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LANDSCAPE OF ADOLESCENT HEALTH IN INDIA

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Maternal and Child Survival Program

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The Maternal and Child Survival Program (MCSP) is a global, United States Agency for International Development (USAID) Cooperative Agreement to introduce and support high-impact health interventions with a focus on 27 high-priority countries with the ultimate goal to prevent child and maternal deaths. The Program is focused on ensuring that all women, newborns and children most in need, have equitable access to quality health care services to save lives. MCSP supports programming in maternal, newborn and child health, immunization, family planning and reproductive health, nutrition, health systems strengthening, water/sanitation/hygiene, malaria, prevention of mother-to-child transmission of HIV, and pediatric HIV care and treatment. Visit www.mcsprogram.org to learn more.

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Executive Summary

Adolescents aged 10–19 years constitute about one-fifth of India's population. This large cohort holds great potential to contribute to India's economic growth and development. But to realize this potential, adolescents must be healthy, educated, and equipped with the information literacy skills and confidence to contribute to their communities and India's socioeconomic growth.

The Government of India (GoI) has made a concerted effort to address the needs of young people through programs and policies directed specifically at them. In 2014, adolescent health programming in India got a much-needed fillip with the government-led Rashtriya Kishor Swasthya Karyakram (RKSK) —an initiative aimed at providing health information and services to all adolescents (10–19 years) in and out of school, married or unmarried, and within vulnerable groups. RKSK brought all adolescent-targeted interventions in the Indian health system under one umbrella, including the Adolescent-Friendly Health Clinics, Menstrual Hygiene Scheme, and Weekly Iron and Folic Acid Supplementation (WIFS) Programme.

RKSK is different from traditional adolescent health programs because it expanded the scope of adolescent health programming beyond sexual and reproductive health (SRH) to include nutrition, mental health, injuries and violence including gender-based violence (GBV), substance misuse, non-communicable diseases, and school health. The RKSK program strategy encompasses community-based outreach, communication for information and behavior change, adolescent-friendly health services, and school-based outreach through the School Health Programme.

The Maternal and Child Survival Program (MCSP), funded by the US Agency for International Development, supported the Adolescent Health Division of India's Ministry of Health and Family Welfare in rolling out the 2018 revised RKSK strategies, specifically the School Health Programme component. At the start of the School Health Programme, MCSP led an in-depth landscape analysis to better understand the key stakeholders and environment for adolescent health in India. This report details key results from the analysis and provides an overview of:

- The health profile of adolescents in India
- Key themes in adolescent health
- Various laws, policies, and programs aimed at securing adolescent health and development
- Existing interventions and support from non-GoI actors
- How mass and digital media are being leveraged to reach out to adolescents
- Innovative initiatives in adolescent health and development that are seen as models to strengthen, support, or inform adolescent health interventions
- Challenges and solutions in achieving convergence across GoI for RKSK

It concludes by highlighting key lessons on planning and implementation and providing recommendations on how to address those lessons.

This report is intended as a reference for informing the formulation and implementation of adolescent health interventions. It should be useful to any stakeholder working in adolescent health and development, including:

- Program planners and managers
- Ministry of Health and Family Welfare
- Jhpiego
- Other government and nongovernment stakeholders

Health profile of adolescents in India

India has the largest adolescent cohort in the world and the health of these 253 million adolescents will decide India's future pathway. Investment in their health and well-being will be an indicator of the nation's health. A large adolescent population is indicative of the fact that India's child survival programs are reaping dividends. Except for a few pockets in the country, fertility rates (2.33) are also stabilizing.1

Data show that two-thirds of adult mortality is attributable to non-communicable conditions originating in habits formed during adolescence. This makes a case for investing in adolescents while it is possible to influence their thinking and attitude formation. As a Lancet commission on adolescent health put it, "adolescence is characterised by dynamic brain development in which the interaction with the social environment shapes the capabilities an individual takes forward into adult life."

Child Marriage, Teenage Pregnancy, and Contraception

While child marriage and teenage pregnancy are declining in India, there are hotspots in the country that continue to have high rates of both. Special attention is needed in 12 states and union territories (UTs) with child marriage rates above the national average:

- West Bengal (25.6%)
- Tripura (21.6%)
- Bihar (19.7%)
- Jharkhand (17.8%)
- Dadra and Nagar Haveli (17.5%)
- Assam (16.7%)
- Andhra Pradesh (16.6%)
- Rajasthan (16.2%)
- Gujarat (13.1%)
- Telangana (12.9%)
- Maharashtra (12.1%)
- Arunachal Pradesh (12.1%)

An analysis of the fourth National Family Health Survey (NFHS-4) shows that among 15- to 19-year-old married girls in India, 31.5% have babies. The following states and UTs still have relatively high prevalence of early childbearing: West Bengal, Tripura, Dadra and Nagar Haveli, Arunachal Pradesh, Telangana, Andhra Pradesh, Jharkhand, Bihar, and Assam. Also among 15- to 19-year-old married girls in India, there has been a marked decline in rates of modern contraceptive use: from 10% in NFHS-3 to 6.9% in NFHS-4, 10 years later. Further, there has been an increase in unmet need for spacing methods among this group.

These numbers show that while RKSK might seek to address other emerging issues like GBV, non-communicable conditions, and mental health, there is a continued need to address SRH issues in a focused manner, especially with married adolescents.

Menstrual Protection

According to NFHS-4, nearly 58% of 15- to 19-year-old girls who had ever menstruated were using hygienic methods of protection (locally prepared napkins, sanitary napkins, and tampons) during their menstrual periods. But sociocultural taboos and lack of access to quality products and basic sanitation facilities to manage periods continue to get in the way of menstrual hygiene management in the country. MHM is addressed by various ministries in the country and requires a strong advocacy effort for all the stakeholders to synergize their efforts for convergent action.

Nutritional Status

Between NFHS-3 and NFHS-4, national levels of anemia prevalence in 15- to 19-year-old boys and girls declined very slightly, from 30.2% to 29.1% in boys and from 55.8% to 54% in girls. Thus, prevalence of anemia remains very high. As per NFHS-4, 10 states/UTs had especially high rates of anemia among girls aged 15–19 years—ranging between 60% and 82%. These include Daman and Diu, Lakshadweep, Bihar, Andhra Pradesh, West Bengal, Haryana, Jharkhand, Andaman and Nicobar Islands, Chandigarh, and Dadra and Nagar Haveli. The GoI has shown its commitment to fighting anemia through the Anemia Mukt Bharat Programme, but here again, the various ministries—including Ministry of Human Resource Development and Ministry of Women and Child Development (MoWCD)—must converge their efforts to push the coverage and reach of the WIFS Programme.

Also between NFHS-3 and NFHS-4, the percentages of boys and girls who were thin have moderately declined. However, prevalence of overweight/obesity among boys and girls has increased around twofold.

