পর্যন্ত বয়সের বাচ্চার ওজন লিপিবদ্ধ করার গ্রোথ মনিটরিং কার্ড **(Growth Monitoring Card)**

(৫) সাধারণ রোগের চিকিৎসার রেজিষ্টার **(Register for treament of minor ailments)**

(৬) সচেতনতা বৃদ্ধি প্রোগ্রামের রেজিষ্টার **(Awareness Programme Register)**

(৭) সাব-হেল্থ পোষ্টের জিনিষপত্রের ষ্টক রেজিষ্টার **(Stock Register)**

এই রেজিষ্টারগুলির নমুনা ও ব্যবহার পদ্ধতির গাইড লাইন সংশ্লিষ্ট পুরসভার পুরপ্রধান ও হেল্থ অফিসারদের কাছে পাঠান হয়েছে। ঐ গাইড লাইন অনুযায়ী FTS-রা কাজ করবেন।

খ) এক নজরে সাব-হেল্থ পোষ্টের ব্লক ভিত্তিক Target Population -এর পরিসংখ্যান

প্রতি সাব-হেল্থ পোষ্টে নিম্নলিখিত ফর্মাট অনুযায়ী চার্ট টাঙিয়ে রাখতে হবে ঃ

ব্লক নং	স্বেচ্ছাসেবী স্বাস্থ্যকর্মীর নাম	মোট জনসংখ্যা	প্রজননশীল দম্পতির সংখ্যা	১ বছরের নীচে বাচ্চার সংখ্যা	১-৫ বছরের বাচ্চার সংখ্যা	গর্ভবতী মায়ের সংখ্যা

*** এই পরিসংখ্যানগুলি প্রতিবছর ১লা এপ্রিল ও ১লা অক্টোবর নবীকরণ করতে হবে।**

Adolescents are vulnerable to harmful consequences of health risks. Some, like depression or interpersonal violence, have immediate effects, while others such as sexually transmitted infections or smoking have harmful or fatal effects in the medium or long term. Adolescents, especially girls, are vulnerable to sexual abuse. The common health problems adolescents usually suffer are grouped as follows.

1. Malnutrition
2. General health problems
3. Menstrual problems
4. Early unprotected sex
5. Addictive behaviors
6. Accidents and violence
7. Sexual abuse
8. Mental health problems-depression and suicide
9. Reproductive tract infections, sexually transmitted diseases, HIV/AIDS, etc.

3.2 *Why health care services for adolescents*

•One fifth of the population is between 10-19 years of age
•22.8% of the Indian population is adolescent
•83.5% of the world's young people lives in developing countries;
•Sexual activity among adolescents is up to 30%
•Malnutrition is found to be around 45% in girls and 20% among boys
•Married female's adolescents are 26-54% of 15-18 years
•36-64% of married teenagers(13-19 years) are either pregnant or mothers
•Around 5% teenagers use *DRUGS*

Level of Awareness

•Misconception about AIDS- 70-80 %
•Awareness about how AIDS spreads- 45- 60%
•Awareness about STDs/ RTIs - 32%
•Source of knowledge comes 78% from peers
•Married teenagers(15-18 yrs)
Use of contraception : 8%
Inability to take decision about health: 83%

Outcomes:

- Reduction of births to teens ages 15-17.
- Promotion and provision of health care, and access to health care for the adolescent population.
- Promotion and implementation of strategies that will reduce the risk-taking behaviours of adolescents.
- Involvement of communities in adolescent issues.

Daily Report on Preventive and Control Measures taken against Dengue during past 24 hours.

Name of ULB : SURI

Total Population of the ULB : 61,818

Date of Reporting : 17.9.05 TO FAX NO : (033) 2358 5800 / 2337 0068 by 1 P.M.

A. Mosquito Control Measures	Information to be furnished by the ULB
1. Anti Larval Measures (Breeding source Reduction through inspection and removal of source)	
i) No. of dwelling houses covered	82
ii) No. of Schools / Institutions / Clubs covered	1
iii) No. of construction sites covered	—
iv) Area-wise no. of special cleaning drives given	7
2. Anti Adult Measures (Fogging with Malathion / ~~Spraying with pyrethrum~~)	
i) No. of Dwelling House covered	1500
ii) No. of Schools / Institutions / Clubs covered	4+5
iii) No. of construction sites covered	8
B. Public Awareness Campaign	
i) No. of houses inspected for breeding source reduction and IEC activities by	
a) HHWs	176
b) Others	—
ii) No. of leaflets distributed	—
iii) Campaign through PA system	~~Yes~~ / No ✓
iv) No. of Hoardings and banners displayed	—
v) Local Cable TV channel used	✓Yes / ~~No~~
C. (i) No. of new cases of Dengue detected	
a) Clinical	—
b) Sero+ve	—
(ii) No. of death due to Dengue	—

17.9.05 17/9/05

Sanitary Inspector | Health Officer / Asst. Health Officer | Chairman

- Provision of coordinated efforts that will reduce morbidity and mortality during adolescence.

Package of services to be made available at each level of care need to be clearly defined. Though there is a strategy of government for providing ARSH services, the strategies proposed should be revisited in light of suggested national strategies. There is needed to be more clarity on suggested immunization for adolescents, growth monitoring, and access to STI services. Similarly we need to provide sufficient details as who will provide counselling services and at what level? How we plan to develop favorable attitudes amongst the stakeholders and gatekeepers on need for services to adolescents. What are additional infrastructure and supplies?

4. ADOLESCENT HEALTH CARE SERVICES PROJECT COMPONENTS FOR KUSP:

1. Health Care need assessment of Adolescents
   - Awareness of RTI/STIs, HIV/AIDS, etc (KABP study)
   - Treatment seeking behaviour
   - Assess the health status of the adolescents- e.g. nutritional, sexual and reproductive health status, psychological and behavioral problems etc.
   - Utilisation of Health care services by adolescents
2. Training need assessment of health care providers
   1. Medical Officers
   2. ANM/Staff nurse
   3. HHW
   4. Councillors
3. Status of health care facilities and evaluation for provision of services for the adolescents.
   - Trained manpower
   - Type of services provided
   - Laboratory facilities
   - Referral services
   - Availability of drugs and medicine
   - Obstacles
4. Intervention Measures to improve the Adolescent health
   - Training of Medical officers on adolescent health services
   - Training of ANM/HHW and councillors
   - Provision of equipments, drugs, chemical and AV aids
   - Provision of health care services to adolescents
     - i.Preventive services
     - ii.Promotional services
     - iii.Curative services

5. ESTIMATED BUDGET FOR ALL COMPONENTS

(In Indian Rupees):

Component	Amount
Assessment status of Health care facilities	189000
Training of Medical Officers under KUSP on adolescent health (one Programme)	157400
Health care need assessment for adolescents	275750
Awareness of adolescents on STDs, RTIs and HIV/AIDS	275750
Intervention (e.g. setting of adolescent clinic, counsellor, etc.)	50000
Grand Total	947900

Details of Equipment (Training) under IPP-VIII (Extn.) O & M as on 31.03.2005

Date of Receipt	Item	Qty.	Amount (In. Rs.)	Remarks
03.01.2001	Portable Photo Display Panel	1	27100.00	
03.01.2001	Rev. Hexagonal Backet Box	1	16200.00	
23.04.2001	UPS	1	17650.00	
16.05.2001	Laptop including MS Office	1	200350.00	
15.06.2001	Overhead Projector	1	8120.00	
	Aotomatic Slide Projector	1	9453.00	
	Public address system	1	7900.00	
26.03.2002	Colour TV	1	9225.00	
14.03.2002	Xerox Machine (coloured)	1	940293.00	
14.03.2002	Laptop	1	181769.00	Issued to M.A. Secretary.
14.03.2002	LCD Projector	1	218151.00	Issued to KMDA (Mr. Ghatak)
19.08.2002	VCP with remote	1	7560.00	
	Total		**16,43,771.00**	

Adolescent Health Care Services Scheme under Health Component of KUSP

1. **Introduction**

2. **Adolescents**

3. **Importance of Adolescent Health Care Scheme**

3.1 **Adolescents Health Problems**

3.2 **Why Health Care Services for Adolescents**

4. **Adolescent Health Care Scheme**

5. **Proposed Budget**

From Serial No. 1 to 3.2 : Same as you have already mentioned in your draft proposal.

Serial No. 4 :

1. Health care need assessment of Adolescents by AIIH & PH

- How many Urban Local Bodies / Adolescents will be interviewed ?
  (There are 40 ULBs under KUSP)
- Target date for submission of final report

2. Trainers Training by AIIH & PH

- We will prefer lady Health Officer / Asstt. Health Officer / Medical Officer
- May be we will confine to 10 ULBs at the initial stage
- Duration of training (3 days ?)
- Venue of training
- No. of participants
- Preparation of training module for the trainers in Bengali.

3. Training of HHWs, FTSs & female STSs at ULB level by the trainers

- Expenditure will be incurred directly by the ULB
- Time to time monitoring & supervision of the training sessions by AIIH & PH
- Feed back to Health Expert, CMU

4. Intervention measures to improve the Adolescents Health

- Preventive & Promotive :

  Mostly awareness generation on normal physiological & Psychological changes during adolescents, motherhood, age of marriage, age of first pregnancy, STD, HIV / AIDS, Personnel Hygiene during menstruation, Sex behaviour, Nutrition etc.
- Curative Services :

  Detection & correction of Anaemia, detection & treatment of RTI and any other specific diseases.

5. Modalities for intervention measures to improve the Adolescents Health

A) Building up of Awareness amongst the Adolescent :

- Awareness Programme by the trainers for the Adolescents. 20 participants in a group, two hours session, pre & post evaluation to be conducted.

B) Clinical Part :

- One adolescent clinic per HAU per month
- Three such clinics per ULB per month
- Thirty such clinics for 10 ULBs per month
- The clinic will be conducted by lady Medical Professional assisted by HHW, FTS, lady STS.

- Cost Involvement against the items as mentioned above where involvement of AIIH & PH is indicated to be mentioned.
- Training need assessment of health care providers and assessment of status of health care facilities for provision of services for the adolescent may be dropped for the present.
- You may kindly find time to give a thought about this and we may discuss on this issue on 4th October, 2005 at 5.30 P.M. at SUDA.

With regard to vector control measures in the Urban areas under KUSP. Some of our preliminary thoughts are as under :

- To take up year long definite vector control programme.
- Sensitization work shop for the elected representatives may be at regional basis.
- Preparation of manual for vector control for different tiers of manpower working in the field like Conservancy Staff, Sanitary Inspector, Honorary Health Workers, Households, Health Officer, Asstt. Health Officers, Municipal Engineers and others.
- Training in different batches at different levels including field training.
- Preparation of Action Plan by the Urban Local Bodies and implementation.
- Monitoring & Supervision of the training programme and activities in the ground.
- If you agree to take up this responsibility, we will write formally to the Director, AIIH & PH for initiating the activities.

I hope this is enough for the present, we will concentrate more on the issue of Adolescent Health on 4th October, 2005. However don't spoil your mood and time during holidays.

Thanking you.

Dr. Shibani Goswami
Health Expert, CMU

C:\Dr. Goswami\KUSP\Adolescent.doc

ULBs in KMA

Total Population VS BPL Population addressed under CUDP III & IPP-VIII

Sl. No.	ULBs	Total Population @ 2001 Census	BPL Population addressed under			% of population addressed	Existing Health Facilities							
							HAU		SC		ESOPD		MH	RDC
			CUDP	IPP	Total		CUDP	IPP	CUDP	IPP	CUDP	IPP	IPP	IPP
	Dist. : North 24 Parganas													
1	Bhatpara	441956		194848	194848	44.09		6		38		1	1	
2	Barrackpore	144331	31086	52949	84035	58.22	1	2	6	11		1	1	
3	Bidhannagar	167848		37157	37157	22.14		1		7		1	1	
4	Baranagar	250615	30620	35720	66340	26.47	1	1	6	7		1	1	
5	Barasat	231515	23862	207462	231324	99.92	1	7	6	43				
6	Dum Dum	101319	21530	29422	50952	50.29	1	1	4	6	1	1	1	1
7	Garulia	76300	61280	35203	96483	126.45	2	1	12	7	1	1		
8	Halisahar	124479	30868	73974	104842	84.22	1	2	6	14	1			
9	Kanchrapara	126118	30988	61378	92366	73.24	1	2	6	13				
10	Khardah	116252	27823	105025	132848	114.28	1	3	6	21				
11	Kamarhati	314334		127309	127309	40.5		4		28				
12	Madhyamgram	155503		95323	95323	61.3		3		19		1	1	
13	Naihati	215432	28875	69089	97964	45.47	1	2	6	14		1	1	1
14	New Barrackpore	83183	19470	55973	75443	90.7	1	2	4	11		1	1	1
15	North Barrackpore	123523	53192	51552	104744	84.8	2	2	12	12	1	1	1	1
16	North Dum Dum	220032	30472	89069	119541	54.33	1	3	6	16		1		
17	Panihati	348379	59060	146534	205594	59.01	2	4	12	28		1		
18	Rajarhat Gopalpur	271781		195672	195672	72		6		32			1	
19	South Dum Dum	392150		197669	197669	50.41		6		41		1	1	
20	Titagarh	124198		104888	104888	84.45		3		20		1	1	
	Total	**4029248**	**449126**	**1966216**	**2415342**		**16**	**61**	**92**	**388**	**4**	**14**	**12**	**4**
	Dist. : South 24 Parganas													
1	Baruipur	44964	22695		22695	50.47	1		5					
2	Budge Budge	75465	30376	50426	80802	107.07	1	2	6	11		1	1	1
3	Maheshtala	389214		199148	199148	51.17		6		41			1	
4	Pujali	33863		35931	35931	106.11		1		7				
5	Rajpur Sonarpur	336390	26897	141312	168209	50	1	4	6	28	1	1	1	1
	Total	**879896**	**79968**	**426817**	**506785**		**3**	**13**	**17**	**87**	**1**	**2**	**3**	**2**

Contd. to P-2.

Sl. No.	ULBs	Total Population @ 2001 Census	BPL Population addressed under			% of population addressed	Existing Health Facilities							
			CUDP	IPP	Total		HAU		SC		ESOPD		MH	RDC
							CUDP	IPP	CUDP	IPP	CUDP	IPP	IPP	IPP
	Dist. : Howrah													
1	Bally	261575	293393	103857	397250	151.87	1	3	6	21	1	1		
2	Howrah MC	1008704	87410	320300	407710	40.42	2	11	16	55				
3	Uluberia	202095	33396	132105	165501	81.89	1	3	6	20		1	1	
	Total	**1472374**	**414199**	**556262**	**970461**		**4**	**17**	**28**	**96**	**1**	**2**	**1**	
	Dist. : Nadia													
1	Gayeshpur	55028	29430	35239	64669	117.52	1	1	6	7			1	
2	Kalyani	81984		35478	35478	43.27		1		7				
	Total	**137012**	**29430**	**70717**	**100147**		**1**	**2**	**6**	**14**	**0**	**0**	**1**	
	Dist. : Hooghly													
1	Baidyabati	108231	31067	47099	78166	72.22	1	2	6	11				
2	Bansberia	104453	29064	70797	99861	95.6	1	2	6	14		1	1	
3	Bhadreswar	105944	61070	57290	118360	111.72	2	2	12	11	1	1	1	1
4	Chandannagore MC	162166	57886	32962	90848	56.02	2	1	12	6		1	1	
5	Champdani	103232	30287	61044	91331	88.47	1	2	6	13			1	
6	Chinsurah	170201	59163	89536	148699	87.37	2	3	12	15		1		
7	Konnagar	72211	30205	35050	65255	90.37	1	1	6	7	1			
8	Rishra	113259	31661	89353	121014	106.85	1	3	6	18		1	1	
9	Serampur	197955	29740	123530	153270	77.43	1	4	6	25		1		
10	Uttarpara Kotrung	150204	48868	67590	116458	77.53	2	2	12	14		1	1	1
	Total	**1287856**	**409011**	**674251**	**1083262**		**14**	**22**	**84**	**134**	**2**	**7**	**6**	**2**
	Grand Total	**7806386**	**1381734**	**3694263**	**5075997**		**38**	**115**	**227**	**719**	**8**	**25**	**23**	**8**

ULBs in KMA
Total Population VS BPL Population addressed under CUDP III & IPP-VIII

Sl. No.	ULBs	Total Population @ 2001 Census	BPL Population addressed under			% of population addressed	Existing Health Facilities							
			CUDP	IPP	Total		HAU		SC		ESOPD		MH	[illegible]
							CUDP	IPP	CUDP	IPP	CUDP	IPP	IPP	IP
1	Bally	261575	293393	103857	397250	151.87	1	3	6	21	1	1		
2	Baidyabati	108231	31067	47099	78166	72.22	1	2	6	11				
3	Bansberia	104453	29064	70797	99861	95.6	1	2	6	14				
4	Bhadreswar	105944	61070	57290	118360	111.72	2	2	12	11	1	1	1	1
5	Bhatpara	441956		194848	194848	44.09		6		38		1	1	
6	Barrackpore	144331	31086	52949	84035	58.22	1	2	6	11		1	1	
7	Bidhannagar	167848		37157	37157	22.14		1		7		1	1	
8	Budge Budge	75465	30376	50426	80802	107.07	1	2	6	11		1	1	1
9	Baranagar	250615	30620	35720	66340	26.47	1	1	6	7		1	1	
10	Barasat	231515	23862	207462	231324	99.92	1	7	6	43				
11	Baruipur	44964	22695		22695	50.47	1		5					
12	Chandannagore MC	162166	57886	32962	90848	56.02	2	1	12	6		1	1	
13	Champdani	103232	30287	61044	91331	88.47	1	2	6	13			1	
14	Dum Dum	101319	21530	29422	50952	50.29	1	1	4	6	1	1	1	1
15	Gayeshpur	55028	29430	35239	64669	117.52	1	1	6	7			1	
16	Garulia	76300	61280	35203	96483	126.45	2	1	12	7	1	1		
17	Chinsurah	170201	59163	89536	148699	87.37	2	3	12	15		1		
18	Howrah MC	1008704	87410	320300	407710	40.42	2	11	16	55				
19	Halisahar	124479	30868	73974	104842	84.22	1	2	6	14	1			
20	Konnagar	72211	30205	35050	65255	90.37	1	1	6	7	1			
21	Kalyani	81984		35478	35478	43.27		1		7				
22	Kanchrapara	126118	30988	61378	92366	73.24	1	2	6	13				
23	Khardah	116252	27823	105025	132848	114.28	1	3	6	21				
24	Kamarhati	314334		127309	127309	40.5		4		28				
25	Madhyamgram	155503		95323	95323	61.3		3		19		1	1	
26	Maheshtala	389214		199148	199148	51.17		6		41			1	
27	Naihati	215432	28875	69089	97964	45.47	1	2	6	14		1	1	1
28	New Barrackpore	83183	19470	55973	75443	90.7	1	2	4	11		1	1	1
29	North Barrackpore	123523	53192	51552	104744	84.8	2	2	12	12	1	1	1	1
30	North Dum Dum	220032	30472	89069	119541	54.33	1	3	6	16		1		

SL No.	ULBs	Total Population @ 2001 Census	BPL Population addressed under			% of population addressed	Existing Health Facilities							
							HAU		SC		ESOPD		MH	RDC
			CUDP	IPP	Total		CUDP	IPP	CUDP	IPP	CUDP	IPP	IPP	IPP
31	Panihati	348379	59060	146534	205594	59.01	2	4	12	28		1		
32	Pujali	33863		35931	35931	106.11		1		7				
33	Rishra	113259	31661	89353	121014	106.85	1	3	6	18		1	1	
34	Rajarhat Gopalpur	271781		195672	195672	72		6		32			1	
35	Rajpur Sonarpur	336390	26897	141312	168209	50	1	4	6	28	1	1	1	1
36	Serampur	197955	29740	123530	153270	77.43	1	4	6	25		1		
37	South Dum Dum	392150		197669	197669	50.41		6		41		1	1	
38	Titagarh	124198		104888	104888	84.45		3		20		1	1	
39	Uttarpara Kotrung	150204	48868	67590	116458	77.53	2	2	12	14		1	1	1
40	Uluberia	202095	33396	132105	165501	81.89	1	3	6	20		1	1	
	TOTAL	**7806386**	**1381734**	**3694263**	**5075997**		**38**	**115**	**227**	**719**	**8**	**25**	**23**	**8**

ULBs in KMA

Total Population VS BPL Population addressed under CUDP III & IPP-VIII

Sl. No.	ULBs	Total Population @ 2001 Census	BPL Population addressed under			% of population addressed	Existing Health Facilities							
							HAU		SC		ESOPD		MH	RDC
			CUDP	IPP	Total		CUDP	IPP	CUDP	IPP	CUDP	IPP	IPP	IPP
	Dist. : North 24 Parganas													
1	Bhatpara	441956		194848	194848	44.09		6		38		1	1	
2	Barrackpore	144331	31086	52949	84035	58.22	1	2	6	11		1	1	
3	Bidhannagar	167848		37157	37157	22.14		1		7		1	1	
4	Baranagar	250615	30620	35720	66340	26.47	1	1	6	7		1	1	
5	Barasat	231515	23862	207462	231324	99.92	1	7	6	43				
6	Dum Dum	101319	21530	29422	50952	50.29	1	1	4	6	1	1	1	1
7	Garulia	76300	61280	35203	96483	126.45	2	1	12	7	1	1		
8	Halisahar	124479	30868	73974	104842	84.22	1	2	6	14	1			
9	Kanchrapara	126118	30988	61378	92366	73.24	1	2	6	13				
10	Khardah	116252	27823	105025	132848	114.28	1	3	6	21				
11	Kamarhati	314334		127309	127309	40.5		4		28				
12	Madhyamgram	155503		95323	95323	61.3		3		19		1	1	
13	Naihati	215432	28875	69089	97964	45.47	1	2	6	14		1	1	1
14	New Barrackpore	83183	19470	55973	75443	90.7	1	2	4	11		1	1	1
15	North Barrackpore	123523	53192	51552	104744	84.8	2	2	12	12	1	1	1	1
16	North Dum Dum	220032	30472	89069	119541	54.33	1	3	6	16		1		
17	Panihati	348379	59060	146534	205594	59.01	2	4	12	28		1		
18	Rajarhat Gopalpur	271781		195672	195672	72		6		32			1	
19	South Dum Dum	392150		197669	197669	50.41		6		41		1	1	
20	Titagarh	124198		104888	104888	84.45		3		20		1	1	
	Total	**4029248**	**449126**	**1966216**	**2415342**		**16**	**61**	**92**	**388**	**4**	**14**	**12**	**4**
	Dist. : South 24 Parganas													
1	Baruipur	44964	22695		22695	50.47	1		5					
2	Budge Budge	75465	30376	50426	80802	107.07	1	2	6	11		1	1	1
3	Maheshtala	389214		199148	199148	51.17		6		41			1	
4	Pujali	33863		35931	35931	106.11		1		7				
5	Rajpur Sonarpur	336390	26897	141312	168209	50	1	4	6	28	1	1	1	1
	Total	**879896**	**79968**	**426817**	**506785**		**3**	**13**	**17**	**87**	**1**	**2**	**3**	**2**

Contd. to P-2.

Sl. No.	ULBs	Total Population @ 2001 Census	BPL Population addressed under			% of population addressed	Existing Health Facilities							
			CUDP	IPP	Total		HAU		SC		ESOPD		MH	RDC
							CUDP	IPP	CUDP	IPP	CUDP	IPP	IPP	IPP
	Dist. : Howrah													
1	Bally	261575	293393	103857	397250	151.87	1	3	6	21	1	1		
2	Howrah MC	1008704	87410	320300	407710	40.42	2	11	16	55				
3	Uluberia	202095	33396	132105	165501	81.89	1	3	6	20		1	1	
	Total	**1472374**	**414199**	**556262**	**970461**		**4**	**17**	**28**	**96**	**1**	**2**	**1**	
	Dist. : Nadia													
1	Gayeshpur	55028	29430	35239	64669	117.52	1	1	6	7			1	
2	Kalyani	81984		35478	35478	43.27		1		7				
	Total	**137012**	**29430**	**70717**	**100147**		**1**	**2**	**6**	**14**	**0**	**0**	**1**	
	Dist. : Hooghly													
1	Baidyabati	108231	31067	47099	78166	72.22	1	2	6	11				
2	Bansberia	104453	29064	70797	99861	95.6	1	2	6	14		1	1	
3	Bhadreswar	105944	61070	57290	118360	111.72	2	2	12	11	1	1	1	1
4	Chandannagore MC	162166	57886	32962	90848	56.02	2	1	12	6		1	1	
5	Champdani	103232	30287	61044	91331	88.47	1	2	6	13			1	
6	Chinsurah	170201	59163	89536	148699	87.37	2	3	12	15		1		
7	Konnagar	72211	30205	35050	65255	90.37	1	1	6	7	1			
8	Rishra	113259	31661	89353	121014	106.85	1	3	6	18		1	1	
9	Serampur	197955	29740	123530	153270	77.43	1	4	6	25		1		
0	Uttarpara Kotrung	150204	48868	67590	116458	77.53	2	2	12	14		1	1	1
	Total	**1287856**	**409011**	**674251**	**1083262**		**14**	**22**	**84**	**134**	**2**	**7**	**6**	**2**
	Grand Total	**7806386**	**1381734**	**3694263**	**5075997**		**38**	**115**	**227**	**719**	**8**	**25**	**23**	**8**

HEALTH CARE NEEDS ASSESSMENT OF ADOLESCENTS

Assessment of health status of the adolescents and treatment seeking behaviour

Introduction :

Surveys in many countries suggest that when young people are looking for urgent treatment for what they consider to be sensitive conditions, public sector health services are often their last resort. Health service providers are often dismayed by these findings, as they want to be a resource for young people — but they do not know how. Yet adolescents can be excluded by poor service delivery or their own lack of awareness, a combination of legal, physical, economic and psychological barriers.

Côte D'Ivoire is one of seven countries in French speaking sub Saharan Africa taking part in a WHO supported initiative to improve reproductive health services for adolescents. In 1998 the research programme surveyed more than 2,200 adolescents in urban and rural areas and analysed 2,400 visits to health facilities. Discussions were held with groups of parents, adolescents and health staff. Young people reported that most visits (72.7%) were for common health problems such as malaria, skin problems, diarrhoea or headache. Health workers said that adolescents mainly accessed services for STI or HIV/AIDS testing, pregnancy testing or contraception. The registers showed that a quarter (23.7%) of total consultations were by adolescents, but that they accounted for half (49%) of antenatal care visits and more than half (56%) of deliveries. The study identified that adolescents did not use services if they judged health workers to be judgmental or rude or believed that traditional remedies cost less and were more effective. Of those who attended clinics, more than a quarter (28.4%) had hesitated a long time, 41% thought fees were too high, 22% did not feel comfortable during consultation, 36% were unable to achieve privacy and 46% felt unable to ask all the questions they wanted to ask. The conclusion was that the project should train staff, modify existing services to become adolescent friendly and provide better information. A baseline study in Senegal showed that 98% of adolescents wanted more information about reproductive health and about services, but that parents were reluctant to discuss sexual matters with their children, especially contraception.

A baseline study in Guinea revealed that 88% of adolescents had had their first sexual experience before the age of 17, but that few knew how to access information or services. Adolescents were five times more likely to attend a health centre for a pregnancy test than for contraception. Obstacles to using services ranged from long waiting times and inconvenient hours to fear of revealing sexual activity.

Objectives :

1. To assess the health status of adolescents with emphasis on nutritional, sexual and reproductive health and behavioural problems.
2. To study the aetiological factors responsible for common health problems.
3. To assess the treatment seeking behaviour
4. To evaluate the extent of utilisation of health care services, public and private for adolescent health problems.

Methodology :

1. Target population: Adolescents (10-19 years)
2. Study design: Cross-sectional epidemiological study
3. Sampling: All the adolescent population in the sampling frame
4. Survey method: House to house survey

DFID assisted HHW Scheme

Journal Register

01.04.2004 to 31.03.2005

Date	Particulars	L/F	Debit Amount Rs.	Credit Amount Rs.
01.04.2004 to 31.03.2005	Sensitization A/C .... Dr.		20059.00	
	Training of Trainers A/C .... Dr.		1800.00	
	Training of HHWs A/C .... Dr.		179980.00	
	Furniture A/C .... Dr.		369989.00	
	IEC & Training Materials A/C............ Dr.		2985.00	
	Salary for MMC A/C .... Dr.		333102.00	
	Honorarium for grass root level functionaries A/C .... Dr.		120000.00	
	O & M A/C .... Dr.		38611.00	
	To Advance Berhampur Municipality A/C			1066526.00
	(Being the amount adjusted against advance received by Berhampur Municipality vide SOE No. 65EN/HHW/DFID/BM/05 dt. 04.05.05).			
01.04.2004 to 31.03.2005	Sensitization A/C .... Dr.		7869.00	
	Training of HHWs A/C .... Dr.		113582.00	
	Furniture A/C .... Dr.		3885.00	
	Equipment A/C .... Dr.		22020.00	
	Salary for MMC A/C .... Dr.		83880.00	
	Honorarium for grass root level functionaries A/C .... Dr.		34333.00	
	O & M A/C .... Dr.		54198.00	
	Documentation A/C .... Dr.		1633.00	
	To Advance Bankura Municipality A/C			321400.00
	(Being the amount adjusted against advance received by Bankura Municipality vide SOE No. A/9/Vou/DFID/164 dt. 31.03.05).			
01.04.2004 to 31.03.2005	Training of HHWs A/C .... Dr.		60679.00	
	IEC & Training Materials A/C .... Dr.		429.00	
	Honorarium for grass root level functionaries A/C .... Dr.		12575.00	
	To Advance Bishnupur Municipality A/C			73683.00
	(Being the amount adjusted against advance received by Bishnupur Municipality vide SOE No. 390/xi-8 dt. 01.06.05).			
01.04.2004 to 31.03.2005	Sensitization A/C .... Dr.		1988.00	
	Training of HHWs A/C .... Dr.		106970.00	
	IEC & Training Materials A/C.......... Dr.		24462.00	
	Salary for MMC A/C .... Dr.		142352.00	
	Honorarium for grass root level functionaries A/C .... Dr.		21000.00	
	O & M A/C .... Dr.		6655.00	
	To Advance Bolpur Municipality A/C			303427.00
	(Being the amount adjusted against advance received by Bolpur Municipality vide SOE No. 6(DFID) dt. 05.05.05).			

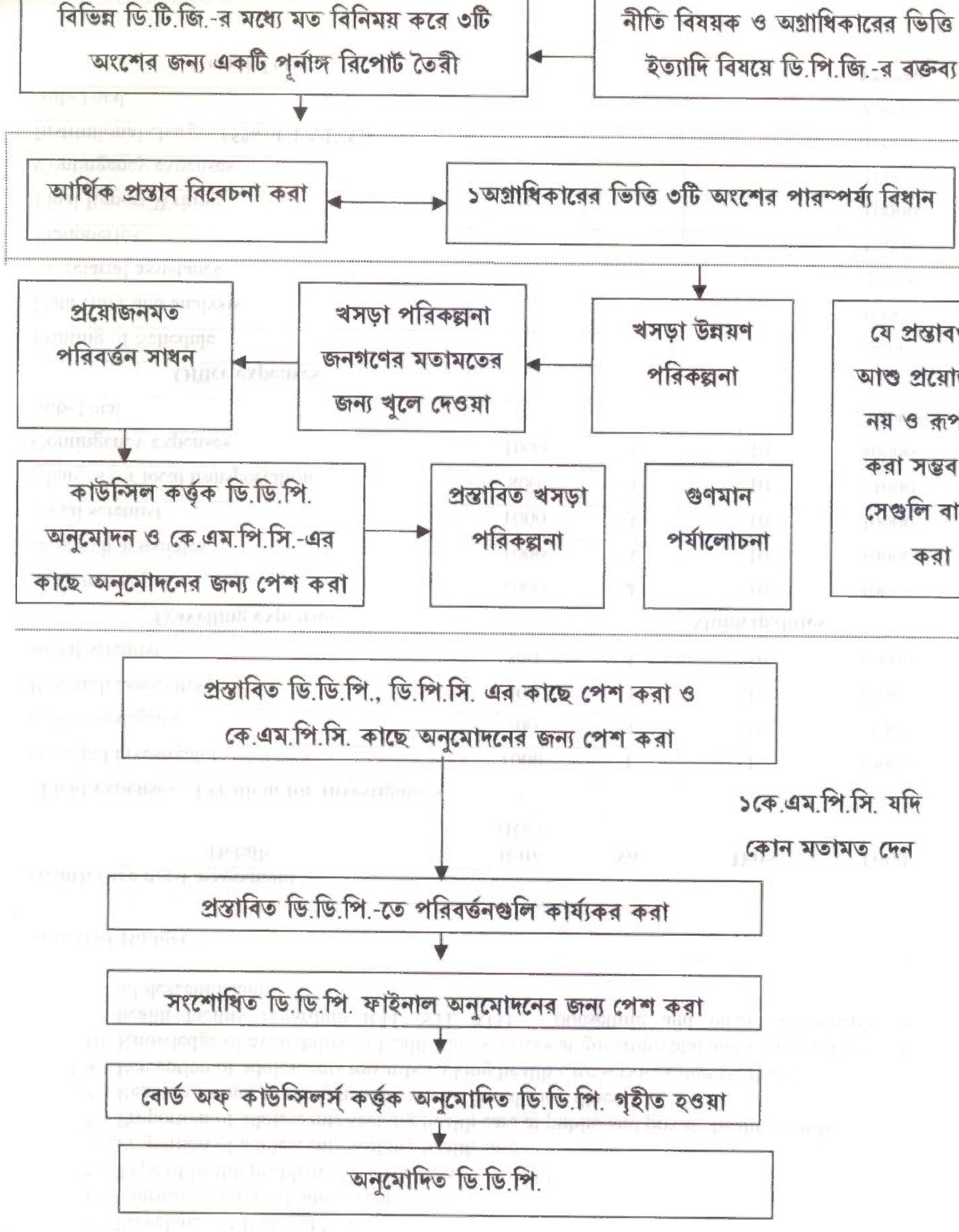
Analysis and interpretation : Use of suitable statistical tool and technique.

Outcome variables :

1. Prevalence of adolescents suffering from different health problems
2. Most prevalent health problems among adolescents
3. Prevalence of RTI and STI
4. Nutritional status of adolescents
5. Type of health problems for which care is sought
6. Proportion of adolescents seeking health care
7. Proportion of adolescents seeking health care at public and private health facility
8. Reasons for not availing health care facility during illness
9. Perception of adolescents towards seeking health care services during illness
10. Knowledge of availability of health care services at governmental and non-governmental health facility regarding RTI, STI, MTP, Counselling and other components of adolescent health.

Estimated Budget :

Health care need assessment				
Details	**Rate (Rs.)**	**No.**	**Days**	**Total**
Field expenses : Per diem for Investigators				
Principal investigator	1000	1	10	10000
field investigator	700	3	10	21000
Research associates	500	3	10	15000
social scientist	500	3	10	15000
Travelling expenses			**Municipalities**	
field investigator	1000	4	10	40000
Research associates	1000	3	10	30000
social scientist	1000	3	10	30000
Charges for local transportation	800	3	10	24000
Contingency expenses	1000	3	10	30000
Sub-Total				215000
Office expenses				
Printing of Schedule				5000
Data entry and analysis				10000
Secretarial assistance				5000
Stationeries				10000
Final Report Writing				10000
Contingency expenses				10000
Institutional charges (5% of TA/DA))				10750
Sub-Total				60750
Grand Total				**275750**



সমস্ত রকম গুণমান পর্যালোচনা চেকলিস্টের মাধ্যমে আভ্যন্তরীনভাবে বা বাইরের বিশেষজ্ঞ নিয়োগ করে করা হবে।

ASSESSMENT OF HEALTH STATUS OF ADOLESCENTS, THEIR TREATMENT SEEKING BEHAVIOR AND UTILIZATION OF HEALTH CARE SERVICES

Objectives :

1. To assess the health status of the adolescents e.g. nutritional, sexual and reproductive health status, psychological and behavioral problems.
2. To study the treatment seeking behavior of the adolescents.
3. To study the utilization of the health care services by adolescents

Material and Methods :

1. Type of study: Observational cross-sectional study and record analysis.
2. Study area: Study will be conducted in four wards of the municipalities under KUSP.
3. Sampling frame: 10 municipalities under KUSP would be selected randomly and from each municipality about 50 adolescents will be selected by simple random method.
4. Study population: Adolescents consisting boys and girls in the selected municipalities and the dispensaries / clinics of the same municipalities under KUSP.
5. Duration of study: One month.
6. Plan of study: Adolescents will be selected by a house to house survey. The adolescent members of each house will be interviewed using a pre-designed, pre-tested questionnaire and examined clinically.
   The records of registers for last one year of the dispensaries/clinics in the selected municipalities will be analyzed for the attendance of the adolescents of the age group of 10-19 years.
7. Tools: a) Pre-designed, Pre-tested questionnaire- containing questions regarding i) present and past history of illness of the adolescents including RTIs, STDs, history of unwanted pregnancy, psychological and behavioral problems like drug addiction, alcoholism, depression etc. ii) treatment seeking behavior of the adolescents i.e. what they do when they are concerned about their health, the source of care, choice of provider and utilization of health care services- why they use or do not use existing health care services. b) Instruments - weighing scale, measuring tape, torch, stethoscope for clinical and anthropometric examination. c) Proforma - about the total no. of patients of the age group of adolescents attending the dispensaries/clinics in every month, and their clinical manifestations for last one year.
8. Analysis of data: Data collected will be analysed using appropriate statistical methods.

Estimated Budget :

Daily Report on Preventive and Control Measures taken against Dengue during past 24 hours.

Name of ULB : SURI

Total Population of the ULB : 61,818

Date of Reporting : 17.9.05 TO FAX NO : (033) 2358 5800 / 2337 0068 by 1 P.M.

A. Mosquito Control Measures	Information to be furnished by the ULB
1. Anti Larval Measures (Breeding source Reduction through inspection and removal of source)	
i) No. of dwelling houses covered	82
ii) No. of Schools / Institutions / Clubs covered	1
iii) No. of construction sites covered	—
iv) Area-wise no. of special cleaning drives given	7
2. Anti Adult Measures (Fogging with Malathion / Spraying with pyrethrum)	
i) No. of Dwelling House covered	1500
ii) No. of Schools / Institutions / Clubs covered	4+5
iii) No. of construction sites covered	8
B. Public Awareness Campaign	
i) No. of houses inspected for breeding source reduction and IEC activities by	
a) HHWs	176
b) Others	—
ii) No. of leaflets distributed	—
iii) Campaign through PA system	Yes / No ✓
iv) No. of Hoardings and banners displayed	—
v) Local Cable TV channel used	Yes / No
C. (i) No. of new cases of Dengue detected	
a) Clinical	—
b) Sero+ve	—
(ii) No. of death due to Dengue	—

[illegible] [illegible] Chairman

INTERVENTION MEASURES TO IMPROVE THE ADOLESCENT HEALTH

Adolescents face a number of health problems like general health problems, menstrual problems, mental health problems, early and unprotected sex, sexual abuse, accidents and violence, addictive behaviors like alcoholism and drug addiction etc. The combination of growing physical maturity, hormonal changes, emotional immaturity and lack of information makes adolescents specially vulnerable to certain types of health events, the effect of which may be serious and permanent e.g. sexually transmitted infections including HIV/AIDS, unwanted teenage pregnancy, unsafe abortions and resultant pelvic infection.