Experience of Violence

Sexual violence from spouses considerably declined between NFHS-3 and NFHS-4, from 33.9% to 23.6%. Nevertheless, the current prevalence is still very high. RKSK and other stakeholders in adolescent health must make a special effort to engage boys meaningfully and help them:

- Realize their role in GBV
- Break norms that perpetuate gender inequality and GBV
- Take steps to free their families, homes, and communities of discrimination and violence

Substance Use

Levels of use of any kind of tobacco, cigarettes or bidis specifically, and alcohol among 15- to 19-year-old adolescents all declined moderately to significantly between NFHS-3 and NFHS-4. NFHS-3 and NFHS-4 also reported very low levels of use of these substances among girls as compared with boys. Furthermore, findings from the two Global Adult Tobacco Surveys conducted in 2009–2010 and 2016–2017 , are consistent with NFHS findings regarding decline in prevalence of tobacco use among young people. The preventive aspects of substance use are included in RKSK, but RKSK must also link with other programs to target risk factors at the family level and educate parents in schools and communities.

Policy, Program, and Legal Environment

To promote adolescents' overall development and well-being and protect their rights, India has enacted several laws and formulated numerous policies and programs addressing:

- Health
- Nutrition
- Education
- Life skills and skill development
- Child marriage
  Age of consent
- Child rights and protection
- Child labor
- Protection of children online

- Women's empowerment and gender equity
- Youth affairs and empowerment
- Substance misuse

Though many of these are well formulated, they are often inadequately enforced or implemented for various reasons including lack of awareness. Policymakers and other stakeholders developing adolescent health interventions need to be cognizant of the relevant laws, policies, and programs when planning interventions.

Research, monitoring, and evaluation are needed to better understand the factors that prevent adolescents and their communities from taking legal recourse and accessing or utilizing programs and services meant for their development and well-being.

Existing Efforts and Support

The India programs of United Nations agencies—specifically those of UNICEF, UNFPA (the United Nations Population Fund), and World Health Organization—include a significant focus on adolescent health. These multilateral organizations extend support to the GoI and state governments to implement RKSK. They pilot models for scale-up, such as:

- The UNFPA-supported nongovernmental organization (NGO) model of implementing RKSK in Madhya Pradesh
- UNICEF's Ankuran project in Bihar for fighting anemia
- World Health Organization's efforts to provide quality adolescent-friendly health services through guidelines and research

NGOs and other bilateral organizations—supported by governments, corporations, multilateral organizations, and other donors—are contributing to all stages of the research cycle, fostering the relevance and effectiveness of the research, setting priorities, and translating knowledge to action. There are several NGOs working on adolescent health and development in India. Their programs span multiple themes, not only addressing health issues but also building and promoting empowerment. NGOs also work in collaboration with and within the framework of government programs to foster replication and scale-up. Many NGOs creatively use mass and digital media to influence sociocultural attitudes that impact adolescent health.

A number of donor agencies support initiatives for adolescents in India by partnering with governmental and nongovernmental agencies, philanthropies, and businesses, among others. Donor agencies fund programs in several areas, including sexual and reproductive health and rights, nutrition, prevention of violence, promoting retention in schools, building agency, and increasing employment opportunities.

Several private- and public-sector companies support initiatives for adolescent health and well-being, primarily through their corporate social responsibility programs and often in partnership with NGOs. These companies' interventions focus on various areas—including sexual and reproductive health and rights, nutrition, life skills and empowerment, and improving employability—and are implemented through various platforms, including schools, NGOs, communities, and families. Corporate social responsibility initiatives range from very small-scale to larger-scale ones that are implemented in multiple states.

Multilateral organizations, NGOs, donors, and corporations can support RKSK implementation by aligning their priorities with those of the government and sharing a framework with clear roles for all stakeholders. MCSP can play a crucial role within RKSK, developing and getting stakeholders on a framework for convergent action on adolescent health in India by:

- Providing technical support at state and district levels
- Collaborating with government at national, state, and district levels to train government health staff
- Mainstreaming RKSK themes into stakeholders' own programs for adolescents and youth
- Promoting RKSK and connecting adolescents to RKSK services through any media-based projects that stakeholders implement

Leveraging Mass and Digital Media to Reach Adolescents

One of the key components of the RKSK strategy is to effectively communicate with and on behalf of adolescents, using a 360-degree approach to social and behavior change communication.
Effective communication uses multiple media platforms to expand its reach and enhance its impact. In India, a wide variety of media platforms and formats are used in communication interventions that have been found effective in reaching out to adolescents and their communities. A few such interventions are highlighted in the landscape analysis:

- Transmedia edutainment initiative AdhaFULL by BBC Media Action
- Edutainment serial Main Kuch Bhi Kar Sakti Hoon by Population Foundation of India
- Digital technology–based YouthLIFE program by Centre for Catalyzing Change
- Saathiya Salah mobile app for adolescents by UNFPA

While there has been substantial experience with use of mass media, there is still little consensus about the most effective strategies for using digital media to reach adolescents. New media including social media and digital technologies are very promising, more so with the rapid growth in mobile phone use. The rapid growth in mobile use and internet access provides a huge opportunity to use digital media/ information and communications technologies for health communication.

However, it is important that media strategies be strongly anchored in evidence regarding what works with adolescents. More research is needed to enhance understanding of how various media platforms influence adolescents in their transition to a secure and healthy adulthood. Agencies that design communication interventions need to track the reach of the various media in different geographies and among different target audiences and adjust their planning accordingly.

Innovative Initiatives in Adolescent Health

The landscape analysis identified certain innovative initiatives in adolescent health and development that have been implemented in diverse settings and contexts. Initiatives showcased include:

- Udaan, Adolescence Education Program, a public-private partnership in Jharkhand with technical assistance from Centre for Catalyzing Change, highlights convergence-based intervention at scale
- The UNICEF-supported initiative in Uttar Pradesh for scaling up and strengthening the WIFS Programme shows the criticality of logistics and supply chain management
- Pathfinder International's Sashakt project to reach adolescents and youth in the extremely marginalized Mahadalit communities in Bihar highlights the need to work with hard-to-reach populations
- CorStone's program in Bihar to empower marginalized adolescent girls and build personal resilience is a case in point for mental health programming

These are useful models that can be drawn upon and adapted to strengthen, support, or inform adolescent health interventions. Existing initiatives also provide several useful lessons that point to factors crucial to the success of adolescent health interventions, especially when seeking to scale initiatives, such as:

- Clear policy commitment by government backed by adequate funding
- Sustained technical support
- Well-functioning logistics and supply chain management, especially in programs for which supply of commodities is critical
- Commitment to constant improvement through process monitoring and evaluation

NGOs and government can successfully work together to develop and implement innovative programs at scale.

Challenges and Way Forward

Convergence for RKSK

A 2016 GoI review of RKSK observed that coordination between the Ministry of Health and Welfare, MoWCD, and Departments of Education had been a challenge and needed to be effectively addressed, for example in the WIFS Programme. Interdepartmental convergence at state and district levels is often inadequate; among other problems, coordination meetings are not held regularly. The absence of a formal coordination mechanism and clear lines of responsibility and reporting further compound the challenges. Patchy implementation of different RKSK components in sub-districts impedes a holistic understanding of how the components should work synergistically to optimize benefits for adolescents.

Recognizing that its strategy cannot be addressed by the health sector alone, RKSK has established a framework for implementing program interventions through convergent efforts both within and between departments. Important stakeholder ministries include MoWCD, Ministry of Human Resource Development, Ministry of Youth Affairs and Sports, and Ministry of Drinking Water and Sanitation.

Adolescent Health Interventions

Despite the evidence underlying certain adolescent health interventions, there are often serious inadequacies in the way programs are planned or implemented, thereby compromising their effectiveness. Table ES-1 highlights the four inadequacies the landscape analysis found especially relevant to the Indian context.

Table ES-1. Problems and possible solutions in India adolescent health programming

	Problem	Solutions to consider
Design	Interventions are often poorly implemented, for example: • Lacking fidelity to critical elements that make the intervention effective in the first place • Picking and choosing from a few approaches rather than implementing one as a whole	• Review the evidence base for proposed interventions and ensure that critical ingredients/success factors are incorporated into program design • Use strong program monitoring mechanisms and process documentation to track fidelity and facilitate course corrections mid-implementation

Reach	• Many adolescents are not being reached as intended by program planners, especially adolescents:
	  • With the most pressing health/SRH needs (like married adolescents)
	  • Who are most marginalized or vulnerable
	• Among the vulnerable groups, two very large groups that are neglected and hard to reach are:
	  • Married adolescent girls
	  • Very young adolescents
		Take specific measures to identify and ensure the inclusion of the most vulnerable, for instance, by:
		• Caste
		• Household Poverty
		• Sex
		• Marital Status

Convergence	Interventions have limited effects because they are delivered piecemeal by various actors, instead of in coordinated and complementary fashion.	• All relevant agencies should be involved in creating comprehensive intervention strategies and a "whole systems" approach.
		• Use convergence plans and implementation mechanisms to ensure that programs:
		  • Are implemented in coordinated and complementary fashion
		  • Include all components of the RKSK strategy

Sustainability	Interventions have a limited or transient effect because they are delivered with inadequate "dosage," that is, intensiveness and/or duration.	Use process documentation and regular monitoring to help determine optimal "dosage" for various interventions.

Key Conclusions

- GoI should elevate RKSK's profile to be on par with programs such as nutrition and AIDS control.
- Convergent action is critical to the success of India's adolescent health programs:
  - Though the responsibility for adolescent health and well-being is shared across ministries, the convergence effort must be clearly anchored in the health departments, which should coordinate with partner departments and ministries to create a shared vision of all partners' contributions to achieving the larger goals.
  - MCSP's Technical Support Unit can play a crucial role in getting stakeholders on a common platform and developing a Convergent Action Framework for Adolescent Health in India within RKSK, for example by:
    - Using technical support to promote convergence.
    - Fostering convergent action across government agencies.
    - Aligning the priorities of multilateral organizations, donors, and civil society organizations with those of the government.
- RKSK implementation has to be contextualized and tailored for different situations:
  - NGOs have the flexibility to try out innovative approaches. NGOs and government can work together to successfully develop and scale up innovative programs.
  - Hotspots for high child marriage and high teenage pregnancy will require specific measures. It will be critical to work with married adolescents in these areas.
  - It is essential to work with boys in a focused manner to reduce GBV. This might require a special curriculum or communication methods specific to communicating with boys.
  - Strong linkages and networking are needed at the Adolescent-Friendly Health Clinics to address the emerging needs of mental health, GBV, and substance misuse.
- Use of technology to reach adolescents is critical, especially on issues which are uncomfortable for SRH gatekeepers to handle face to face.
- Research is needed to enhance understanding of how various media platforms can influence adolescents in their transition to a secure and healthy adulthood. It is important that media strategies be strongly anchored in evidence regarding what works with adolescents.

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1

Introduction

Evolution of adolescent health programming in India

Developments prior to 2014

The health needs of adolescents began receiving concerted attention from the Government of India (GoI) following the International Conference on Population and Development (ICPD) in 1994. The ICPD emphasized the need to focus on the reproductive health needs of adolescents as a distinct group. In pursuance of its commitment to the ICPD declaration, the Government of India initiated development of an Adolescent Reproductive and Sexual Health (ARSH) policy. The Reproductive and Child Health-I (RCH-I) Program (1998-2004) had limited focus on adolescents: it included a component on Adolescent Health Care and Family Life Education and envisaged promotion activities for adolescent health. The National AIDS Control Program II (NACP II) (1999-2006) had an increased focus on adolescent health. NACP II formulated the School AIDS Education Programme (SAEP) in the 9th and 11th grades at the national level and several states introduced it in their school systems.

The Reproductive and Child Health-II (RCH-II) Program gave much greater importance to adolescent health than RCH-I had. The goals of RCH-II were achieving reduction in Maternal and Infant Mortality and in Total Fertility Rate (TFR). The RCH-II Program included ARSH as one among its four components (in addition to Maternal Health, Child Health, and Family Planning) to reduce Maternal and Infant mortality and the Total Fertility Rate (TFR).