But, health of the adolescent population are relatively neglected both at the family and at the health provider level. There is a relative gap in the health care of the adolescents, resulting in occurrence of preventable morbidities and mortalities affecting the potential workforce of the country. Adolescents do not appreciate the importance of seeking treatment when they are unwell and often underestimate the severity of their condition. Even when they choose to seek care, there may be important barriers preventing their access to such care. The health services may not be available, accessible or acceptable to the adolescent people. Cultural reason, physical distance, time disparity, fear of being recognized, lack of confidentiality, natural aversion to be in a clinic or treatment centre and rude or judgmental health workers may act as obstacles in utilization of health care services by the adolescent individuals.

To improve the health of the adolescents will have to make the services adolescent friendly with high clinical standards and qualities that young people seek. It should be accessible, acceptable, equitable, comprehensive and appropriate- in the right place in the right time and affordable and to be delivered by competent and motivated providers.

The suggested intervention measures are -

1. Training of medical officers on adolescent health services
2. Training of ANM/HHW and counsellors
3. Provision of equipment, drugs, chemicals and AV aids at the health care facilities
4. Provision of services specific for the adolescents
   a) Preventive service
   b) Promotive service
   c) Curative service

STATE URBAN DEVELOPMENT AGENCY

HEALTH WING
"ILGUS BHAVAN"
H-C BLOCK, SECTOR-III, BIDHANNAGAR, CALCUTTA-700 091
West Bengal

Ref No. ...**SUDA-Health/DFID/04/559** *Date*.........**20.06.2005**

From : Dr. Shibani Goswami
Project Officer
Health Wing, SUDA

To : The Chairman
Suri Municipality

Sub : Software for Civil Registration.

Sir,

Reference is invited to the communication of Health Officer, Suri Municipality under memo no. 220/SM dt. 09.06.2005.

For computerization of Civil Registration I had a talk with the Project Director, KUSP. With regard to Software for Civil Registration, you may contact Sri Tapas Ghatak, GIS Specialist, telephone no. (033) 2337 2217.

~~In view of the circumstances stated by you, there might not be any objection for deputing~~ your ~~ANM for participation in the discussion~~ session.

Thanking you.

Yours faithfully,

Project Officer

SUDA-Health/DFID/04/559(1) 20.06.2005

CC

The Project Director, HHW Scheme - DFID, Suri Municipality - for kind information and necessary action.

Project Officer

C:\Dr. Goswami\DFID\DFID - ULBS.doc

Tel/Fax No.: 359-3184

1. **Training of Medical Officers on adolescent health services**:-
   Medical officers are the team leaders of clinics/dispensaries. They are the most important persons for providing effective service to the adolescents and making the service adolescence friendly. Therefore, they should be technically competent and know how to communicate with young people without being patronizing or judgmental.
   Medical officers should have a good knowledge of normal adolescent development and skills to diagnose and treat common conditions such as anaemia or menstrual disorders in adolescent girls and to recognize signs of sexual or physical abuse. They need access to the correct drugs and supplies to treat common conditions and prevent health problems. They should know where to refer adolescents for specialist physical or psychological treatment.
   Technical competence must be accompanied by respect and sensitivity to draw the young persons out and to discover the underlying problems. A sympathetic professional approach should be combined with a non-judgmental approach, so that young people are willing to attend the clinics. These skills can be sustained through regular post qualification training and through a system of clinical protocol and guidelines. Training programmes need to be devised to ensure that Medical officers are knowledgeable, skilled and welcoming. Pre service training should be amended to include adolescent health and development issues as well as a communication skill component.

Objective of the training programme:
To orient and train the medical officers to the special needs and concerns of adolescents so that they can respond to their problems more effectively and with greater sensitivity.

Specific objectives:
1. To orient the medical officers about adolescent health and development and their sexual and reproductive health concerns.
2. To orient them about the health problems of the adolescents and how to address these.
3. To train the medical officers about importance of counselling and health education and to communicate with the adolescent clients in dealing with their problems more effectively.

Purulia Municipality

Amount in Rs

Sl. No.	Item of Expenditure	Estimated Budget	SOE received upto 15.06.2005	Anticipated expenditure upto 31st August, 2005
	Non-recurring			
1	Sensitisation / Orientation session	142000	7612	50000
2	Training of trainers	5000	1838	2000
3	Training of HHWs	132000	174052	0
4	Innovative (Base line by external agency - DHFW)			
5	Participatory need assessment	20000	4000	0
	Procurement			
6	Furniture	303000	140583	160000
7	Equipment	319000	50192	260000
8	IEC training materials			
9	Drugs	657000	187293	250000
	Recurring			
10	Salary for MMC	267000	97534	80000
11	Salary for Management Cell at SUDA			
12	Honorarium for grass root level functionaries	175000	94690	120000
13(a)	Rent	12000		6000
13(b)	Refurbication	35000	1157	65000
14	O & M	99000	37007	50000
15	Consultant of DHFW			
16(a)	Documentation - Project proposal writing by ULB		500	0
16(b)	Process writing by DHFW			
17	Dissemination workshop - DHFW			
	TOTAL	2166000	796458	1043000

Methodology:

Orientation programme is to be implemented in a workshop setting. The following methods are to be used for teaching and learning sessions during the training programme-

- Questionnaire before the start and end of the training programme to be answered by the participants (Pre-test & Post-test)
- Interactive sessions like lectures, small group discussions
- Small group works
- Demonstrations
- Field visit
- Overnight reading

Media to be used in facilitating teaching/learning:

Multimedia projector, slide projector, OHP. Chalk board.

Duration of the training programme: Three days

Course contents:

1. Adolescent health and development
2. Sexual and reproductive health concerns of adolescents
3. Nutrition and anaemia in adolescents
4. Adolescent pregnancy
5. Adolescent contraception
6. Unsafe abortion in adolescents
7. Prevention and control of RTIs/STIs & HIV/AIDS
8. Communicating with the adolescent client
9. Role of Counseling in dealing with adolescents' health related problems.

Estimated Budget.

Intervention (e.g. setting of adolescent clinic, counselor, etc.) approximate(Rs.)	50000

Medinipur Municipality

(Amount in Rs.)

Sl. No.	Item of Expenditure	Estimated Budget	SOE received till 15.06.2005	Anticipated expenditure upto 31st August, 2005
	Non-recurring			
1	Sensitisation / Orientation session	158000		100000
2	Training of trainers	5000		2000
3	Training of HHWs	166000	134885	0
4	Innovative (Base line by external agency - DHFW)			
5	Participatory need assessment	20000		1500
	Procurement			
6	Furniture	337000		300000
7	Equipment	371000		250000
8	IEC training materials			
9	Drugs	844000	233570	600000
	Recurring			
10	Salary for MMC	200000	30710	170000
11	Salary for Management Cell at SUDA			
12	Honorarium for grass root level functionaries	151000	113088	150000
13(a)	Rent	20000		20000
13(b)	Refurbication	77000		77000
14	O & M	102000	50801	50000
15	Consultant of DHFW			
16(a)	Documentation - Project proposal writing by ULB			
16(b)	Process writing by DHFW			
17	Dissemination workshop - DHFW			
	TOTAL	**2451000**	**563054**	**1720500**

DFID

Department for International Development

DFID India
British High Commission
New Delhi

B28, Tara Crescent
Qutab Institutional Area
New Delhi 110 016

Tel: (91 11) 6529123
Fax: (91 11) 6529296

Dear Shibani,

I hope you find this interesting.

With compliments

Managua, May 24th 2005

It is with great pleasure and satisfaction that Marie Stopes International: Nicaragua presents this publication outlining our experience of work with adolescents in urban areas. Above all, we are grateful for the opportunity to have witnessed the transformation seen in them. Equally, we are extremely happy to be able to share the lessons we have learned through the participation of all those involved, adolescents, non-governmental and government organisations alike, in creating committed alliances which permitted the achievement of the results described.

The results demonstrate the imperative need to continue working with adolescents on sexual and reproductive health, an area of vital importance for their future and personal development.

We hope that the results of this model, implemented with various methodologies, will contribute to the continued improvement of sexual and reproductive health services and, as a consequence, access to these services for young people.

We would like to extend our thanks to DfID for their financial support which made this experience possible as well as to all of the national, departmental, municipal and local government agencies, participating NGOs (INPRHU, CAPRI, NITCA, UENIC, Los Quinchos) and of course the adolescents themselves.

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Providing choices in reproductive healthcare

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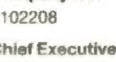
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A model for access to sexual and reproductive health education and services for adolescents in Managua, Nicaragua

January 2005

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Background

Introduction

As a result of dictatorship, revolution, natural disasters, hyperinflation and economic crises, Nicaragua's history has been turbulent, leaving the country one of the poorest in Latin America with 80% of the population surviving on less than two dollars a day. In this context, attempts to address the unmet needs of adolescents who make up a quarter of the total population have met with limited success. With regard to sexual and reproductive health (SRH) specifically, progress has been slight. Ministry of Health (MoH) statistics indicate that almost half of 15–19 year olds who are sexually active use no method of contraception, resulting in the alarming statistic that births to adolescent mothers constitute approximately 30% of all births in Nicaragua. There is widespread recognition that adolescent pregnancy is a serious problem that compromises not only the health but also the economic and social development of young people.

One of the main difficulties facing those who work with adolescents in Nicaragua and other parts of Latin America is that while this group requires health services, they rarely use them. There are a variety of reasons for this, including the attitudes of service providers and adolescents themselves. Adolescents in Nicaragua rarely perceive the need for health services for curative care, even less so for SRH care which is largely preventative. In addition, services provided by adults are considered to be for adults, and health advice is sought primarily through informal channels. A further complication is that adolescents lack the purchasing power to pay for services and medication. Last, but by no means least, research shows that adolescent girls, particularly those from lower socio-economic groups, do not perceive early pregnancy as a problem and many actively seek to become pregnant.

Within this context, Marie Stopes International (MSI) and Marie Stopes International: Nicaragua (MSI: Nicaragua) have, since 1999, implemented two consecutive projects aimed at this hard to reach target group. Both projects, which have been funded by the UK's Department for International Development (DFID), developed information, education and communication (IEC) initiatives aimed specifically at adolescents and provided them with access to services and to a referral system in a

Project participants taking part in a theatre group presentation

cost-effective manner. The lessons learnt from the first project (Phase one) were used to inform and develop the second project (Phase two). This report focuses primarily on Phase two and its outcomes.

Phase one

In the first project, four local organisations already working with young people became SRH franchisees. Each franchisee used a slightly different model to reach their target audience.

The three models used were:

- a mobile unit
- a static private clinic
- a community-based initiative – of which there were three variations.

Lessons learnt

A formal evaluation of the first phase was done at the end of the project in June 2000 by an external consultant. The evaluation found that none of the models used had proved to be an entirely satisfactory way of delivering services to the target group and so a second project was developed based on the experiences of the first, using lessons learnt and the best practices.

The principal lessons learnt from the first project included:

- mobile units are preferable to static clinics as a primary contact point for young people
- privacy and the provision of confidential counselling is essential – this was particularly evident in the community centre initiative where the presence of other services interfered with those offered by the social franchise
- involving adolescents themselves in the development of IEC materials ensures that the materials are relevant and are accepted by young people
- for an initiative to be successful, the support of key local actors (community leaders, teachers etc.) is vital
- locations which are densely populated but which lack health services are the best locations for services.

Phase two

The second project began in November 2001 and was completed in December 2004. At the beginning of the project a baseline study was done. As well as MSI: Nicaragua, the implementing actors included other non government organisations (NGOs), municipal authorities and the MoH at departmental level. The project itself was comprised of four main elements:

- MSI: Nicaragua mobile units
- a referral system – involving both the private and public sectors
- information, education and communication activities
- recruitment and training of peer promoters.

Methodology

Mobile units: giving adolescents direct access

Two mobile units were staffed by a nurse/educator, a psychologist/educator and a driver. The units visited schools, organisations and community centres on a fortnightly basis with each visit lasting between two-three hours.

During these visits, the mobile team ran participatory educational sessions with groups of up to 60 adolescents, tackling topics

Finding out about family planning

such as life plans, life skills, self-esteem, violence and conduct, addictions and SRH. The choice of themes was informed by the team's past experiences and by feedback from the adolescents themselves. In addition, the nurse/educator offered confidential family planning counselling and basic SRH care which included providing condoms and oral contraceptive pills. If required, she was also able to refer people on to local health centres and to MSI: Nicaragua's franchised service centres for more specialised care including more detailed examinations and syndromic treatment of sexually transmitted infections. Psychological services were also offered on an individual, couple or group basis.

All of these initiatives were provided free of charge to maximise up-take.

A referral system: ensuring continuity of care

To ensure that the target population could access the widest possible range of services and information it was essential that they had access to an integrated referral system. At the outset of the project the team sought to develop existing relationships between the public and private sectors and to establish new ones. They also sought to work as closely as possible with the MoH to ensure that there were appropriate and youth-friendly services for adolescents in the city. As part of this collaboration the project provided training to more than 250 public service providers.

One of the educational fairs

At the centre of the referral process were the promoters who referred adolescents to the mobile unit. If the adolescents then needed additional services then the mobile unit teams would refer them on to either the local health centre or the MSI: Nicaragua franchise service centres. Once an adolescent had been seen at a centre the centre team would then refer him/her back to the mobile unit so that the adolescent received follow up. In order to help ensure continuity of care, incentivised promoters accompanied the adolescent through the entire referral process.

Information, education and communication: changing behaviour to protect health

A variety of IEC material was produced, all of which was reviewed by adolescent peer groups. An educational manual *Preparing me for the future* which covers a range of SRH themes was developed and specific elements of it were also adapted for use as posters and leaflets to complement other educational aids such as board games and pocket books. To ensure that the IEC materials reached as many people as possible, this element of the project was approached from three main angles:

- firstly, information was distributed to schools and participatory educational sessions were undertaken in a variety of schools. These sessions were based around SRH issues that adolescents had identified either during the baseline study or during the promoter training. At the start of the project, activities were initiated in five schools and over the course of the project a further 34 schools became involved. Most of those involved were public schools although some private ones also took part
- secondly, a number of educational fairs were carried out in communities, organisations and schools to both provide information and ensure a safe space for adolescents to learn about and discuss SRH issues. The fairs provided a low cost, low infrastructure and informal environment to provide IEC to large groups of adolescents
- lastly, a youth theatre group was formed. The group wrote plays dealing with social issues such as teenage pregnancy and domestic violence and performed them in front of peer audiences in schools and community centres.

Peer promoter training: extending information among peers

This element was key to the sustainability of the project. The MSI: Nicaragua team identified and trained peer promoters in SRH information and training techniques, which included participatory methods, theatre, and puppetry. The manual *Preparing me for the future* was used as the basis for participatory sessions. As well as training the promoters, the team also trained teachers, community leaders and parents.

Some of the peer promoters

Monitoring and evaluation

During the course of the second project, MSI: Nicaragua and MSI carried out on-going monitoring across all activities to ensure that they were as effective as possible. To ensure good communication between the collaborating organisations, regular meetings were held to discuss project results, successes and lessons learnt.

In November 2003, a formal mid-term evaluation of the project was carried out by an external consultant which resulted in the following observations and recommendations being made:

- the promoters play a very valuable role in the referral process
- service providers should be trained how to provide youth friendly services
- the IEC activities should be extended to include parents, both together with their children and in separate groups
- separate information should be developed for young men and women which takes into account the cultural differences between the sexes
- the mobile unit should be promoted amongst a younger populations (10 to 14) to encourage those who are not yet sexually active to seek information so that they can make informed decisions when the time comes
- when assessing the impact of IEC materials the emphasis should be on measuring behavioural change
- group and couple counselling about sexually transmitted infections (STIs) and their prevention should be offered
- the promoters' training programme should be extended so that the promoters are able to take into consideration an individual's circumstance, age and sex when offering informal counselling, thus helping to ensure that new knowledge is effectively transmitted into behavioural change
- the quality of information provided by the promoters should be monitored through observation, and on-going training
- a code of conduct should be developed for promoters to ensure appropriate, risk free behaviour
- the number of promoters should be increased and those that have already been trained should become part of the training team
- *Preparing me for the future* should be promoted more extensively through existing networks and organisations
- promoters should be actively encouraged to develop initiatives within their communities that include SRH issues and are beyond the project framework.

These recommendations were all adopted and were incorporated into the plans for the final stages of the project.

Managua youth

One of the peer promoters doing IEC work

Results

Information, education and communication activities				
IEC activities	Mobile unit, talks and videos	Workshops run by promoters	*Preparing me for future* manual	Events
Number of adolescents reached	12,728	3,251	500 copies distributed	6,098

Information, education and communication activities
In total, over 15,000 adolescents gained access to SRH IEC materials, activities and services during the second project.

The design of the IEC strategies and materials were greatly enhanced by involving the adolescents themselves in their development. This approach not only helped to ensure that the content of the resulting materials was appropriate but also their design had maximum appeal to the target audience. As the project proceeded, additional needs emerged and the materials were adapted to meet those needs. New themes included: boyfriends, girlfriends and how to negotiate relationships. All of the participating organisations felt that the materials produced were of a high quality.

The *Preparing me for the future* manual was particularly successful and not only were elements adapted for use in a variety of ways, but the manual itself has been used in other projects run by the Ministry of Youth.

Services
The number of psychological services provided exceeded expectations and proved successful. In the evaluation, the adolescents surveyed said they considered group psychological consultations with their parents and peers very valuable and helped their self-esteem. They also felt that these consultations improved communication between the generations and gave them (the adolescents) the opportunity to express their emotions and discuss their plans for future. However, uptake of family planning methods via the mobile unit proved less successful as a way of delivering family planning methods direct to adolescents.

Services		
	Counselling	Family planning consultations
Number of adolescents reached	4,018	436

The referral system
Referrals between institutions and organisations generally worked well and improved over time. However, this element required constant monitoring. A key finding was that when adolescents were accompanied to a referral by a peer promoter there was a higher probability of continuity of care. Depending on the individual promoter's level of motivation, which in turn depended to an extent on how much support s/he received, the success of the referral system varied. To improve the promoter's motivation, non-cash incentives were used and these proved successful.

The training of peer promoters

A total of 129 promoters were trained on SRH issues, 118 of whom then carried out SRH workshops. By the end of the project 71 of the promoters were still active. A further 38 were trained specifically to use theatre and puppetry techniques to explore SRH issues and another 35 were trained in exploring gender issues, particularly those around masculinity. The quality of the training was measured through pre and post testing. All of the agencies involved agreed that the participatory methods were extremely successful in engaging young people.

At the end of the project there was a 10% increase in knowledge of SRH and STIs amongst project beneficiaries compared against non beneficiaries. Attitudes to various key issues had also changed, for example, awareness and understanding of women's rights had increased by 25%. However, there remained significant gaps between awareness and practice, for example, 40% of those who were sexually active said that they never used family planning methods.

Making theatre costumes

Co-operation between different sectors

The success of the project depended largely on the healthy relationship between the different sectors and the various organisations and institutions involved. At the end of the project those involved rated the project favourably. For some, it helped them reach more of their target populations across their target areas, whilst others were able to expand the adolescent services that they provided. It was generally acknowledged that commitment to the project was assured by including organisations who already worked with young people and for whom working with this target group was central.

Although written agreements between the various agencies existed and regular meetings took place, there were some weaknesses:

- despite best efforts to break down the prejudices and barriers felt by the adolescents towards accessing services via public health centres, at the end of the project many of those barriers still remained and it was recognised that dealing with some of these barriers were outside of the project's capacity and remit
- although the mobile unit played a very central role within the referral system, those played by other organisations and the promoters were not so clearly established with the result that when the project finished the continuation of the referral system was threatened.