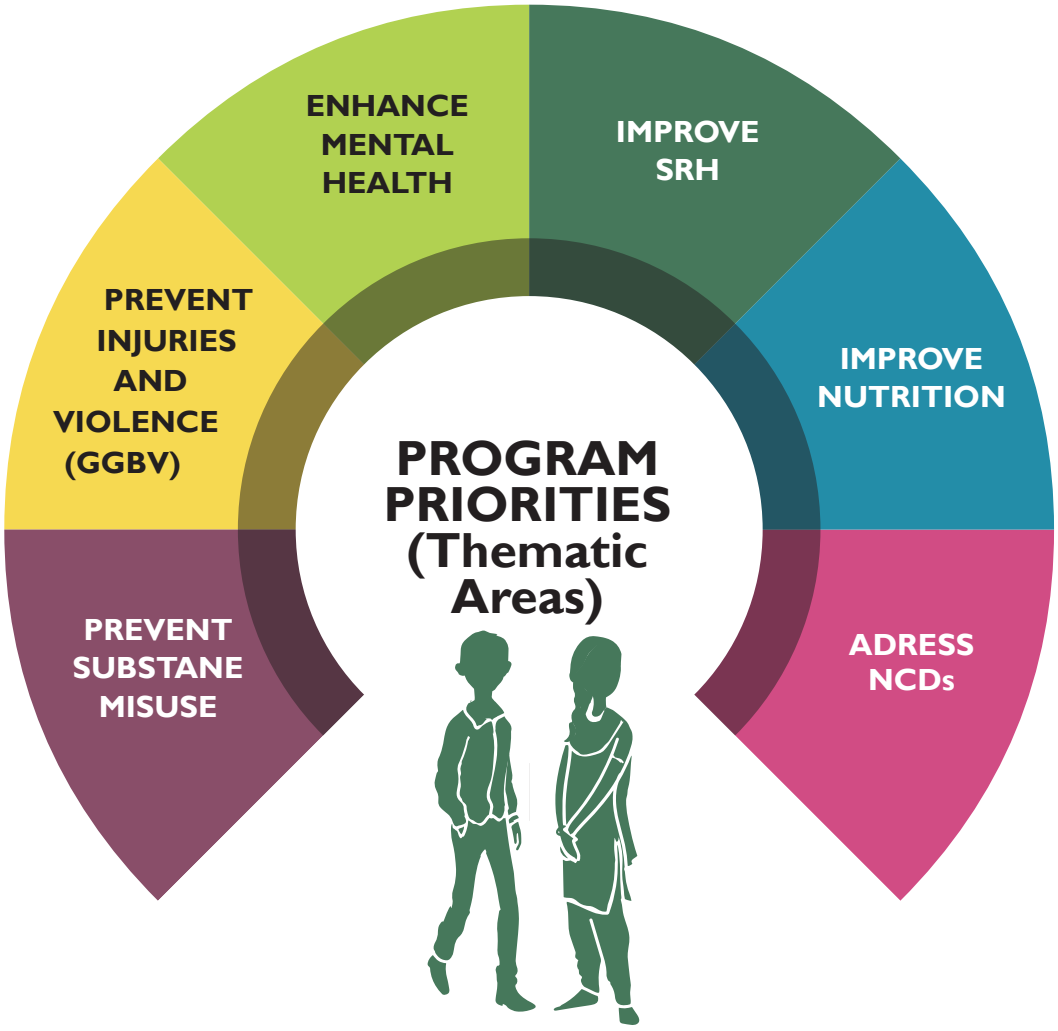
In 2005, under the National Rural Health Mission (NRHM), GoI approved a national strategy for ARSH as a component of RCH-II. Various states included this national strategy as a part of their State and District RCH-II plans after suitably adapting it. Steps were taken to ensure improved service delivery to adolescents during routine check-ups at Sub Centre (SC) clinics and to ensure service availability on fixed days and timings at the Primary Health Centre (PHC) and Community Health Centre (CHC) levels. A core package of services including preventive, promotive, curative and counselling services were provided for adolescents. The Reproductive, Maternal, Neonatal, Child and Adolescent

Health (RMNCH+A) strategy, which was launched under the NRHM in 2013, had an emphasis on strengthening synergies amongst program components and establishing a 'continuum of care' approach. The RMNCH+A included adolescence as a distinct 'life stage' in the overall strategy. Priority interventions for adolescents included: community-based services through peer educators, delaying age at marriage, strengthening ARSH clinics, Weekly Iron and Folic Acid Supplementation (WIFS), and promotion of Menstrual hygiene.

Thus far, the ARSH component had remained focused mainly on female sexual and reproductive health. Recognizing this, as also the growing evidence that it is during adolescence that minds can be influenced positively, and attitudes and behavior modified for the better, the central Ministry of Health and Family Welfare (MoHFW) developed a new adolescent health strategy to strengthen and complement the adolescent component of RMNCH+A. This strategy planning process culminated in the formulation of Rashtriya Kishor Swasthya Karyakaram (RKSK) which was launched on 7th January 2014.

Rashtriya Kishor Swasthya Karyakram (RKSK)

The Rashtriya Kishor Swasthya Karyakram (RKSK), which was launched by Government of India in 2014, targets adolescents in the age groups 10–14 years and 15–19 years. **The RKSK strategy signals a paradigm shift in the approach to adolescent health, substantially expanding its scope beyond Sexual and Reproductive Health (SRH) to also include nutrition, mental health, injuries and violence including Gender-Based Violence (GBV), substance misuse, and Non-Communicable Diseases (NCDs)**.



The program aims to ensure universal coverage with health information and services for all adolescents—those in and out of school, married or unmarried, and vulnerable groups. The RKSK strategy is based on a continuum of care approach for adolescent health through provision of information, commodities and services at the community level and linking adolescents to the public health system through referrals. **The distinctive feature of this strategy is that it goes beyond the existing facility-based approach and adopts a health promotion approach.** The program's interventions and approaches work at building protective factors that can help young people develop 'resilience', to resist negative behavior and operate in four major areas: the individual, family, school and community by providing a comprehensive package of information, commodities and services.

To bring about the paradigm shift that characterizes the program, the RKSK strategy identifies seven critical components (7Cs) that need to be ensured across all program areas. These components are: coverage, content, communities, clinics (health facilities), counselling, communication and convergence.

The key elements of the program strategy include community-based outreach through Peer Educators (PEs) and counsellors, communication for information and behavior change and Adolescent Friendly Health Clinics (AFHCs):

A. Community-based interventions

- Peer Education (PE)
- Quarterly Adolescent Health Day (AHD)
- Weekly Iron Folic Acid Supplementation Programme (WIFS)
- Menstrual Hygiene Scheme (MHS)

B. Facility-based interventions
Strengthening of Adolescent Friendly Health Clinics (AFHC)

C. Convergence with relevant schemes of the Ministry of Health & Family Welfare and of other ministries

D. Social and behavior change communication with focus on inter personal communication

The main interventions under RKSK are depicted below:

Rationale for the study

Jhpiego is an international, non-profit health organization affiliated with The Johns Hopkins University. Jhpiego uses its global presence and technical leadership to develop technology-based innovations and systems for significant global health impact. In India, Jhpiego works across several states - in close collaboration with national and state governments, providing technical assistance in the areas of family planning, maternal and child health, and pre-service nursing midwifery education.

Through the United States Agency for International Development (USAID) supported Maternal and Child Survival Program (MCSP), Jhpiego is providing technical assistance to meet the emerging needs of the Rashtriya Kishor Swasthya Karyakram (RKSK) (Adolescent Health Program) of Government of India (GoI) through a Technical Support Unit (TSU) that works in close coordination with Adolescent Health (AH) division of Ministry of Health and Family Welfare (MoHFW), GoI.

Considering the evolving nature of the field of adolescent health across the world, and the diverse themes that it encompasses, Jhpiego felt the need for a resource document and ready reference to support the work of the Jhpiego-TSU(AH) and MoHFW.

While there do exist several studies and resources on adolescent health in India, most of these focus on certain selected components or aspects. Further, both in India and globally, studies have focused more on sexual and reproductive health than on the other components of adolescent health. This fragmented nature of the knowledge base is an impediment to gaining an understanding of the inter-connected and synergistic operation of the different determinants and components of adolescent health, an understanding that is vital for fvormulating and implementing effective interventions.

It is to address this gap that Jhpiego commissioned a landscape study of adolescent health in India covering various topics of relevance to adolescent health. This document is the outcome of the landscape study.

Scope of the landscape document

This document is intended as a resource base to which planners and program managers may refer to inform the formulation, implementation and strengthening of adolescent health interventions. It is envisaged that it would be useful not only to MoHFW but also to other government and non-government stakeholders whose mandate includes adolescent health and development.

This landscape document:

- Provides an overview of the health profile of adolescents in India
- Provides an overview of the laws, policies and programs aimed at securing adolescent health and development
- Outlines adolescent-focused interventions of NGOs, autonomous institutions, multilateral organizations, donors and corporates
- Discusses certain innovative initiatives in adolescent health and development that could serve as models to strengthen, support or inform adolescent health interventions
- Discusses how mass and digital media are being leveraged for reaching out to adolescents
- Provides an overview of the convergence plans of RKSK, discusses challenges in achieving convergence and suggests ways to address the challenges
- Adolescent-focused interventions: evidence and recommendations for programming and research
- Concludes with a summary of key findings and broad suggestions for the way forward

The coverage of the above topics is not exhaustive but is intended to serve as an adequate base to inform planning and programming. Each chapter covers a distinct theme. This is a working document which in future can be augmented and updated based on new developments and the expanding research base.

Methodology

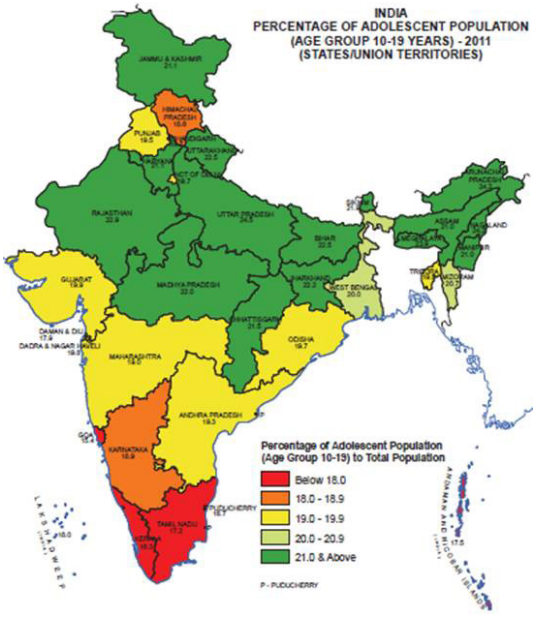
The following activities were carried out as part of the landscape study process:

- Extensive and in-depth desk review of documents and other material on the topics of interest. While some documents were made available by stakeholders, the majority were sourced through online research.
- Discussions with various stakeholders including central government departments, United Nations agencies and NGOs.
- Field visits to Uttarakhand and Madhya Pradesh to review the adolescent health program in the two states. Discussions were held with various stakeholders from among government agencies, NGOs and the community in these states.
- Analysis and synthesis of findings from the desk review, discussions with stakeholders and observations made in the field.

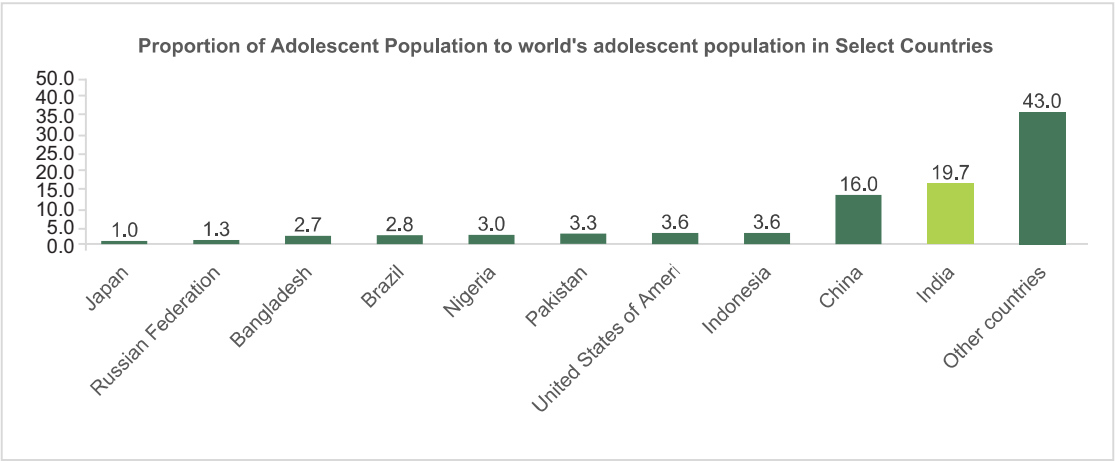
2

Situation of Adolescent Health in India

Situation of Adolescent Health in India



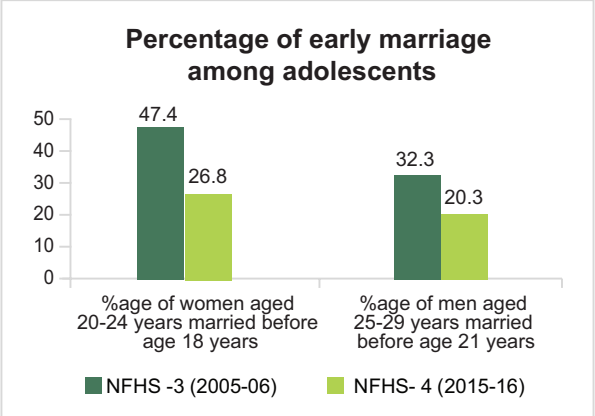
India's Adolescent Population to world's adolescent population is the highest in the planet. Moreover, Adolescents constitute a sizeable portion of the India's population—about 21% (Census 2011). A vast majority of India's 253 million adolescents, around 71%, live in rural areas. In certain states/UTs, adolescents account for a significantly larger share of the total state/UT population than their share (21%) at the national level. Adolescents' share in the total population of the following states/UTs ranges between 23% and 24%: Uttar Pradesh, Meghalaya, Nagaland, Arunachal Pradesh, Rajasthan and Uttarakhand. Notably, most of these states/UTs are in the north and north-eastern parts of the country.



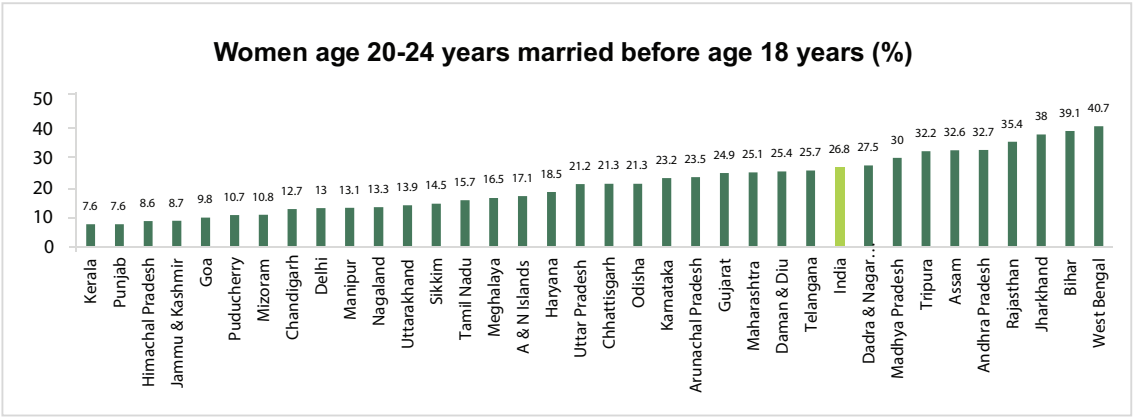
Source: World Population Prospects, The 2012 Revision, United Nations New York, 2013
Note: Selected countries are top ten populous countries in the World

Early marriage among adolescents

At the national level, there has been a substantial decline in rates of early marriage amongst both men and women between National Family Health Survey – 3 (NFHS-3) (2005-06) and National Family Health Survey – 4 (NFHS-4) (2015-16).