Although all of the NGOs involved had previously worked with the MoH, they all acknowledged MSI: Nicaragua's professional and structured efforts to develop a good relationship and efficient collaboration with the Ministry at a district level. In terms of the Ministry of Education (MoE), although there was no formal contract there were informal agreements at a local level and 39 primary and secondary schools were involved in the project. In addition, 179 teachers and 220 parents were trained in SRH issues with the teachers receiving additional training in how to successfully communicate SRH information to adolescents.

All of those involved also identified the potential for MSI: Nicaragua to continue as the facilitator and provide on-going technical support to help continue inter-institutional relationships.

Conclusion

The end of project evaluation, which took place in October 2004, was very favourable and illustrated the positive impact that can be achieved when working with adolescents.

Targeting young men in Nicaragua

The model created a safe space for adolescents in which they had the opportunity to increase their awareness and knowledge of SRH issues, leading to a shift in attitudes and some behaviour change, although in terms of the latter there is still much work to be done. The project has also contributed to goals of the Programme of Action of the 1994 International Conference on Population and Development in relation the protection and promotion of the rights of adolescents to SRH education, information and care, as well as to DFID's priority areas.

There were a number of elements that contributed to the project's success including:

- by designing the activities and materials in conjunction with the adolescents themselves, the team ensured that:
  - they were appropriate for the target population's needs
  - the target group could identify with the project and so were keen to participate
- training promoters who could then work with other adolescents in a way that was both appropriate and accessible was a key element of the strategy. The promoters also ensured that the IEC materials were distributed a widely as possible – via their families, schools and the community
- collaborating with the MoE at a local level ensured access to the key target group in schools as well as giving the project access to teachers who were then trained in SRH – it is anticipated that the teachers who were involved, along with the promoters, will continue the work even though the project has ended
- using a mobile unit appealed to young people for several reasons:
  - it was staffed by a psychologist/educator and nurse/educator – both of whom were perceived by adolescents to be more approachable than medical staff
  - waiting times at the unit were shorter than those for static clinics
  - the hours and locations of the mobile unit were more convenient ie within school hours and at located at schools
- training health providers to provide youth-friendly services also worked well. Not only were the health providers skills enhanced but they also provided more effective services.

Handing out IEC material

Sustainability

On-going sustainability will be difficult for a number of reasons:

- the funding has now ended
- adolescents have a low purchasing power for services generally so without additional funding many of the organisations involved are not able to continue the activities undertaken
- MSI: Nicaragua played a central facilitating role but are no longer able to be involved.

However, sustainability is not impossible provided:

- the other participating organisations:
  - involve additional organisations who work in the SRH field with adolescents
  - develop a clear strategy for the future, for example, how to provide on-going support for the promoters; what additional materials are required; how the referral system can continue to operate etc.
  - seek additional sources of funding so that work can continue
  - continue to meet regularly with the MoH at a district level; build on further strengthening the other relationships that have developed out of the project and continue to collaborate with the MoE at a local level
- in the participating schools, SRH becomes an assimilated part of the curriculum
- adolescents themselves continue to replicate the information learnt both formally and informally via their family, friends, peers etc.

Replicating the model

Replicating the model in other countries with similar organisations which are already involved in or are interested in starting health work for adolescents is certainly possible.

Any attempt to replicate the franchise model should take the following factors into account:

- participating organisations should:
  - be committed to the project and devote time to it
  - give health a high priority
  - be prepared to carry out on-going monitoring and regularly follow-up and support the promoters
- SRH work should be integrated with the participating organisations' other activities and not be seen as a separate project
- efficient co-ordination mechanisms should be established between the participating organisations and with other institutions such as the Ministries of Health and Education
- adolescents should be involved in the design of methods and materials and
- promoters should be motivated through receiving free medical services, promotional materials, refreshments, travel costs, equipment and costumes for popular theatre work, and recreational activities.

Training needs assessment of health care providers

In India, early marriage receives religious and social sanction. Despite laws increasing the legal age of marriage to 18 for girls, there are strong cultural pressures on parents to marry their daughters early. 15.4% girls are married by age 13 years, 33.3% by the time they are 15 and 64.6% girls are married by age 18(Source: NFHS 1998-99). The median age at first marriage is 16.4 years (18.4 in urban and 15.8 in rural girls) and age at first cohabitation is 17 years (18.6 for urban and 16.6 for rural girls). In addition to the psychological immaturity of an adolescent bride, very often her body is not prepared to accommodate the early onset of childbearing.

For young girls in India, poor nutrition, early childbearing and reproductive health complications compound the difficulties of adolescent physical development. Anaemia is one of the primary contributors to maternal mortality (maternal mortality is five times higher in anaemic women) and is associated with the progressive physical deterioration of girls ages 10-19. Nutritional deprivation, increased demand of her body, excessive menstrual loss, and early/frequent pregnancies all aggravate and exacerbate anaemia and its effects.

Young boys in India face different set of problems and have needs, equally sensitive to those of girls. However, the entrenched patriarchal familial, societal, institutional practices in India and their own geographical areas and cultures do not allow them to express their problems and needs easily. Their issues and concerns require acknowledgement and response which is empathetic and positive.]

Adolescents are not a homogeneous group. Their situation varies by age, sex, marital status, class, region and cultural context. This calls for interventions that are flexible and responsible to their needs.

Use of services by adolescents is limited. Poor knowledge and lack of awareness are the main underlying factors. Service provision for adolescents is influenced by many factors. For example at the level of the health system, lack of adequate privacy and confidentiality and judgmental attitudes of service providers, who often lack counselling skills, are barriers that limit access to services. Shortcomings in their professional capabilities often result in service providers being unable and sometimes unwilling to deal with adolescents in an effective and sensitive manner.

It is important to influence the health seeking behaviour of adolescents as their situation will be central in determining India's health, mortality, morbidity and population growth scenario. Adolescent pregnancy excess risk of maternal and infant mortality, reproductive tract infections, sexually transmitted infections and the rapidly rising incidence of HIV/AIDS in this age group are some of the public health challenges. In context of the Reproductive and Child Health (RCH) program goals of the Ministry of Health and Family Welfare (MoHFW) of the Govt. of India, with special reference to the reduction of IMR, MMR and TFR addressing adolescents in the program framework will yield dividends in terms of delaying age at marriage, reducing incidence of teenage pregnancy, prevention and management of obstetric complications including access for early and safe abortion services and reduction of unsafe sexual behaviour.

THE SUGGESTED STRUCTURE FOR 3 TIER HEALTH FACILITY

TIERS	HEALTH FACILITY
1st TIER	**A) At grass root Level :** (1 HHW for every 400 families or 2000 population approx.) **Health Manpower :** • Community based Honorary Health Worker : @ 1 per 2000 population, as first contact person between the community and health functionaries. • Eligibility : 25 - 35 age group, preferable married, resident of the community concerned, minimum eight standard pass, able to spare four hours a day. **Functions :** ❑ Fortnightly home visit to BPL families and once in every two months to families other than BPL ❑ Filling up of the family schedule. ❑ Treatment of minor ailments at door step, distribution of drugs for 3 days maximum. ❑ Early registration of pregnancies, identification of danger signs. ❑ Referral to health facilities of all types of cases. ❑ Act as depot holder of ORS, Nirodh, OCP, Iron Folic Acid Tablet. ❑ Counselling on child nutrition, immunisation, adolescent health care. ❑ Promotion of institutional delivery and safe abortion. ❑ Promoting I.E.C. activities. ❑ Preparation and submission of HMIS report. ❑ Assisting towards implementation of other on going National Health Programmes namely National Malaria Control Programme (NMCP), Revised National TB control programme (RNTCP), AIDs Control Programme, National Leprosy Eradication Programme (NLEP) and the like. **Honorarium :** Rs. 1000/- per month. **B) At Sub-Centre Level :** **Health Manpower :** • First Tier Supervisor (FTS) will be in charge of Sub-Centre. 1 FTS will be selected amongst the 5 HHWs of a Sub-Centre after performing services for a period of 6 months. • Medical Officer and Second Tier Supervisor (STS) will attend the clinic days of Sub-Centre.

To address this need, the 'Orientation Programme for Medical Officers, ANM & LHVs and Programme Managers' has been developed to enhance skills of service providers to deliver adolescent-friendly health services.

Overall Aim

The overall aim is to orient ANMs/LHVs to the special needs and concerns of adolescent boys and girls and to design appropriate approaches to address these. This will strengthen the abilities of health-service providers to be able to respond to adolescents needs more effectively and with greater sensitivity. It is expected that this Orientation Programme will significantly contribute to building capacity on adolescent health and development issues.

Intended Beneficiaries

The Orientation Programme is intended for health-service providers (Medical Officer, AMNs, LHVs and Progrmme Managers) who provide preventive, promotive and curative health services to the adolescents. This five day Orientation Programme for ANMs and LHVs is in addition to that for Medical Officers and for Programme Managers.

Expected Outcomes

It is expected that ANMs/LHVs who participate in this Programme will:

- Be more knowledgeable and aware about the characteristics of adolescence and the various issues and concerns of adolescent health and development.
- Be more sensitive to adolescent needs and concerns.
- Be able to provide "adolescent-friendly" health services that respond to their needs and are sensitive to their preferences.
- Be able to refer them to doctors in a timely manner- referral
- Design a personal plan of action indicating the changes they will make in their personal and professional lives and their surroundings.

The orientation is not intended to equip participants with specific clinical skills in adolescent health care.

In practical terms, this orientation programme will provide participants with ideas and practical tips to the key question:

- What do I, as an ANM/LHV, need to know and do differently if the person who walks into my health centre is aged 16 years, rather than 3 or 36?

Medical Officers
ANM/Staff nurse
HHW
Councillors

- Staffing pattern at each health centre
- Availability of trained manpower
- Training received in the adolescent health care

TIERS	HEALTH FACILITY
1st TIER	**Functions :** • Antenatal care, post natal care, referral for institutional deliveries • Child Care • Immunisation • Services under national health programmes like DOTS, NMCP etc. • Family Planning including IUD& referral for terminal methods • Treatment of minor ailments including RTI / STI referred by ~~FLV~~ HAW, • Depot holder services for contraceptive and ORS • Demand generation through targeted I.E.C.
2nd TIER	**C) At Health Administrative Unit (HAU) Level :** **Manpower :** • Medical Officer - 2 to 3 per HAU • STS – 1 per HAU • Statistician – 1 per HAU • Personnel of HAU will attend clinics at Sub-Centres. (At least 7 clinics i.e. 2 Antenatal clinics, 1 Immunisation clinic, 4 General treatment clinics will be held per month per Sub-Centre). **Function :** • HAU is the controlling centre for all health activities in the reference area • Antenatal care, post natal care, referral for institutional deliveries • Child Care • Immunisation • Services under national programmes like DOTS, NMCP etc. • Family Planning including IUD& NSV referral for terminal methods • Treatment of minor ailments including RTI / STI ~~referred by FLV~~ HAW • Depot holder services for contraceptive and ORS

Estimated Budget:

Training of Medical Officers under KUSP on adolescent health Budget for training of Medical Officers under KUSP on adolescent health	Total
Per diem for 5 Resource persons @ Rs. 1000 for 3 days	15000
Honorariums to facilitators @ Rs. 500 per session	9000
Travelling expenses for 5 Resource persons @ 2000/person (outside experts)	10000
Per diem for 20 participants @ Rs. 500 for 3 days	30000
Travelling expenses for 20 participants @ 500/person	10000
Secretarial assistance	3000
Training materials (file, folder, bags etc.)	15000
Banner, decoration	1000
Hospitality expenses	
Lunch, tea, coffee for 40 persons @ Rs. 200 per day for 3 days	24000
Audio-visual aid @ Rs. 1000 for 3 days	3000
Travel expenses for field visit	5000
Coordinator fees	15000
Report publication	5000
Sub total	145000
Contingency expenses 5%	6050
Institutional overhead charges (5%)	6350
Grand Total	**157400**

<table>
<tr><th>TIERS</th><th>HEALTH FACILITY</th></tr>
<tr><td>2nd TIER</td><td>
• Demand generation through targeted I.E.C.
• Training
• It provides storage facilities for immunisation materials, drugs and others.
• Venue for the review meetings of different tiers of health activities.
• Compilation of computerized HMIS
D) <u>At OPD with Laboratory :</u>
Manpower :
• Specialist (Paediatrics, G & O, General Medicine and MO Pathologist) – 1 specialist in each disciplines per OPD per ULB.
(Specialist Services will be hired on fee basis per clinic – 2 clinics for each speciality per week, thus 8 clinics per month).
• Nurse – 2 per OPD per ULB.
• Lab. Technician – 1 per OPD per ULB.
• Helper to Lab. Technician – Do
• Pharmacist – Do
• Attendant – Do
Function :
• Providing specialist services in 3 disciplines to the clienteles.
• Providing routine and ordinary Laboratory investigations.
</td></tr>
<tr><td>3rd TIER</td><td>
Referral Hospital (Sub-division, District, Maternity Home, Nursing Home etc.)
Function :
• Institutional delivery
• Emergency Obstetric Care
• Terminal methods of family planning
• 2nd tier curative services for RTI /STI
• Speciality services of all disciplines
</td></tr>
</table>

ASSESSMENT OF STATUS OF HEALTH CARE FACILITIES FOR PROVISION OF SERVICES FOR THE ADOLESCENTS

Objectives:

1. To assess the availability of trained manpower in the health care facilities for providing services for the adolescents.
2. To identify the type of services available for the adolescents referral services.
3. To study the availability of drugs and equipment and other facilities.
4. To find out laboratory facilities if any for diagnosis of RTI/STI.
5. To identify the obstacles in provision of health care services for adolescents and suggest measures for its solution.

Material and Methods:

1. Study area: Health facilities i.e. dispensaries/clinics under the municipalities of KUSP.
2. Sampling frame:
3. Method of data collection: The data will be collected -a) by actual observation and b) by interview with the person in charge of the health care facility on the day of the visit.
4. Duration of study: One month.
5. Tools: Pre-designed, pre-tested schedule containing both closed and open ended questions regarding availability of general facilities, services, staff pattern- their training status, IEC materials, medical examination facilities, drugs, equipment and laboratory facilities- their working condition, referral services etc.
6. Data analysis: Collected data will be analyzed using appropriate statistical methods.
7. Estimated Budget.

STATE URBAN DEVELOPMENT AGENCY

HEALTH WING
"ILGUS BHAVAN"
H-C BLOCK, SECTOR-III, BIDHANNAGAR, CALCUTTA-700 091
West Bengal

Ref No. .... *Date* ....

CHALLAN

From : Dr. Shibani Goswami
Project Officer
Health Wing, SUDA

To : The Chairman

.... Municipality

Quantity	Item Description	Value in (Rupees)
	Growth Monitoring Card Size 11" x 9¼"	(Not to be billed, free distribution)

Challan No. : SUDA-Health/DFID/04/ Dated :

Project Officer
Health Wing, SUDA

Please sign and return

C:\Dr. Goswami\DFID\DFID - ULBS.doc

1. Assessment status of Health care facilities

Budget for health care need assessment	**Total**
Field expenses	
For the principal investigator	
Per-diem @ Rs. 1000/- per day for 30 days	30000
Per-diem for field investigator @ Rs. 700 per day for 30 days	21000
Perdiem for Research associates @ Rs. 400 perday for 30 days	12000
Per diem for social scientist @ Rs. 500 perday for 30 days	15000
Travelling expenses	
Travelling expenses for field investigator @ Rs. 1000 for 10 municipalities	5000
Travelling expenses for Research associates @ Rs. 700 for 10 municipalities	10000
Travelling expenses for social scientist @ Rs. 800 for 10 municipalities	7000
Local Transport & P.O.L @ Rs. 1000 for 10 days x 2/facility	20000
Contingency expenses @ Rs. 300 per day for 30 days	9000
Office expenses	
Printing of Schedule	5000
Data entry and analysis	10000
Secretarial assistance	5000
Stationaries	10000
Final Report Writing	10000
Contingency expenses	10000
Institutional charges	10000
Grand Total	189000

STATE URBAN DEVELOPMENT AGENCY

HEALTH WING
"ILGUS BHAVAN"
H-C BLOCK, SECTOR-III, BIDHANNAGAR, CALCUTTA-700 091
West Bengal

Ref No. .... *Date* ....

CHALLAN

From : Dr. Shibani Goswami
Project Officer
Health Wing, SUDA

To : The Chairman

.... **Municipality**

Quantity	Item Description	Value in (Rupees)
	Growth Monitoring Card Size 11" x 9¼"	(Not to be billed, free distribution)

Challan No. : SUDA-Health/DFID/07 **Dated :**

Project Officer
Health Wing, SUDA

Please sign and return

C:\Dr. Goswami\DFID\DFID - ULBS.doc

HEALTH CARE NEEDS ASSESSMENT OF ADOLESCENTS

1.Awareness of RTI's/STI's, HIV/AIDS, (KABP study)

I. Introduction:

The adolescence is an important stage in life, characterized by physical, mental and emotional changes. Boys and girls learn and internalise behavioural patterns that will stay with them for the most of their lives. The level of knowledge among the adolescent boys and girls in India on matters of sex, love and marriage seems to be inadequate and the prevailing taboos on sex and sexuality which prevent the boys and girls from obtaining 'correct' knowledge even on the important and life threatening diseases like HIV/AIDS through objective and scientific mean. The modernizing of increased sexual stimulation through media and other sources together confuse the Indian adolescents and leak of formal channels of information on sex and sexuality leads to development of risky behaviours.

II. Adolescent health Situation in India:

Adolescent population in India is 21.4%(National Youth Policy 2000). A behavioral surveillance survey carried out in 15-49 years shows 76.1% had ever heard of HIV/AIDS, while only 32% had heard of STD. The median age at first sex is 21 for males and 18 years for girls. Moreover 12% reported sex with non-regular partner. A prospective cohort study in three STD clinics in Pune (India) shows highest prevalence rate of 24.4% in the age 20-29 years. (HIV infection amongst person with high risk behavior in Pune city: Update on findings from a prospective cohort study, Sanjay Mehendale, ARR (1998), 1:2-9). A behavior study in Adolescents of 11th and 12th grade (16-17 years) was conducted in Mumbai indicates 4.0% has actual sex experience(R. Mathai, M.W. Ross, S. Hira, AIDS Care (1997), 9:5: 563-576).

Young people are our greatest opportunity to defeat HIV/AIDS. This study is important in order to develop base line information on adolescent health issues pertaining reproductive and sexual health, nutritional problems, etc. and to follow trends in HIV risk behaviours and contribute to the measurement of impact of ongoing state and local intervention. The best prospect for changing the cause of the HIV epidemic is in substantially reducing new infection rates among successive cohorts of 15-19 year olds. The survey among representative samples of adolescence will enable to review the behavioural trends prevailing among them and the extent of knowledge, beliefs and their attitude for prevention and control of HIV/AIDs.

III. Purpose:

The purpose of this study is to assess the current Knowledge, attitude and behavioural practices for HIV/AIDS/STD, sexual and reproductive health among adolescence population in Municipalities of Kolkata and to develop baseline measurements for behavioural indicators to be used in assessing changes in behaviour over time.

IV. Aim:

To positively influence adolescent sexual behaviours in order to reduce HIV/AIDS and sexually transmitted infection by improving correct knowledge and Behaviour change communication.

V. Objective:

1. To study the knowledge, attitudes, behaviors and beliefs of HIV/AIDS among (15-19 years) adolescents in Kolkata (India) and assess gender bias.
2. To study the sources of information on HIV/STD infection.
3. To develop the key behavioral indicators predictor of high-risk behavior changes over the time for HIV/STD infection, sexual and reproductive health.
4. To develop, plan and implement the intervention programme for adolescents for adopting and developing positive life style, improving reproductive hygiene and healthy behavioral practices for prevention and control of HIV/STD infection.

Required Manpower at ULB Level

A) For Management & Supervision Cell :

	Health Officer	PHN / GNM	Statistician	Storekeeper cum Clerk	Computer Asstt.	Attendant
For 1 ULB	1	1	1	1	1	1
For 63 ULBs	63	63	63	63	63	63

B) For Health Administrative Unit :

	Medical Officer	STS	Storekeeper cum Clerk	Attendant	Sweeper
For 1 HAU	2	1	1	1	1
For 79 HAUs	158	79	79	79	79

C) For OPD with Laboratory at 32 ULBs

Manpower	Nos.
Paediatrician	32
Gynae & Obs. Specialist	32
General Medicine Specialist	32
Nurse	64
MO Pathologist	32
Lab. Technician	32
Helper to Lab. Technician	32
Pharmacist	32
Attendant	32

D) For Sub-Centre :

	FTS
For 1 SC	1
For 342 SCs	342

E) For Block :

	HHW
For 1 Block	1
For 1703 Blocks	1703

For Training

Required Manpower at State HQ Level ~~at SUDA~~

For Co-ordinating, Monitoring & Supervision Cell

Designation	No.
Technical Adviser	1
Project Officer	1
Medical Officer @ 1 Officer per 5 ULBs	12
Finance Officer	1
Accounts Asstt.	3
MIES Officer	2
Computer Assistant	2
Clerk cum Storekeeper	2
Attendant	2

VI. Methodology:

A. Design:

An epidemiological cross-sectional study design. Sampling is based on randomized two stage sampling strategy. The target group of adolescents between 15-19 years will be included by complete enumeration method from the sampling sites. The quantitative research will be accompanied by qualitative research to enhance the interpretation of the findings. Interviews with the adolescence will be based on structured self administered, anonymous questionnaire. Questionnaires will include information on demographical, socio-economic, gender characteristics. Reproductive and sexual heath and HIV/AIDS related Knowledge, beliefs, attitudes and behaviour and information on mode of transmission, prevention and protective methods, misbelieves, risk factors and source of getting this information will also be included. The sample size of adolescent children will be decided on the basis of municipalities that would be included in the programme.

B. Sampling:

1. Select one site from each center on the basis of sampling from each municipalities/ zone.
2. Selection of adolescents (15-19 years) by complete enumeration method.
3. Carry out pre-test on KABP on HIV/STD/AIDS and behavioural indicator.
   (i) Conduct session on health education and promotion on HIV/STD by different modes of communication, ex. Lectures, posters, audio-visual etc.
   (ii) Carry out post-test on KABP on HIV/STD/AIDS for assessing enhancement of knowledge and change in the behavior and attitude for prevention of HIV/STD.
   (iii) Carry out intervention programme as mentioned & as per guidelines.
   (iv) Study the behavioral trends each year.
   (v) Implement phase-II to cover other municipalities, and conduct similar behavioral surveys.

C. Intervention:

1. Development of behavioural indicators.
2. Preparing and developing adolescence Reproductive health and HIV/STD prevention module.
3. Intervention targeted at adolescents (Peer groups-school children).
   i) Development of adolescence team of school going children (peer group) who will spread the knowledge in different areas/localities/para's by organizing regular programmes for promotion of reproductive, nutritional health and prevention of HIV/STD.
   ii) Organization of debate, quiz and poster competition on different themes of reproductive nutritional health, prevention and control of HIV/STD/AIDS every year.
   iii) Adolescents will educate at least five families (parents) and five young children (out of school adolescents).

iii) Intervention targeted at local teachers to organize, plan, coordinate and co-operate the adolescents to conduct and organize adolescent programmes.

- Geographical distribution of area to the grass root level HHWs.
- The HHWs will be allotted a population of 2000 i.e. to cover 400 families approximately. It has been estimated that about 30% is the BPL population in the ULB. Therefore out of 400 families, 120 families are likely to be BPL families.
- The HHW will visit BPL families once in a fortnight while they will visit the families other than BPL once in every two months for awareness generation, motivation for availing primary health care services and collection of information for preparation of HMIS of the ULB as a whole.
- Among the health infrastructures only the Health Administrative Unit (HAU) would be newly constructed for which the municipality will have to provide suitable land at free of cost.
- A Sub-Centre will cover 10,000 population.
- 50% of the Sub-Centres will be newly constructed at a land provided free by the Municipality. The remaining 50% of the Sub-Centre will be accommodated either in municipal accommodation or in some CBO / club accommodation for which service charges towards electricity, cleaning and provision of drinking water is to be provided as rental.
- For 32 ULBs where there is no existing SD hospital, one OPD along with Lab. facility is to be established which will be constructed as extension to one HAU of the ULB to provide specialist services in three major disciplines i.e. paediatrics, G & O, General Medicine.
- Service of a MO Pathologist and the laboratory will be made available.
- No Maternity Home will be constructed in the Municipality under this project. Referral services to the nearest Govt. hospital will be linked and availed for the purpose.
- One suitable ambulance will be provided to the ULBs for transportation of patients.
- Due to paucity of availability of PTMO on honorarium basis, suitable Medical Officer will be deployed to run the clinics at the Sub-Centres on reasonable fee basis per clinic.
- Components of curative services are to be conjugated with primary health care services to provide comprehensive health care to the whole Municipal population. For this purpose adequate arrangement and provision of medicines & MSR would be made available at Sub-Centre / HAU.
- Formation of Health & FW Committee as per the existing Govt. order at each ULB.
- Collection of subscription of Rs. 2/- per family per month for both APL & BPL families as user charges will be made through the HHWs. This amount will be deposited in the Municipal Health Fund. This collection will not only facilitate to raise fund for sustainability but also will ensure social audit for services rendered.
- Specialists engaged at OPD will be on fee basis per clinic.
- For Laboratory investigations suitable charges at subsidised rates may be considered to be levied from the clientele, if agreed upon in policy. The charges so realised will be deposited in the Municipal Health fund.

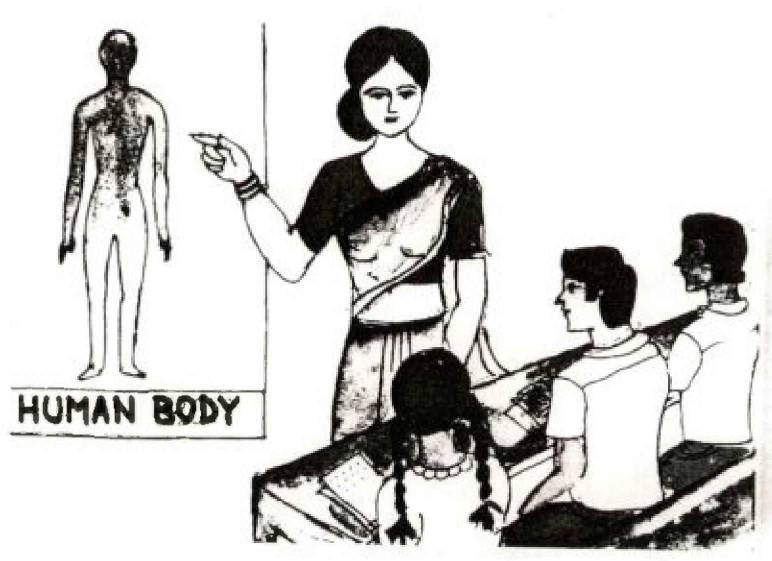
VII. Budget

1. Awareness of adolescents on STDs, RTIsand HIV/AIDS

Details	Rate(Rs.)	No.	Days	Total
Field expenses : Per diem for Investigators				
Principal investigator	1000	1	10	10000
field investigator	700	3	10	21000
Research associates	500	3	10	15000
social scientist	500	3	10	15000
Travelling expenses			Municipalities	
field investigator	1000	4	10	40000
Research associates	1000	3	10	30000
social scientist	1000	3	10	30000
Charges for local transportation	800	3	10	24000
Contingency expenses	1000	3	10	30000
Sub-Total				215000
Office expenses				
Printing of Schedule				5000
Data entry and analysis				10000
Secretarial assistance				5000
Stationaries				10000
Final Report Writing				10000
Contingency expenses				10000
Institutional charges (5% of TA/DA))				10750
Sub-Total				60750
Grand Total				**275750**

- Community participation for effective implementation, supervision and monitoring the programme.
- Involvement of elected representatives, mother leaders at each and every steps of this programme.
- Decentralization of services in three tier system i.e. grass root (door step), Sub-Centre and referral for effective permeation to whole urban population.
- Male participation to be ensured for accelerating the programme particularly the family planning programme.
- Establishment of both horizontal and vertical linkages and coordination including the national health programmes.
- Partnership with Private and NGO sector - for effective implementation of the programme. The local CBOs may be entrusted with task in suitable spheres, imparting the community the onus of belongingness.
- Creation of health fund municipal level through user charges at family level, mobilisation of NSDP fund, special drive for donation etc. for sustenance of the activities.
- Development of strong I.E.C. base for enhancing motivation and health awareness generation.
- Development of computerised comprehensive HMIS.
- Establishment of a suitable Management & Supervision Cell at ULB each level
- Establishment of a Central Co-ordinating, Management & Supervision Cell at State Head Quarter level.

MODULE FOR TEACHER COUNSELOR
ON
ADOLESCENCE HEALTH



DEPARTMENT OF COMMUNITY MEDICINE
NORTH BENGAL MEDICAL COLLEGE
SUSHRUTA NAGAR, DARJEELING

DECEMBER - 2003

CONTENTS:

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II. Definition of Adolescence and need for special approach

III. Phases of Development.

IV. Socio-Cultural Development and Adolescence

V. Medical Problems during Adolescence

VI. Nutrition in Adolescence.

VII. Personal Hygiene.

VIII. Sexually Transmitted Diseases and AIDS.

IX. Mental Health in Adolescence.

X. Teachers Role

XI. Counseling

XII. Key-notes

PREFACE

Adolescence is a period of transition from childhood to adulthood – the period of life between 10-19 years. It is a crucial period when complex process of physical, cognitive, emotional, social and moral maturation of individuals to adulthood occurs.

Adolescence is a period of preparation for undertaking greater responsibilities including healthy responsible parenthood. The future of any society depends on adolescents which constitute about 20% of the population and form a great human resource for the society. Again, due to lack of accurate information adolescents are prone to various behavioral problems in absence of proper guidance and counseling. Recognizing the importance of the adolescent years in preparing the children for adult roles and to meet their special needs the WHO-GOI collaborative programme has established "Adolescent Friendly Health Clinic" at North Bengal Medical College and Hospital. WHO is supporting a total of 8 such projects in different parts of the country including one at Medical College, Kolkata(West Bengal)

A special environment needs to be created to facilitate easier approach for adolescents to fulfill their needs through training of teacher- counselor who can play an active role in influencing the development of attitudes and changes in sexual behavior. Keeping this in mind the present module for training of teacher-counselor has been developed by the Community Medicine Department, North Bengal Medical College.

Participation of teachers in workshops on dealing with problems of the adolescent will help them prepare for their role as counselors and give them proper orientation to adolescent care including information on body image issues, diet and nutrition, human reproduction and reproductive health needs of the adolescent.

for their active participation and support in organizing meetings and visits to schools. Their untiring efforts have made this publication possible. Mr. Suman Sengupta of Nicholas Piramaul Pharmaceuticals deserves more than sincere appreciation for providing teaching materials on adolescent health. I, thank Mr. Babul Biswas for his help in Computer designing and layout.

I, shall be failing in my duty if I don't acknowledge the cooperation extended to our Dept. by School authorities, teachers, parents and of course large number of students for whom this module is prepared.

Finally, I wish to express my sincere appreciation to WHO / GOI for financial assistance.

Sushruta Nagar

Dr. M. Chakraborty
Professor & Head,
Community Medicine
North Bengal Medical College

I. INTRODUCTION:

The word adolescence is derived from the Latin term ***adolescens*** which means growing up. Growing up is a natural process. Human beings, like every living being, undergo certain changes at every stage of development. Adolescence is a critical stage of growth and development.

One in every 5 people in the world is an adolescent. As defined by WHO, an adolescent is a person aged between 10 – 19 years. Out of 1.2 billion adolescents world wide, 80% live in the developing countries and the remainder in the industrialized world. In India, adolescent constitute the second largest group of population (22.5%) after the 1-9 years age group. Adolescence is generally thought to be the healthiest period of human life. By the second decade of life, they have survived the diseases of childhood, yet many of them die prematurely. Every year an estimated 1.7 million young boys and girls lose their life- mostly through accidents, suicide, violence, pregnancy related complications and other illnesses that are either preventable or treatable.

This period is crucial as it is the formative years in the life of an individual. It is a normal part of the adolescence development to take on new responsibilities and roles which can incur risks to experiment with things symbolic of adult life and raise questions about families, social rules and customs. Realizing the increasing need of "ADOLESCENT CARE" in India, WHO came forward in collaboration with Govt of India to constitute a National Task Force for adolescent care.

The teacher can play great role to provide accurate information, proper guidance and counselling so that proper physical, psychological and behavioural changes take place among the adolescents and they can undertake greater responsibilities including healthy, responsible parenthood. **This module has been prepared with the following learning objectives**:

LEARNING OBJECTIVES: At the end of the session the teacher should be able to

- Describe the Anatomical and Physiological changes during adolescence.
- Explain the Psychosocial changes and Behavioral disorders during this period.
- Discuss the importance of Nutrition during adolescence.
- Narrate the importance of Personal hygiene.
- Recognize the common and special Health problems including Reproductive Health and Behavioral Problems early and refer timely.
- Act as Teacher- Counselor for the students and even for the parents under special circumstances.

II. Definition

Adolescence is a phase of transition from childhood to adulthood. It is the period of life between 10-19 years, the period extending from puberty to the attainment of full reproductive maturity, when major physical, psychological & behavioural changes take place. It is a time of turmoil: a time when physical maturation takes place by awakening of the endocrine forces.

According to ***Hotingshed, Adolescence is the period of life of an individual when society no longer views him/her as a child, but does not as yet concede him/her either the roles or the function interment in the status of adult'.***

II.1. ADOLESCENCE - **Why special?**

Until recently adolescents remained neglected by the medical profession both the physicians and the pediatricians. They are actually appeared to be no ones' responsibility. The WHO along with the UNICEF has begun a world wide campaign to focus attention on adolescence.

Reasons:

A Physical Growth:

A period of **rapid** growth spurt -- important mile stone of a child.

B. Psychological & Behavioral Developments:

1. A period of extreme emotional sensitivity. Even unintentional remarks may cause very negative feeling with deleterious effects afterwards. A period when ability to cope with intense emotions develops.

2. A period of cognitive developments when foundation of logical thinking takes place. Unrestricted thinking should be encouraged as abstract thinking is the forte of adolescence.

3. A period of development of core-identity, values and beliefs.

4. A period when creativity starts and hence creates such situations where they can contribute positively.

5. A period which needs greater understanding – need for privacy, need for identity of their own, need for recognition, need for respect for self and others.

6. A period which needs guidance for developing healthy expression of one's feelings and thoughts.

(***Key words:*** **Understanding. Forbearance. Tolerance. Recognition.**)

C. Social:

A period of acceptance of responsibility for one's actions and roles.

II.2. Characteristics of adolescence:

Physical:

Rapid physical growth and changes in physiological processes take place. Hormonal changes during this period lead to reproductive maturation which is identified with the development of secondary sexual character.

Psychological:

Mental, intellectual and emotional maturation takes place. They begin to define and understand their relationship with opposite sex. Individuals may experience intense sex drive for the first time which may be psychologically stressful.

Socio-cultural:

Society does not define a distinctively definite role for adolescence. They are caught in the ambiguous overlap between the roles of childhood and adulthood. Their psychological needs also are not appreciated which may cause aggressiveness and reactionary behavior.

Behavioral:

- Independence: They start distancing themselves from the adult world. They begin to shift from parents to peers and from the existing to new belief system.
- Identify: They tend to assert their individuality. They display the gender role identity, a positive body image and a sense of esteem and competence through their behaviour.
- Intimacy: They suddenly discover their special interest in the opposite sex. They find it difficult to distinguish between infatuations and love with or without sexual orientation.
- Peer group dependence: They tend to break away from the close emotional ties of parents and prefer the company of their friends. Where-ever the socio-cultural milieu does not permit interaction between boys and girls, adolescents of each gender group develop homo-social orientation and form gender specific peer groups.
- Intellect: They become capable of conceptual thinking and of understanding logic and deductive reasoning.

III. Phases of development:

Adolescence is usually divided into three phases – early, mid and late adolescence with a great deal of overlapping among these three phases.

- Early adolescence (age 10-13): There is a sudden and distinct spurt in physical growth. The gain in height can be as much as 6-8 cm in a year. Gender differences in height may be seen at this time. Girls become taller and slightly heavier than boys. Sexual fantasies and other sexual manifestations start at this age. Some parents do not accept this as normal behaviour and make them feel guilty. They are generally confused and preoccupied with body wonders. The best friend becomes very important at this age. Boys form groups of the same age and the girls have just one or two special friends.
- Mid adolescence (age 14-15): The secondary sex characters continue to develop and the reproductive organs become functional. This phase of development is a time of experimentation in the spirit of adventure. He/she starts defining his/her relationship to himself/herself, the opposite sex and peer groups. At this time there is a feeling of self dependence, sense of responsibility and curiosity to know his/her place in the society. Along with this mental reaction becomes more complex with deeper emotions and development of own choice.
- Late adolescence (age 16-19): They establish a set body image and arrive at a fairly consistent and realistic view of the outside world. Peer groups become less important for them; rather they become more selective about friends. They begin to define life goals, although economic dependence on parents may continue for many years. They are concerned with their preparation for future. A continuous graded support from the parents and society at this stage is helpful to increase their power to cope up with their new role in life.

III.1 Physical growth & Development

The term puberty is defined as the period when sexual maturity is reached. It is the time of first external sign of sexual maturation, menarche in female and first seminal emission in males. But this definition is not comprehensive. On the other hand, adolescence is the period extending from puberty to full reproductive maturity during which accelerated physical growth and development occurs. The increased release of sex hormones, progesterone and estrogen in females and testosterone in males, is responsible for development of secondary sexual characteristics both in females and males.