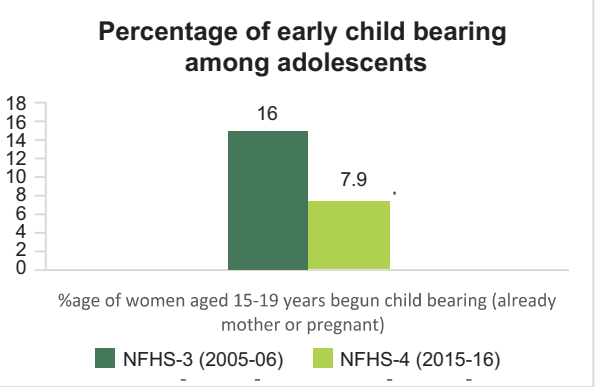


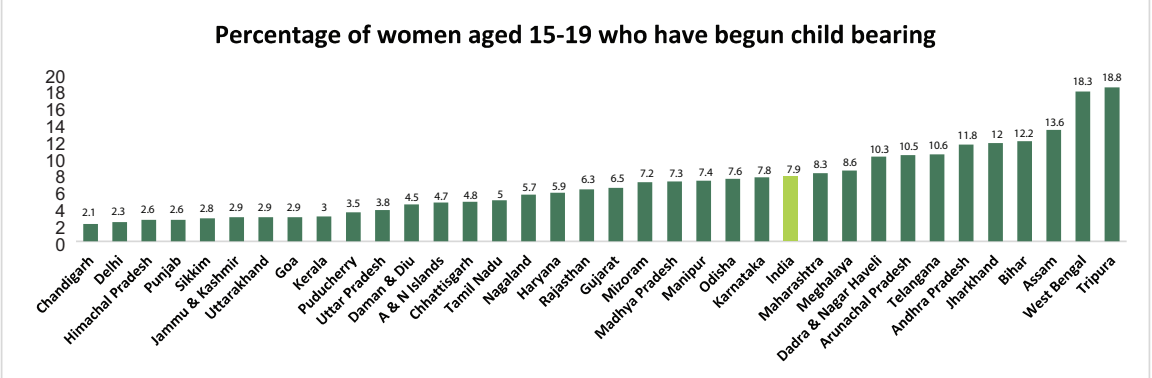
However, NFHS-4 data shows that eight out of the 36 states/UTs in the country still have especially high rates of early marriage (30%-41%) amongst women. These include Madhya Pradesh, Tripura, Assam, Andhra Pradesh, Rajasthan, Jharkhand, Bihar and West Bengal. On the other hand, five states/UTs have much lower rates of early marriage (below 10%): these include Kerala, Punjab, Himachal Pradesh, Jammu & Kashmir and Goa.



Child bearing among adolescents

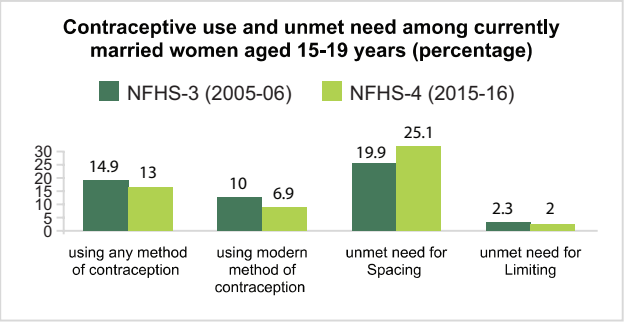
Almost 50% decline in rates of child bearing was seen among adolescent girls in the last decade. However, as the graph below shows, there are considerable inter-state variations. West Bengal and Tripura had especially high rates of early child bearing—over 18%.





Contraceptive use and unmet need for contraception

At the national level, there has been a significant decline, between NFHS-3 and NFHS-4, in percentage of currently married women aged 15-19 years who use modern methods of contraception. Further, there has been a significant increase in unmet need for spacing methods amongst this group.



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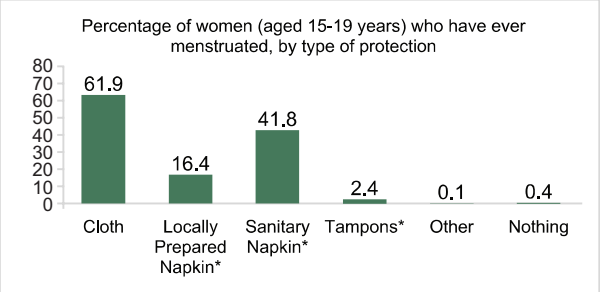
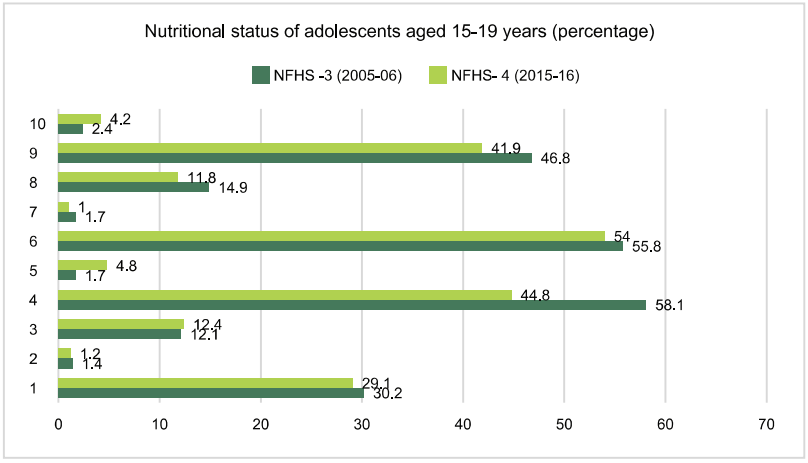
Menstrual Protection

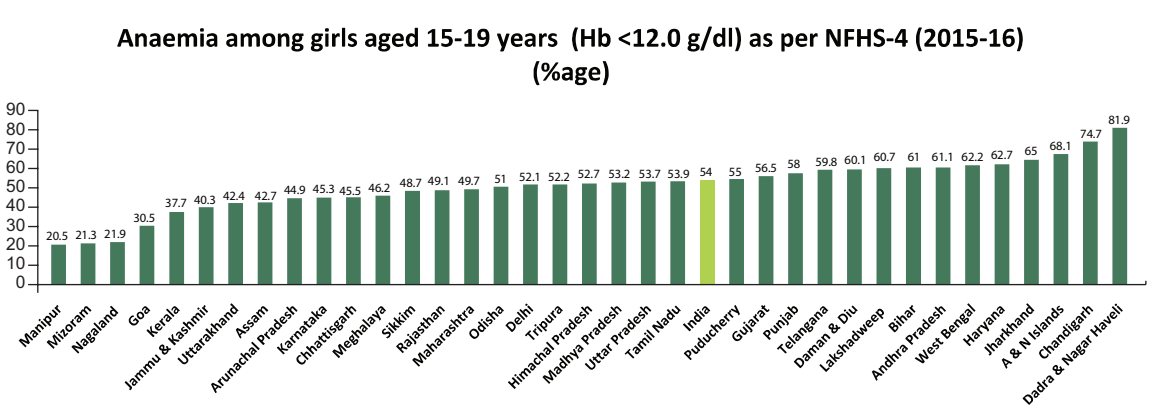
Various types of menstrual protection are used by women aged 15-19 years. NFHS-4 has considered locally prepared napkins, sanitary napkins, and tampons as hygienic methods of protection. By this consideration, 57.7% of women (aged 15-19 years) who have ever menstruated were using hygienic methods of protection during their menstrual periods.