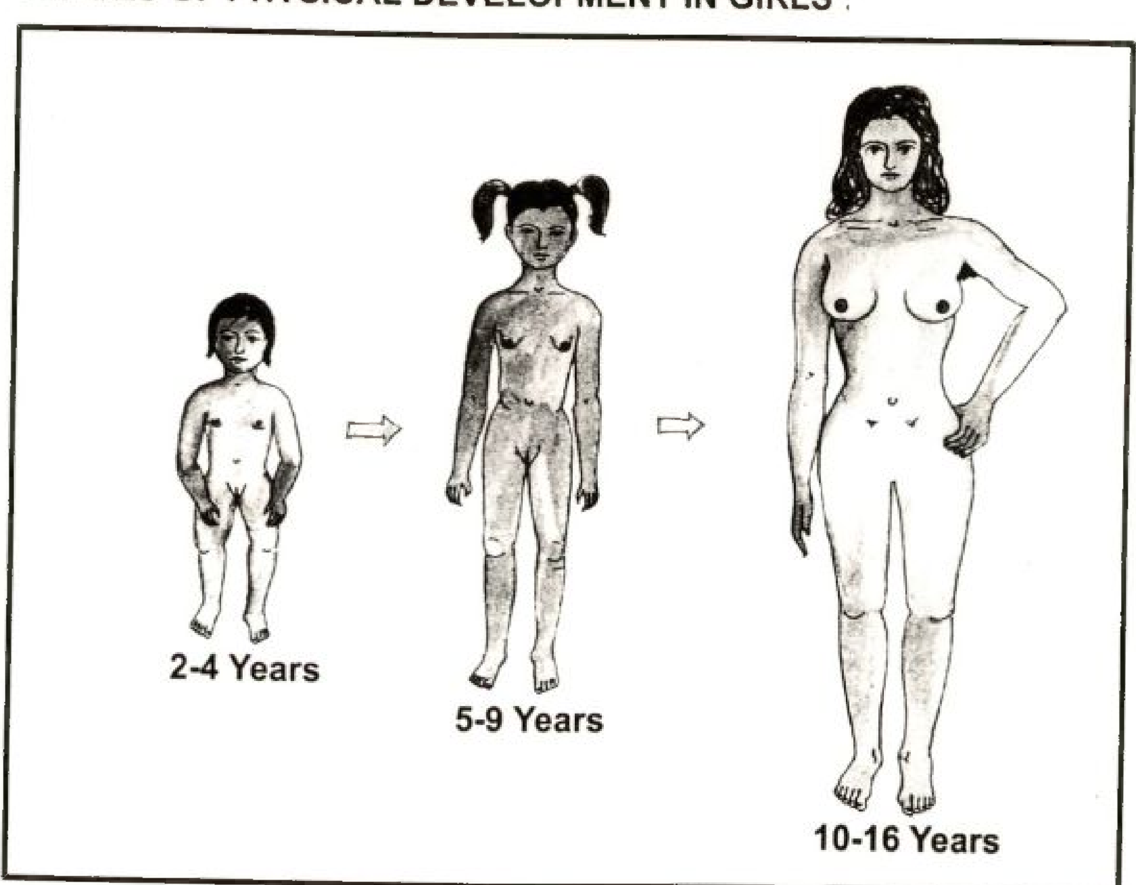
III.1.1. Puberty in Girls:

Physical changes appear earlier than in boys, usually at 10-11 years and ends around 16 years of age.

- Growth spurt occurs during this period and a girl attains 98% of her adult Height at the age of 14 years.
- Widening of the pelvic inlet and broadening of hips.
- Hairs appear in the pubic region and under arms.
- Breast enlargement occurs, nipples also grow.
- Face becomes oily and pimples appear.
- Accelerated growth & development of genital organs- like vulva, vagina, uterus & ovaries.
- Ovaries began to ovulate i.e. ovum production starts around 11-14 years.

  Menarche: The average age of menarche in India is 13.7 years (range: 9-18 years). Menstruation occurs once a month as a regular rhythmic period and remains as a normal physiological phenomenon through out the childbearing years except during pregnancy and sometimes during lactation .It stops permanently at menopause (age: 45-55 years.)

STAGES OF PHYSICAL DEVELOPMENT IN GIRLS :



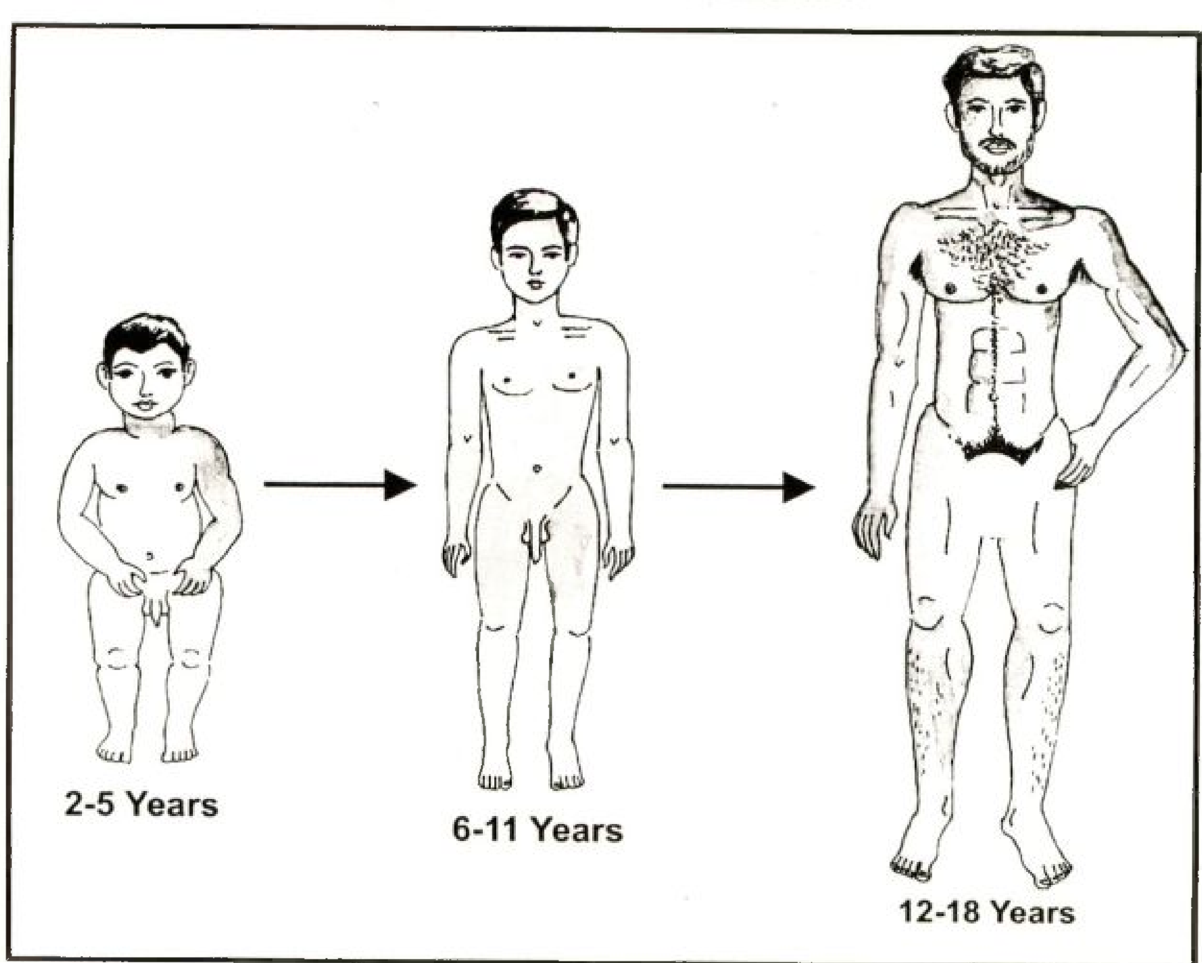
II.1.2. *Puberty in boys*

Usually it appears at the age of 11-13 years. Growth spurt occurs at this age. An average boy of 16 years has already reached 98% of his adult height.

- Change in voice occurs due to enlargement of the larynx.
- Facial skin becomes oily & pimples appear due to over production of the sebaceous glands (as a result of stimulation of androgen hormone.)
- Hair appears on chin, under arms, face, chest & pubic region.
- Development and enlargement of external genitals (testes and scrotum) takes place between the age 10- 13.5 years and completed within 14.4-18 years.
- Sperm production starts: occasionally penile erection & involuntary ejaculation also occur.

From puberty onwards, testes continually produce billions of sperms in the course of adult lifetime. The decline of testicular function is more gradual than ovaries in terms of both sperm and hormone production.

STAGES OF PHYSICAL DEVELOPMENT IN BOYS :



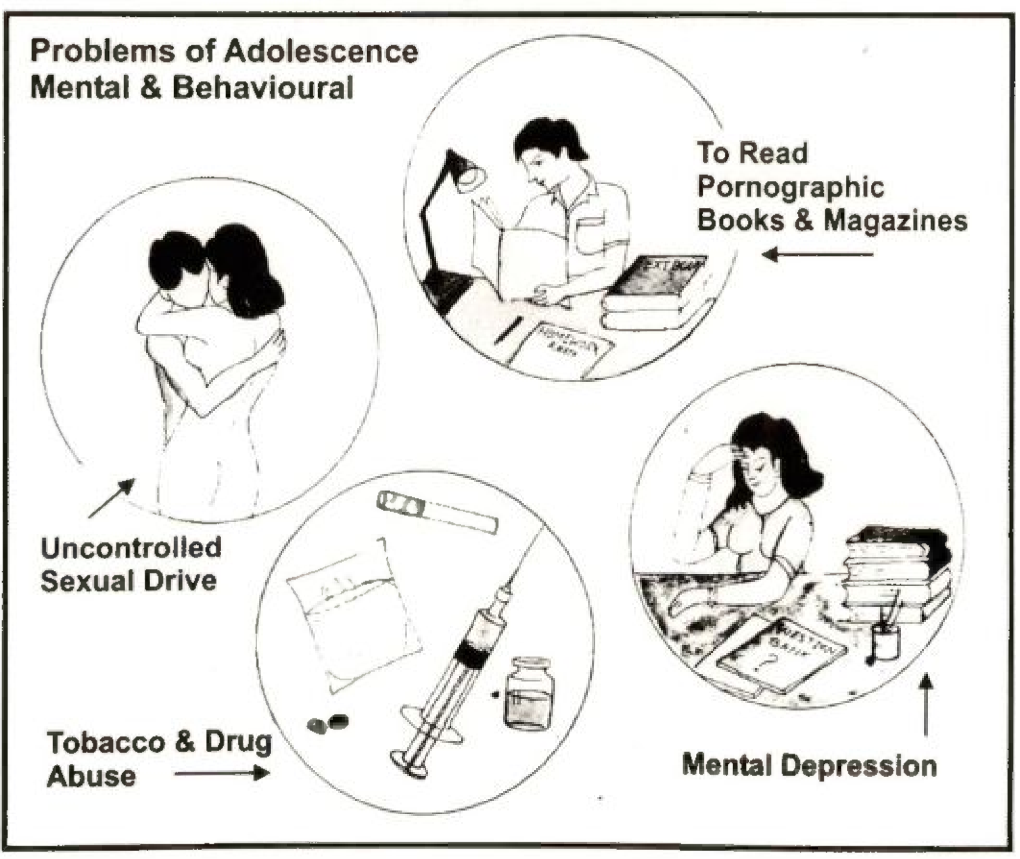
IV. SOCIO-CULTURAL DEVELOPMENT AND ADOLESCENCE

Adolescent boys and girls in all society are considered to have outgrown childhood but they do not have defined roles of their own. Most adolescents welcome the opportunity to take on more responsibilities and become more independent. Not all children grow from infancy through their adolescent years without experiencing some bumps along the way. While every child is unique and special, sometimes they encounter emotions, feelings or behaviour that causes problems in their lives and the lives of those around them. As adolescents mature physically, they normally develop a sense of personal identity and greater self confidence. The emotional changes influence their sense of self identity, body image, self-esteem and self-concept. They also experience sudden change in their social relationship with their parents, peer-groups and especially with opposite sex.

IV.1. Emotional Development:

Adolescence is considered a turbulent period when the changes that take place result in sudden upsurge of sexual feelings. Growing adolescents may experience sexual excitement from simply watching and being near to someone they are attracted to.

EMOTIONAL CHANGES :



. Increased production of hormones result in sexual thoughts in them but because of social control these types of excitements are not expressed in reality which results in day-dreaming or nocturnal emissions or wet dream and personal and social maladjustment. During this time due to hormonal imbalance adolescents experience frequent shift of mood, quickly and unpredictably. Some become irritable, restless, angry and tense.

If they are aware of their changes and developments and if the parents and teachers are aware of them, it will be easier for the adolescents to cope up with these changes. There is need to provide opportunities to the adolescents to express their emotions by creating healthy environments for literature, science, poetry, religion, music, art-work and physical exercise in the school and in the community, which are some common methods of sexual sublimation.

IV.2 Identity development:

During the process of growing up adolescents try to define themselves and establish their personal identity. They are expected to develop a gender role identity, a positive body image and a sense of self esteem and self confidence.

IV.3 Body Image:

Body image is an individual concept of how ones body appears to others. It also refers to the way a person feels about his or her physical appearance. The size, shape, height, colour and some other characteristics of the body, though strongly influenced by the heredity, are also influenced by environmental factors. The media and the role models have immense impact on the concept of body image of the adolescents. They need to be made aware that attractive physical appearance is not the total body image.

IV.4 Self esteem and self concept:

Self esteem is closely identical with self respect. It includes a proper regard to oneself as a human being and accurate sense of one's personal place within the society. Social development of an individual is based on the foundation of self esteem. An exaggerated self esteem leads to a superiority complex regarding one's ability, importance and wit. Lack of self esteem results in feeling of unworthiness.

Self concept can be defined as a person's perceptions of himself or herself. It includes one's ability, character, attitude, traits, aims and actions. It reflects the human behavior and acts in accordance with his or her self concept. A confident person with high regard for himself or herself behaves differently from another incompetent, inferior and insecure person.

IV.5 Social relationship:

Adolescents gradually develop socially mainly by expanding and redefining their relationship with parents, peer group and members of the opposite sex. Due to physical and psychological changes, they often show disrespect to the elders and prevalent family and social values and engage themselves in different anti-social activities.

IV.5.1 *Changing relations with parents;*

Adolescents begin to shift from close parental care, protection and guidance and start defining their personal identity and assert their independence. Parents often do not accept it leading to increasing conflicts with the adolescents perpetuating their stress and strain.

The stress and strain is more marked where there is parental domination preceded by anxiety.

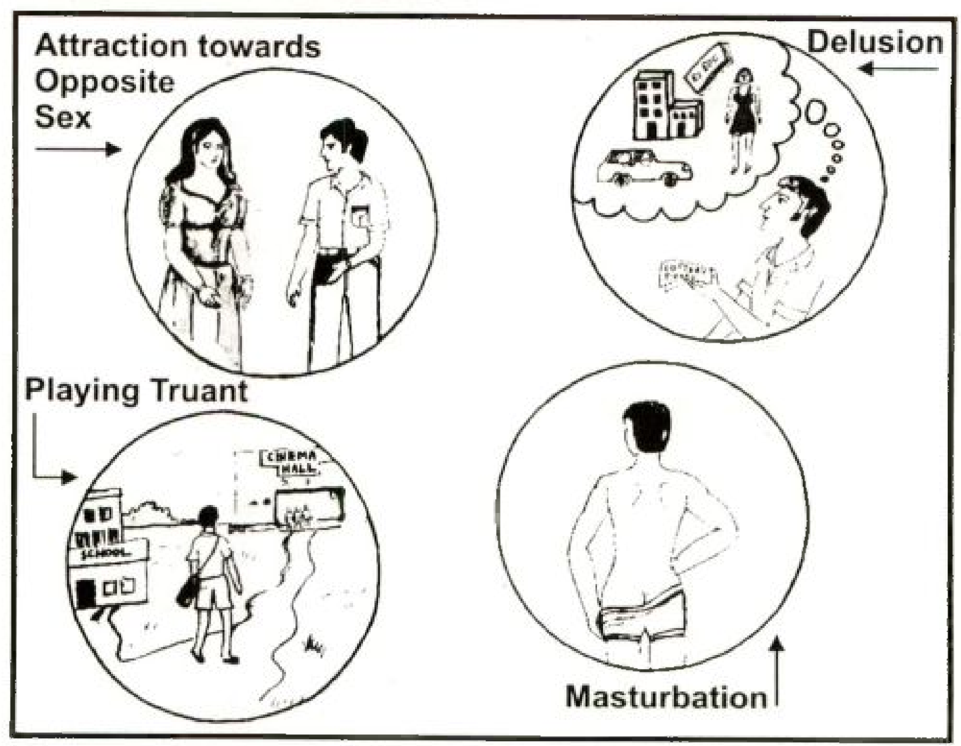
Social development is easier for those adolescents who feel that their parents love and trust them. Adolescents need to be given increasing opportunity for freedom and self direction and restrictions on them require to be imposed only when it is essential, that to with due consideration of their commitments and desires.

The parent child relationship should be friendly. The parent should be helpful, caring, open-minded, disciplined and of good nature. The modern father no longer personifies the old value system and can not be a role model for his son. The adolescent undergoes a "crisis of identification" and fails to see in his or her parent a personality worth emulating. Thus the child feels he knows best and shuns parental advice. Separation from parents has negetive psychological effect on adolescents.

IV.5.2 Peer *Group Relationship*

Most of them deeply involved with their circle of friends. The teenagers increasingly become dependant on their peer group. Peer group- relationships help adolescents learn to deal with people while the peer influence helps them in a positive manner in establishing individual independent identies.Often the peer pressure at times initiates negative orientations in them. This is the time for exploration of one's capabilities and potentials which can lead to confusion and experimentation with harmful substances like smoking, drugs or alcohol. and risky behavior like rash driving causing accidents. Usually boys and girls form a homo-social gender peer groups. Within the same group, the adolescents define the heterosexual orientations and relationships.

EMOTIONAL CHANGES :



IV.5.3 ***Appreciation for opposite sex:***

During adolescence period, full psychosexual maturity occurs. Sexual adjustment is an important part of the total development of individual into maturity. The mutual attraction between boys and girls is a completely normal and universal human behavior. However adolescents face problems in controlling their sex drive, because they are not helped in appreciating the real nature of these developments, to understand the sublimity of relationship with opposite sex and significance of social control and standard of moral code. These results in deviant behaviour of adolescents when they seek sexual gratification at a purely physical level leading to sexual violence like rape or may develop anxiety and apprehension. To develop an appreciation amongst them, an understanding of the fundamental basis of male female relationship is essential.

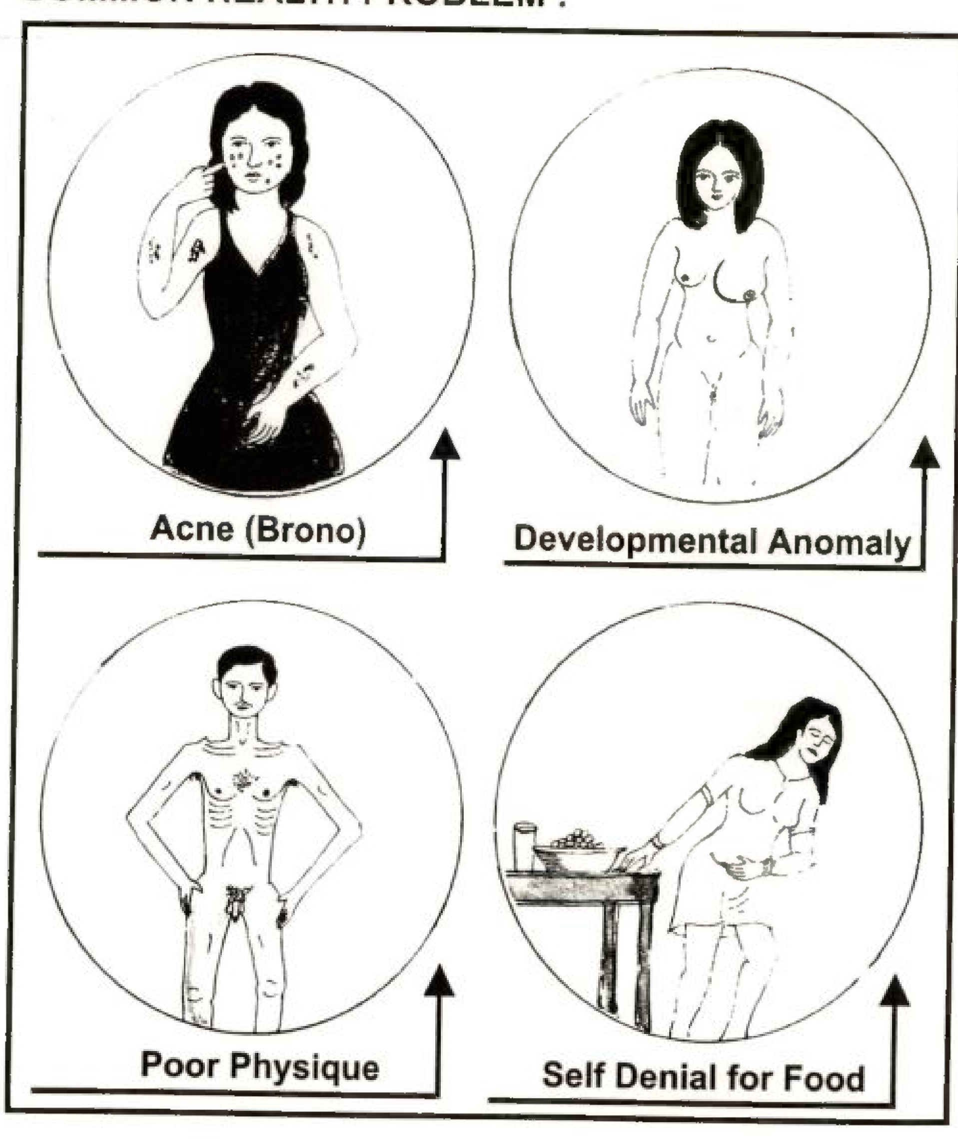
Most adolescent boys and girls think they are in love when they are actually infatuated. At that stage the relationship is far too immature to be considered love. In order to build a positive relationship with opposite sex, it is essential that both the sexes treat and respect each other equally.

V.I. Common Medical problems:

Some health problems among adolescents are consequences of certain childhood infections like repeated diarroeal and respiratory infections, poliomyelitis or other factors affecting health status like malnutrition.

- Under nutrition and over nutrition
  - Impaired growth.
  - Anemia
  - Iodine Deficiency Disorders
  - Myopia
  - Acne
  - Common Endemic Diseases
    - -Malaria
    - - Tuberculosis
    - - Asthma
  - Diseases related to Reproductive Health

COMMON HEALTH PROBLEM :

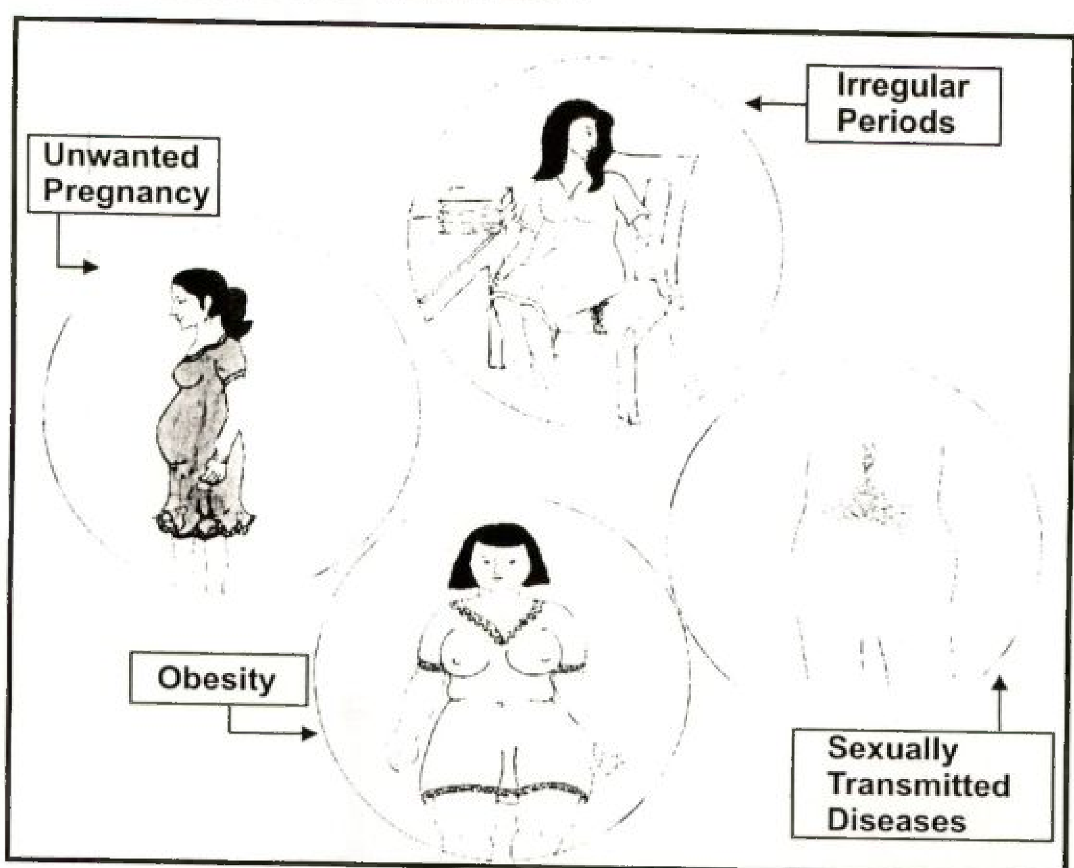


V.2. Special Health related problems

- Chronic Diseases-Juvenile Diabetes, Arthritis, Heamoglobinopathies etc.
- Some diseases which manifest in adulthood may start developing in this period like Diabetes, Hypertension, and Obesity etc.
- Health related problems like Alcoholism & Drug abuse.
- Unprotected sexual act leading to unmarried teenaged pregnancy.
- Reproductive tract infections like Syphilis, Gonorrhoea, and AIDS etc.from unsafe sexual practice.
- Psychological Stress leading to Mental Disorder.
- Rheumatic Heart Diseases.

Health of the adolescent girls are at risk if they are married at very young age which leads to early child bearing chances of anemia, retarded fetal growth, premature birth and complications during labour are significantly higher for adolescent mother and even may lead to death.

SPECIAL HEALTH PROBLEMS :



V.3. IMPORTANT ADOLESCENT PROBLEMS FOR REFERRAL:

- Depression and frustration shown by sustained, prolonged negative mood and attitude, often accompanied by loss of appetite and sleep.
- Gradual deterioration in school performance.
- Inability to cope with problems and daily activities, lack of interest in social activities.
- Deterioration of relationship with parents, close relatives and friends.
- Sexual abuse and persistent nightmares.
- Self- Destructive behaviors like rash driving, suicidal tendency or harm to others.
- Indifferent attitude towards self presentation.e.g. Poor hygiene, shabby dresses, unshaven appearances etc.
- Curiosity about addictive medicines and chemicals, abuse of alcohol and/or drugs.
- Severe mental tension e.g. Failure in exam, loss/death of nearest one, frustration in love etc.
- Violence, juvenile delinquency, truancy, thefts, or vandalism.
- Nutritional Deficiency Disorders e.g. PEM, Vitamin deficiencies etc.
- Any other medical problem e.g. STDs, HIV/AIDS, Tuberculosis, Malaria etc.
- Occupational Hazards.
- Severe injuries and accidents.

VI. NUTRITION IN ADOLESCENCE:

The adolescents need more energy for each kilogram of body weight than adults. This is because they show a good deal of physical activity almost equal to hard work by adults. This is also an age when puberty sets in and there is a spurt of growth with an increased metabolic rate.

VI.I. Important conditions/risk factors common in adolescence affecting nutritional status:

- Inappropriate food intake
  - Frequent dieting
  - Skipped meals
  - Monotonous diet
  - Frequent use of inappropriately chosen fast food.

- Poverty

- Nutrition related conditions
  - Diabetes Mellitus
  - Obesity
  - Inflammatory bowel disease
  - Renal diseases, etc

- Psychological factors
  - Family dysfunction
  - Athletic competition
  - Depression
  - Body image
  - Eating disorder, etc

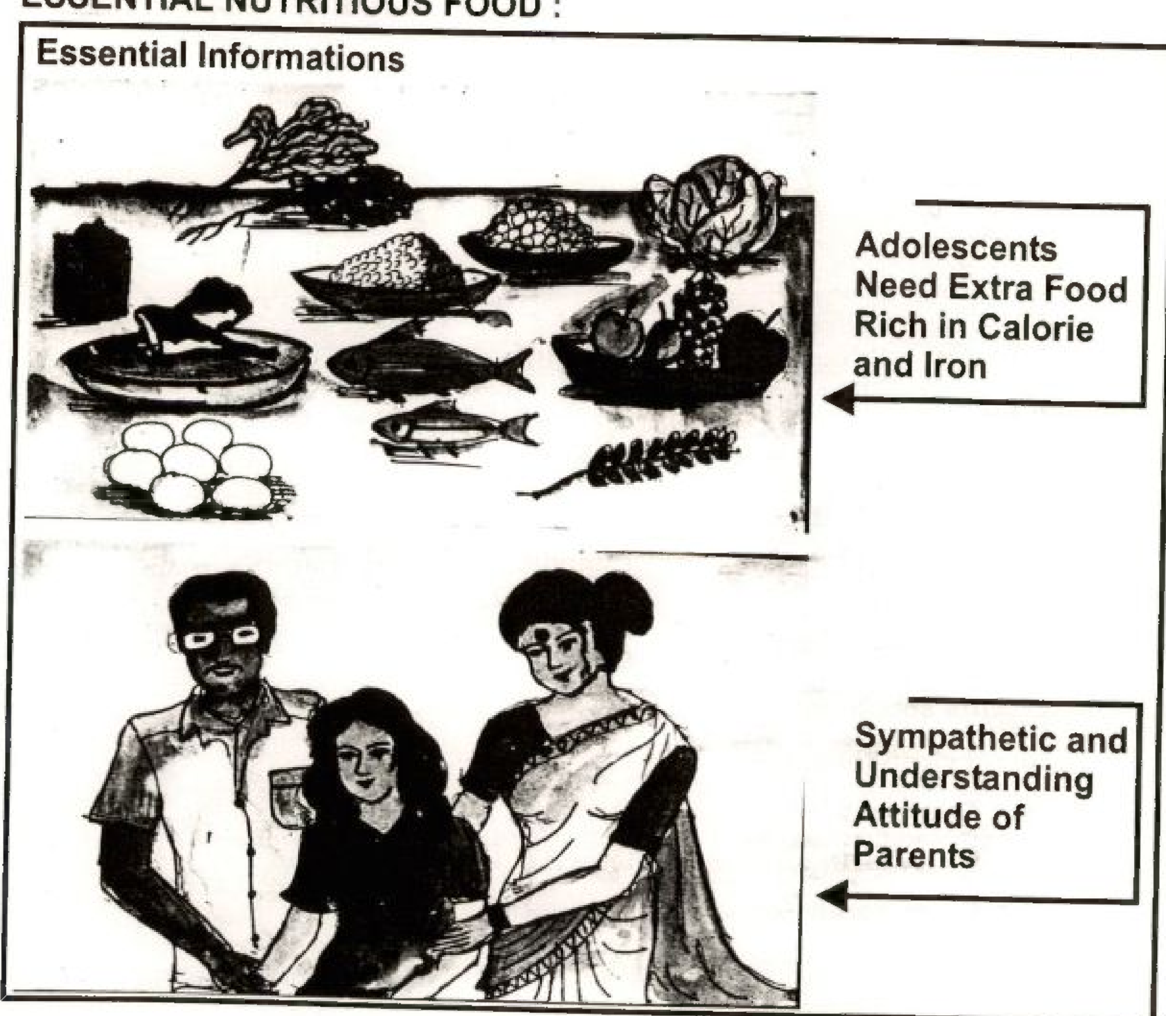
- Lifestyle
  - Sedentary lifestyle
  - Alcohol abuse
  - Tobacco, etc

VI.2. Dietary guidelines:

Adolescents need more of all nutrients particularly Calcium, Iodine and Iron because of growth spurt. Commonly recommended guidelines are as follows-

- Eat variety of foods
- Maintain a healthy weight by balancing energy intake with output.
- Choose a diet low in fat, Saturated fat and cholesterol.
- Eat plenty of fruits, vegetables and whole grains.

ESSENTIAL NUTRITIOUS FOOD :



VI.3. Nutrient Requirement of Adolescents

	Age Groups (years)					
	10-12		13-15		16-19	
	Boys	Girls	Boys	Girls	Boys	Girls
Weight (kg)	35.54	37.91	47.88	46.66	57.28	49.92
Calories (K Cal)	2190	1970	2450	2060	2640	2060
Protein (gm)	54	57	70	65	78	73
Calcium (mg)	600	600	600	600	500	500
Iron (mg)	34	19	41	28	50	30
Iodine (mcg)	150	150	150	150	150	150
Folic Acid (mcg)	70	70	100	100	10	100
Vitamin A (mcg)	600	600	600	600	600	600

VI.4. <u>Nutrition Education and Counseling</u>:

Aim of nutrition education and counselling is to increase the individual's awareness, knowledge and skills and motivation for healthful and nutritious dietary choices. The educational process is especially dependant on practitioner's knowledge of adolescent growth and development and understanding of dietary patterns, malnutrition risk and chronic disease status.

VII. PERSONAL HYGIENE IN ADOLESCENCE:

The adolescents should take care of the following measures regarding their personal hygiene-

- General cleanliness i. e.
  - Take daily bath.
  - Clean teeth and tongue twice daily after meal.
  - Clean hands properly before and after taking food and after toilet.
- Adolescents should keep their groin clean and dry to prevent fungal infection.
- Boys should give attention to clean "Smegma" i. e. a thick secretion collected under the foreskin of the penis, during bathing and after urination with soap and water.
- Adolescent girls should use clean cloths, pads or sanitary napkins during periods or if there is any vaginal discharge. It should be frequently changed and external genitalia should be kept clean and dry.

Adolescent girls should clean their perineal area each time after passage of urine and stool from front to back (and not reverse) to prevent urinary infection.

VIII. SEXUALLY TRANSMITTED DISEASES AND HIV/AIDS – PROBLEM IN ADOLESCENTS:

Worldwide AIDS kills more than 8,000 people everyday, 1 person every 10 seconds.

- HIV accounts for the highest number of deaths by any single infectious agent.
- AIDS has already claimed more than 25 million lives; more than 14 million Children have lost one or both parents to AIDS.
- Every year, an estimated 3 million people die of AIDS of whom 5, 00,000 are children under the age of 15 years.
- There are 40 million persons living with HIV/AIDS, worldwide. Of these, 2.5 million are children less than 15 years of age.
- HIV has already spread to an estimated 6 million people in the South-East Asia Region (SEAR); the second highest number of cases in the world after sub-Saharan Africa.
- Throughout the Region, injecting drug use is adding to the rapid spread of the epidemic. Around half of injecting drug users has already acquired the infection in Nepal, Myanmar, Thailand, Indonesia and Manipur state in India.
- 20% - 25% of HIV infections is seen in the age range of 10 – 24 years.
- Adolescents often take risks.
- Adolescents in India hear about sex from peers and porn.
- Perception of sexuality differs throughout India.
- Increase in drug use especially injecting drug use by Adolescents in the country.

VIII.I. Someone with AIDS:

Some physical effects of AIDS might be

- Extreme weight loss
- Changes of appearance
- Weakness
- Extreme stress or upset
- Feeling anxious about the course of illness
- Feeling of powerlessness and loss of control
- Not knowing what will happen

- Feelings of guilt about having the disease
- Dependence upon others
- Rejection and isolation because of others fears and prejudice

VIII.2. Need for Sex Education:

With the influx of AIDS, the need for sex education has multiplied considerably. As the sex is the most common mode of transmission of AIDS virus, sex education needs to be introduced in the curriculum of educational institution. Sex education is very much a part of AIDS education. Apart from AIDS, sex education is necessary for other reasons also, like – rising incidence of teenage pregnancies in unmarried girls, rising frequency of sexually transmitted diseases, rising abuse of drugs and alcohol and sexually related crimes.

In India, sex education is not lacking just at the primary schools & college levels, but is a grossly neglected aspect even in the curriculum of medical institutions. As a result of this , sexual dysfunctions / difficulties are often misinterpreted . Sex education is not merely a discussion on physiology of human reproductive system, conception, psycho-sexuality, gender sexual differences but also the aspects of human sexual behaviour that are responsible for the development of a child in to a healthy and responsible ad t capable of using his/her sex instincts to the maximum without being obsessed by them, acceptable to both society and themselves without creating any unnecessary conflicts between individual expression and social norms. Sex education enables an individual to recognize and be comfortable with one's sexuality.

The family as well as community has a crucial role in shaping the adolescents behavior. The family members and the community need to be informed about the physiological and psychological changes that take place during this age group, sexuality in human being and its implication on the health with special reference to health needs of them. The teacher can also play a great role to educate the parents and others so that family can ensure a safe, secure and supportive environment for the adolescents during their formative years of growth and development so that they can adopt a healthy life and behaviors.

IX. MENTAL HEALTH IN ADOLESCENCE

The transition from adolescence to manhood is often a stormy one and fraught with dangers to mental health, manifested in the form of mental ill health among the young, and juvenile delinquents in particular.

The basic needs of the adolescents are:

1. The need to be needed by others
2. The need for increasing independence
3. The need to achieve adequate adjustment to the opposite sex and
4. The need to rethink the cherished beliefs of one's elders

The failure to recognize and understand these basic needs may prevent sound mental development.

School Child:

a) Everything that happens in the school affects the mental health of the child.

b) Programmes and practices of the school may satisfy or frustrate the emotional needs of the child.

c) Proper teacher-pupil relationship and climate of the class room are very important.

IX.I. Mental Retardation

Intelligence means the ability to reason, comprehend and make judgments.

In mental retardation (lay man's- "Low IQ") there is impaired intellectual and social functioning which is evident from early childhood.

Measurement of Intelligence (IQ)test is done through standardized tests.

The clinical suspicion of a child having mental retardation or low IQ is confirmed through IQ tests. According to range of IQ, mental retardation is classified in four categories, though there may be overlapping.

Score:

Score	Category
50 – 69	Mild Mental Retardation
35-- 49	Moderate Mental Retardation
20 - 34	Severe Mental Retardation
< 20	Profound

These children will have disability mainly in:

- Delayed developmental milestones.
- Language skill
- Self care
- Mobility
- Academic achievement
- Ability to work

IX.2. Attention deficit/Hyperactivity disorder:

Main features –

- Over activity
- Impulsiveness.
- Restlessness
- Inattention
- Distractibility

These children are clumsy, accident prone and get into trouble with parents and teachers as they act without thinking. Symptoms are usually present from early age but mostly evident when the child is in elementary school i.e,upto 6 years. They often fail to give close attention to details, fail to complete and makes careless mistakes in schoolwork. They have difficulty in keeping sustained attention in talk or play or listening to spoken direction.

They are forgetful, unable to organize tasks and lose things necessary for tasks.

They also avoid and dislike engaging in tasks that require sustained mental effort.

The hyperactive child fidgets with hands and feet, leaves seat in classroom, runs about or climbs inappropriate to the situation, can not play or leisure quietly, talks more than usual. Impulsive children often gives answer before question is completed, do not wait for turn and interrupt or intrude on other's conversation or games. In adult hood these children develop conduct disorder, anti social personality disorders, get addicted to drug and develop several mental disorders.

In some, improvement takes place with advancement of age but many symptoms persists in later life. These children require medication and behavioral therapy which results in improved academic performance and social behavior.

IX.3.Oppositional Defiant Disorder

In this disorder, child shows

- Temper tantrums
- Disobedient
- Negativistic
- Hostile but usually do not harm others
- Defiant behavior.

It typically begins by the age of 8 years. They often argue with adults, loose their temper and get angry and annoyed by others. They actively defy adults and blame others for their own mistakes but justify themselves. It interferes with relationship and school performance and as a result they become friendless. They may start using alcohol and other drugs. Moreover they do not severely break social norms and do not harm others.(in contrast to anti-social person)

In some, spontaneous recovery occurs but many progress to develop conduct disorder. Treatment is by counseling and parent's training in how to manage child which include good parent-child relationship and encouragement of appropriate behavior.

IX.4.Conduct Disorder

This is characterized by

- Aggressive, harmful to others.
- Associated with other psychiatric problems.