Nutritional Status

Slight decline in prevalence of anaemia amongst both boys and girls aged 15-19 years. However, prevalence of anemia remains very high. There has been moderate decline, between the two surveys, in the percentages of both boys and girls who were thin. However, prevalence of overweight/obesity amongst both boys and girls has increased around twofold.



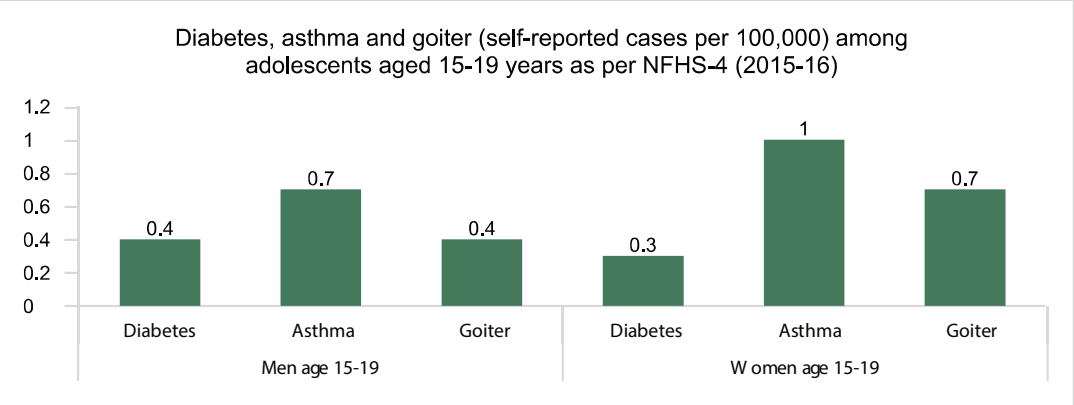


Anaemia in girls aged 15-19 years old as per NFHS-4

As per NFHS-4, at the national level, 54% of girls aged 15-19 years had anemia (Hb <12.0 g/dl). Ten states/UTs had especially high rates of anemia among girls aged 15-19 years—ranging between 60% and 82%. These include Daman & Diu, Lakshadweep, Bihar, Andhra Pradesh, West Bengal, Haryana, Jharkhand, Andaman & Nicobar Islands, Chandigarh and Dadra & Nagar Haveli. At the other end, the following four states/UTs had relatively low rates ranging between 20% and 31%: Manipur, Mizoram, Nagaland and Goa.

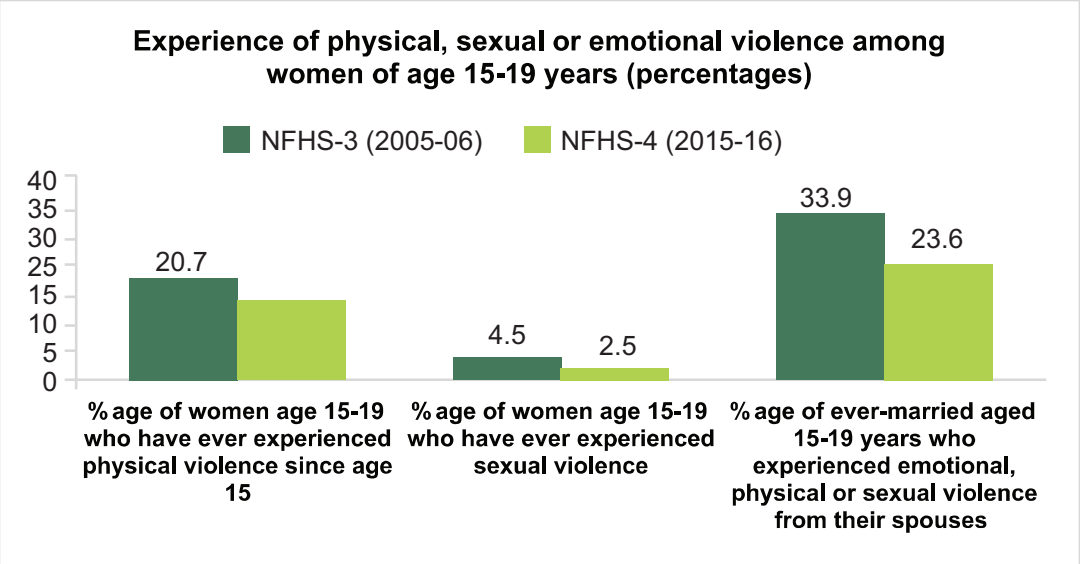
Non-Communicable diseases

Prevalence of self-reported cases of diabetes, asthma and goiter among adolescents aged 15-19 years old is low ranging between 0.3 and 1 case per 100,000 for the three diseases.



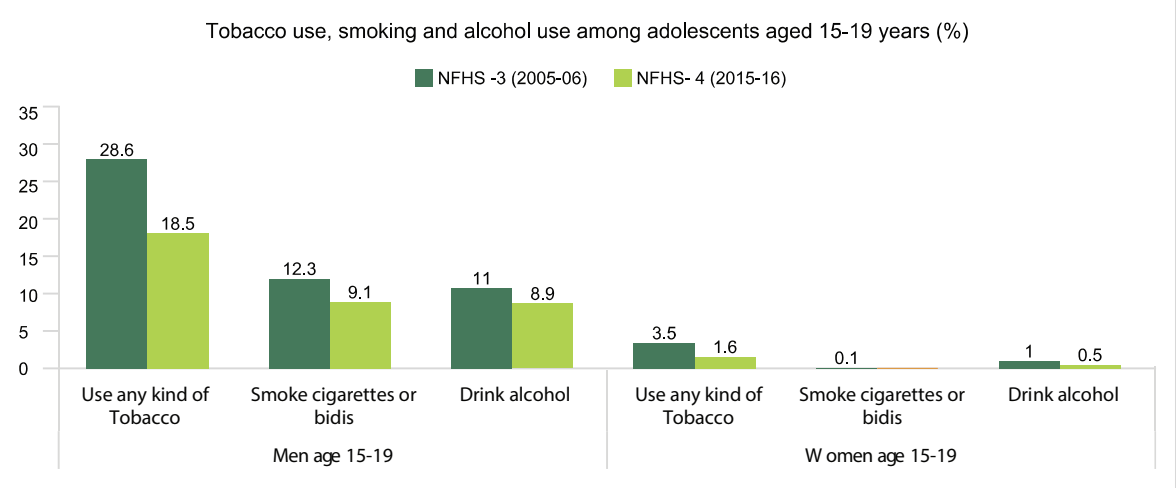
Experience of violence among adolescent girls

Between NFHS-3 and NFHS-4, at the national level there was moderate decline in the percentage of women of age 15-19 years who ever experienced physical violence since the age of 15 years. Further, there was significant decline in the percentage of women of age 15-19 years who ever experienced sexual violence. There was a significant decline too in the percentage of ever-married women of age 15-19 years who experienced emotional, physical or sexual violence from their spouses.