Aggressive anti-social behavior relates to cruelty to animals, fire setting, stealing, destructive behavior, truancy, criminal activity, illicit sexual activity and frequently initiates physical fights often using weapons. They usually break promises to obtain goods and stays out after dark despite objection by parents.

They are very difficult to treat. Treatment is by setting environment with consistent rules and following it with personal evaluation. Drug therapy helps in limiting some aggressive behavior.

IX.5.Learning Disorders:

It includes reading disorder, writing disorder and mathematics disorder.

IX.5.1.Reading Disorder {Dyslexia}:

This is suspected when the child could not recognize words, reads slowly and inaccurately, understands poorly what he reads. There are omissions and substitutions of words while reading. They also have poor memory and dislike recalling. These children have impaired reading if not treated. Treatment is by well matched educational approach and personal counseling.

IX.5.2.Writing Disorder {Dysgraphia}:

In this disorder the children will show poor handwriting, difficulty with spelling, grammar and vocabulary, and poor paragraph organization. They often find problem in writing on a horizontal line and use of poor spacing despite being instructed earlier. They write slowly, inattentively with omissions, insertions and inconsistencies and have difficulty in finishing papers. Individually targeted one to one writing therapy appears to improve the situation.

IX.5.3.Mathematics Disorder {Dyscalculia}:

The children with this disorder fail to understand mathematical terms and converting written problems in mathematical symbols (arithmetic sums). They are also unable to understand symbols (+, -, £, % etc.), to do basic addition, subtraction, multiplication etc. and to copy figures and symbols correctly. This may interfere with school and daily life activities. Treatment involves focusing on development of problem solving skill rather than only computation.

IX.6.Other major psychiatric problems in adolescence are as follows:

IX.6.1.Depressive Disorder:

Sadness of mood, not taking interest in otherwise enjoyable activities, poorly interacting, death wishes, often crying without reason, hopeless about future, feeling himself worthless, lack of appetite and sleep and keep himself unhygienic. Treatment consists of counseling and drug therapy.

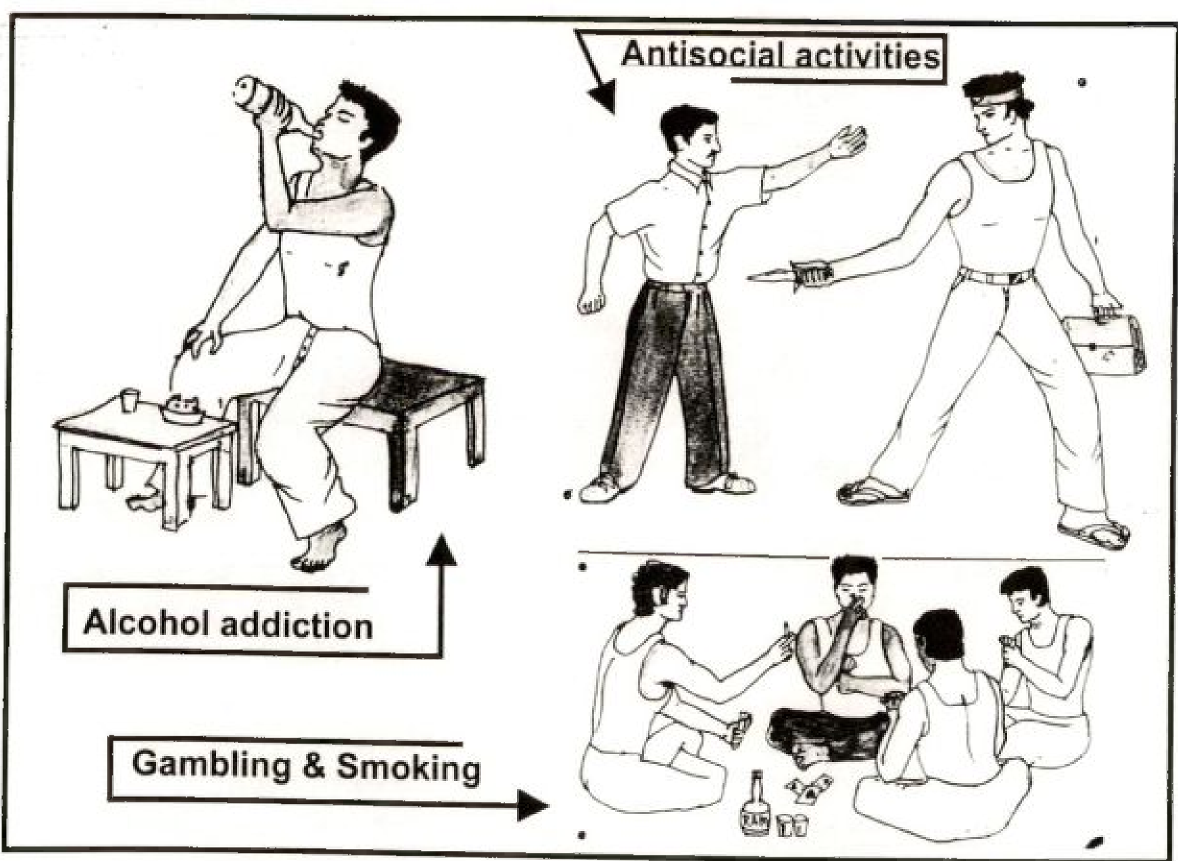
IX.6.2. SUBSTANCE ABUSE

Drug abuse means taking of substances like alcohol, drugs, tobacco in an amount, strength, frequency or manner that damages the physical or mental functioning of an individual.

Causes of substance abuse:

- Peer pressure
- Temptation of teenagers "to look & behave" like an adult
- Curiosity or to have some pleasure or as an adventure
- Lack of love & understanding/Rebellion.
- To overcome boredom, depression & fatigue

SEQUELAE OF DRUG ABUSE :



How to recognize a substance abuser/ drug addict?

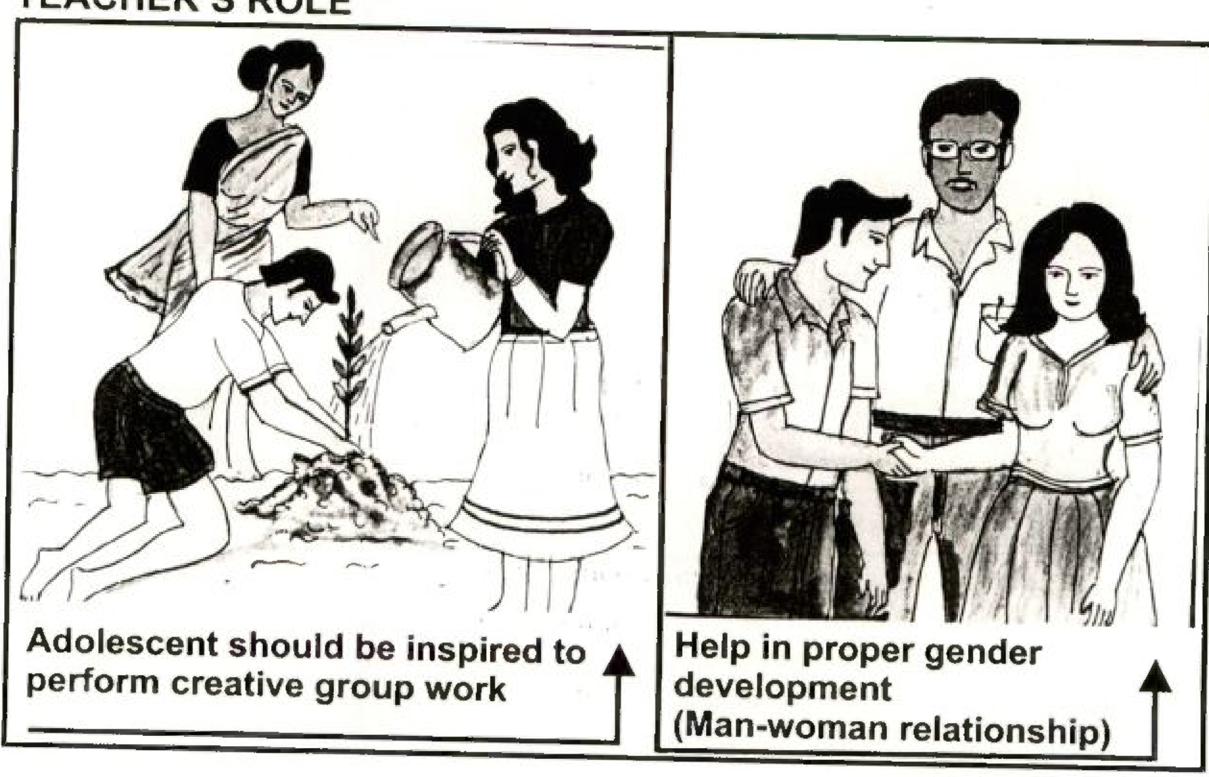
- Loss of interest in sports & daily routine
- Loss of appetite , nausea, vomiting, abdominal cramps & loss of weight
- Unsteady gait / clumsy movements /tremors/Slurred speech.
- Red / puffy eyes
- Drowsiness/insomnia/lethargy/ impaired memory & concentration
- Moodiness/ temper tantrums/anxiety/depression
- Depersonalization and emotional detachment

X.TEACHER`S ROLE:

Communicate informally and openly with students and be a patient listener. Try to Understand and respect his/her views.

- Help students to develop self confidence-be critical to actions not the person.
- Keep yourself interested in students` activities and their interests. Observe continuously their behavior within and outside class.
- Talk with students about the problems of adolescence like drug abuse; guide them and try to tackle the problems with great care by cooperating with his/her family.
- The students should be encouraged to participate in the constructive educational and recreational work.

TEACHER'S ROLE

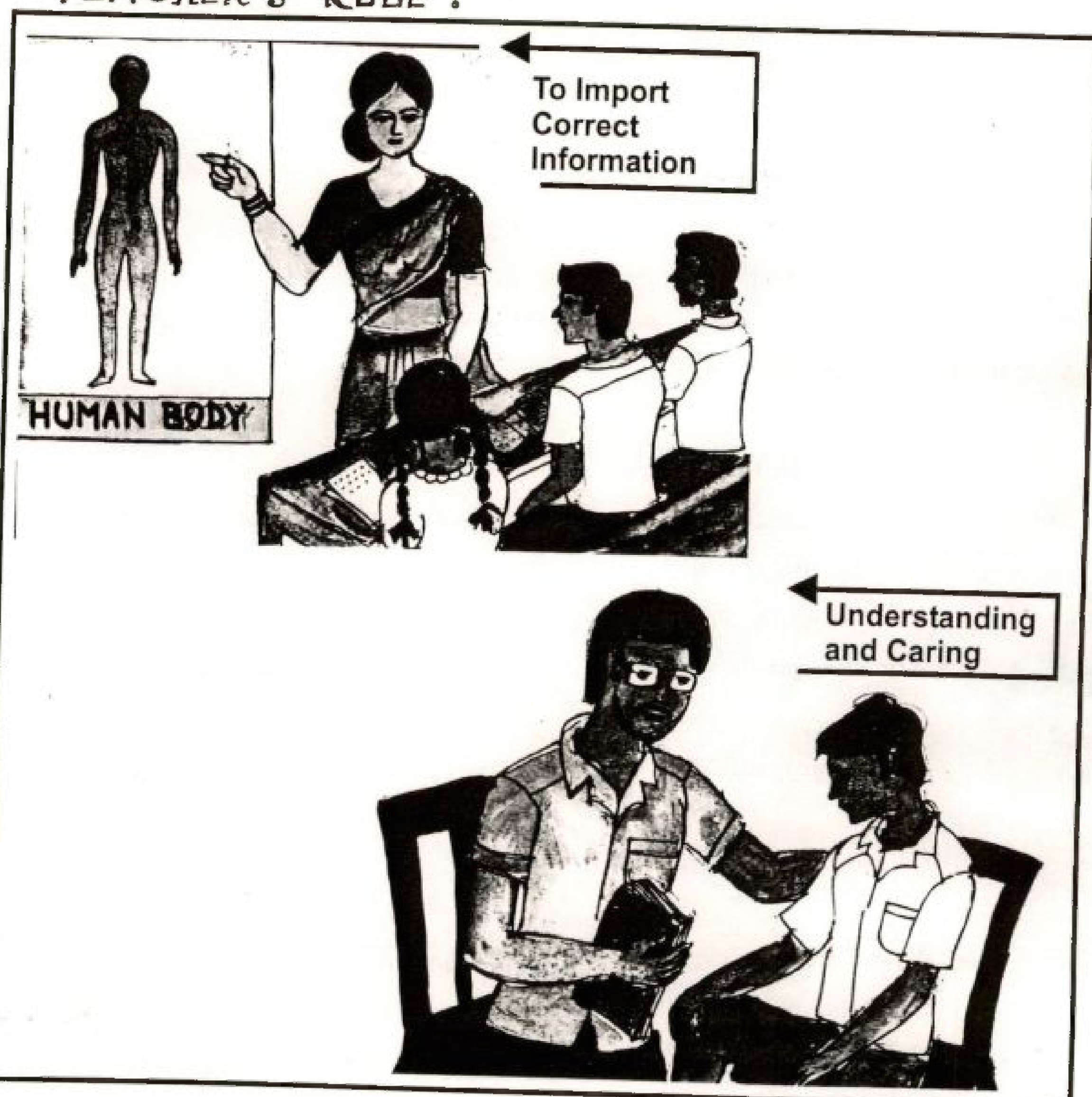


- Help in career options and encourage them to set goals and achieve goals.

- Inform detail of physical, psychological, emotional, social changes during adolescence. Try to share the problems, academic and personal, of students and guide them on how to handle their problems. Be careful in advising them and try not to make any judgment on their views and actions.

- Educate them about healthy life style and behavior.

TEACHER'S ROLE :



XI. Counseling

XI.I.What is counseling?

It is a process of assisting and guiding a person (client) by a trained person (Counselor) to solve personal, social or psychological problems and difficulties.
In counseling of adolescent health issues, an adolescent boy or girl is helped to make his/her own healthy decision that is appropriate to solve his/her problems and that suit him/her on the basis of correct information, feelings, situation and need through person to person (face to face) discussion .

XI.2.Attributes of a counselor:

The counselor has to make an effort to have an understanding, empathetic attitude and patience. The pupils need constant help, support and encouragement to express their feelings and the counselor need to be sensitive and observant to their needs. Counselor as a person should be:

- Friendly and respectful.
- An active listener- the counsellor indicates by words, expression & gesture that he understands what the adolescent is saying.
- Encouraging- The counsellor should encourage the expression of feeling.
- Knowledgeable – He should be able to give all information the students want.
- Good communicator – communication is the counsellor's **primary tool.**

Counselor in relation to his pupil should be:

- Understanding – The counsellor should be skilled in recognizing the various emotions the adolescent is expressing.
- Empathizing – Empathy is more than sympathy, it involves trying to place oneself in another situation.
- Patient
- Sensitive
- Observant

XI.3. Steps of counseling: The steps of counselling are-

G - Greet your pupil with a smile and in a friendly and respectful manner.

A - Ask the needs/problems.

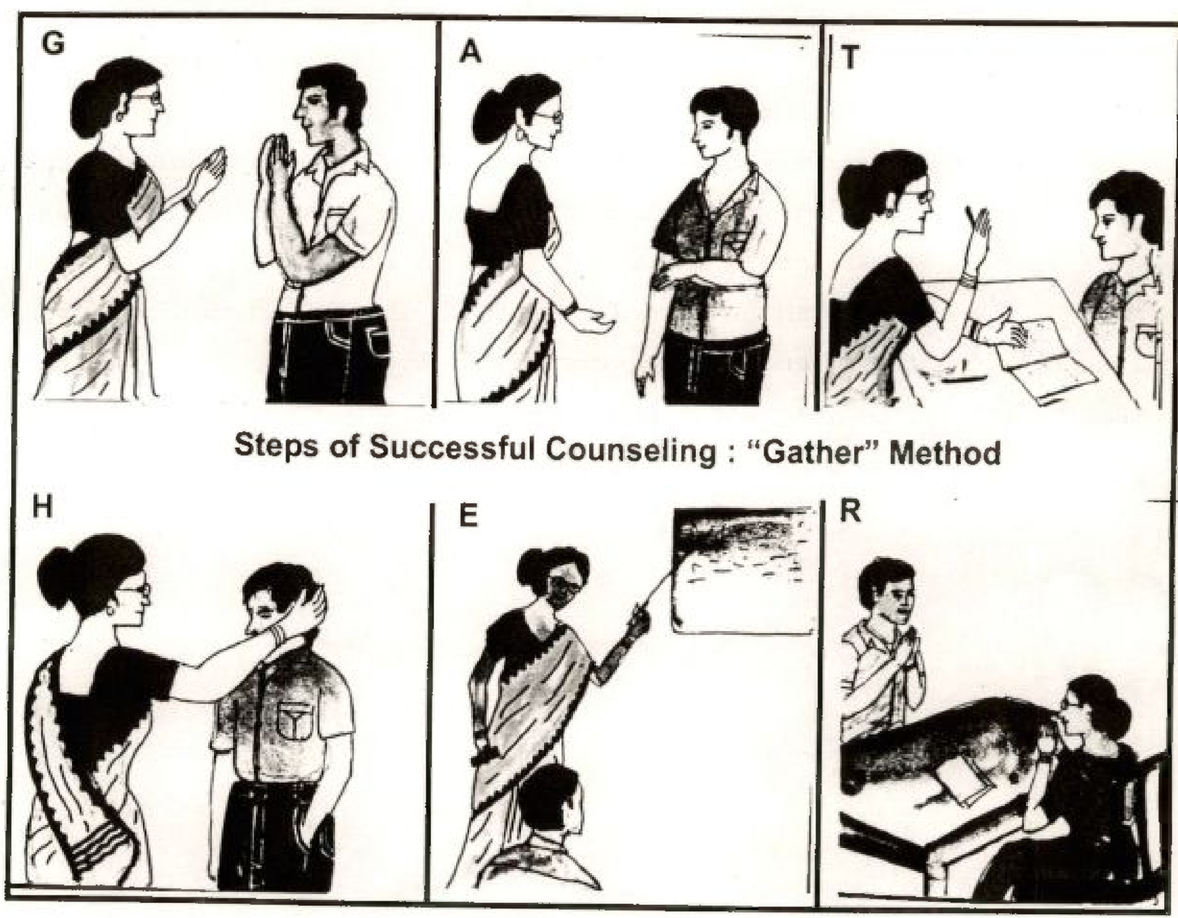
T - Tell about the available methods.

H - Help to make voluntary decision.

E - Explain the use of chosen method- how the client will carry out his/her own decision.

R - Return visit should be scheduled.

COUNSELING STEPS :



XI.4. Counseling techniques and skills:

- Active Listening Focus your attention on what the pupil is saying.
- Reflection of feeling Accept your pupil's ideas and feelings-be non-judgmental.
- Probing- To understand clearly your pupil's problems or worries.
- Paraphrasing It means restating what the speaker has said in your own words to correctly assess the pupil's needs and requirements.
- Summarizing- Listing out the main points of discussion.

XII. KEY POINTS:

- Adolescents need extra food as they are growing very fast. Iron rich foods like Green leafy vegetables, whole pulses, fish, meat, egg jaggery etc. should be given in adequate quantity and iodised salt should be used.
- They should be dealt with in a sympathetic and understanding manner to know their problems by the family members, teachers and other adults in the community as often they are under psychological stress.
- They should be encouraged to ask and given correct information about sexual behaviors and risks of unprotected sex like STDs, unwanted pregnancy, induced abortion etc.
- Adolescence may not have adequate information about consequences of experimenting with use of dangerous substances like drugs and alcohol, smoking, risky driving etc.
- A pregnant girl below the age of 18 years is 2-5 times more at risk of dying than pregnant women between 18-25 years.
- STDs are major causes of reproductive health complications and their sequelae including infertility.