Substance use

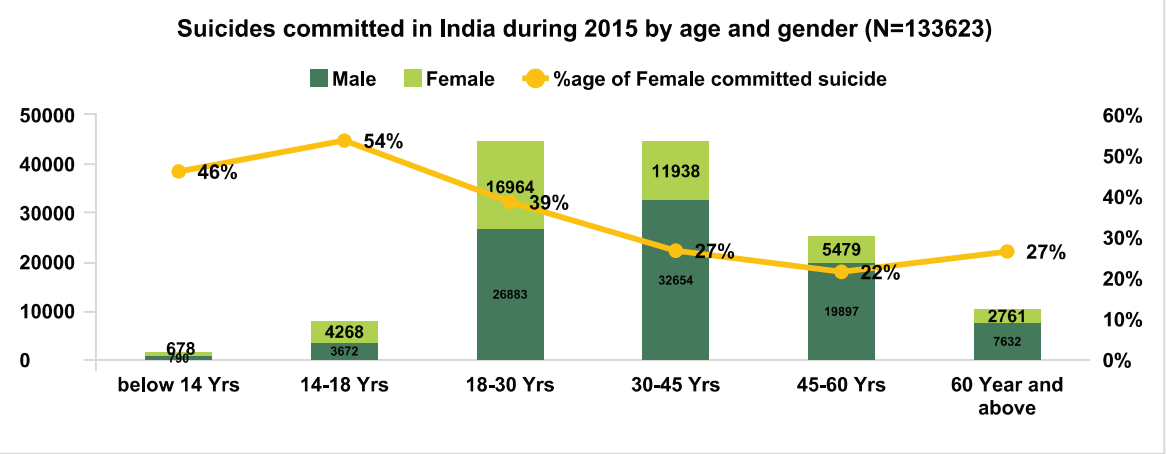
At the national level, the levels of use of any kind of tobacco, cigarettes or bidis specifically, and alcohol, among adolescents of age 15-19 years all registered moderate to significant declines between NFHS-3 and NFHS-4. Both surveys reported very low levels of use of these substances amongst girls as compared with boys.



Suicides amongst adolescents

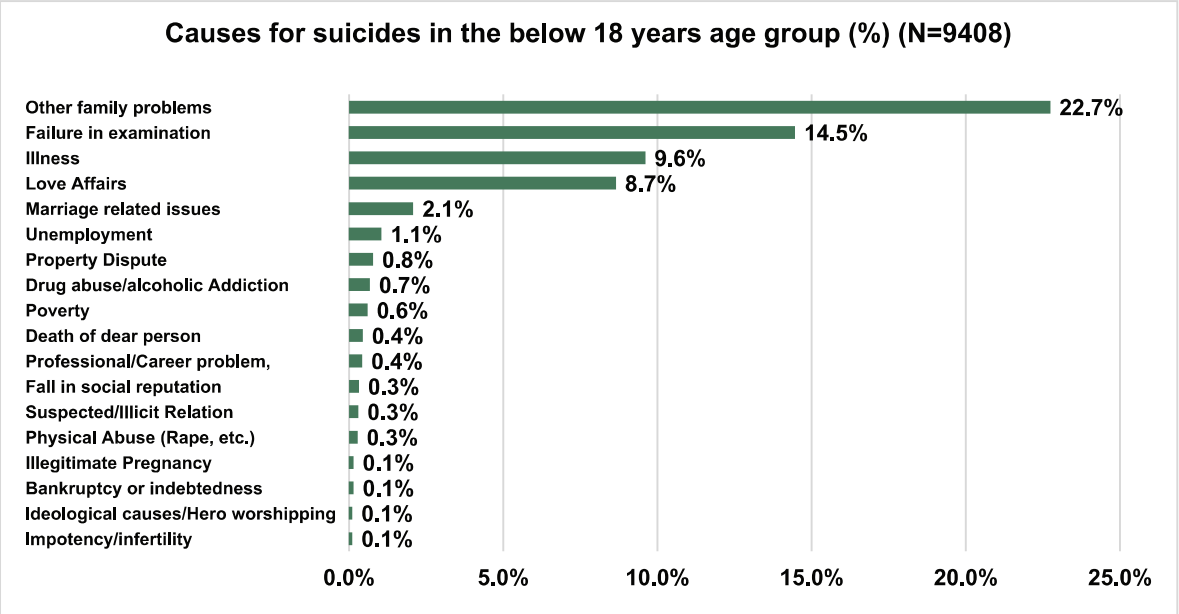
The total number of suicides during 2015 as recorded by National Crime Records Bureau, GoI was 1,33,623. There were substantially fewer cases of suicide amongst the below 18 years age groups as compared with the higher age groups. Notably however, there were significantly higher rates of female suicides in the below 18 years age groups compared with those in the higher age groups. While female suicides accounted for around half of total suicides in the under 18 years age groups, the ratio of female suicides to total suicides in the higher age groups was significantly lower (ranging between 22% and 39%). The overall male: female ratio of suicide victims for the year 2015 was 68:32. However, the proportion of boys: girls suicide victims (below 18 years of age) was 47:53.

boys: girls suicide victims (below 18 years of age) was 47:53



Causes for suicides in the below 18 years age group

Among the specified causes for suicides among the below 18 years age group, the main causes were 'Family Problems (other than marriage related issues)', 'Failure in Examination', 'Illness' and 'Love Affairs'.



3 Laws and Policies

Policies and Programmes

Ministries	Policy	Programs
Ministry of Health and Family Welfare	• National Health Policy 2017 • National AIDS Prevention and Control Policy 2002	• Rashtriya Kishor Swasthya Karyakram (RKSK) • Rashtriya Bal Swasthya Karyakram (RBSK) • Other national health programs that include adolescents among their target groups: Family Planning, Maternal Health, National AIDS Control Programme (NACP), National Tobacco Control Programme (NTCP), National Mental Health Programme, National Programme For Prevention and Control of Cancer, Diabetes, Cardiovascular Disease and Stroke (NPCDCS) and National Oral Health Programme (NOHP) • Anemia Mukt Bharat strategy (2018) (Intensified National Iron Plus Initiative (I-NIPI)) • National Deworming Day

Ministries	Policy	Programs
Ministry of Women and Child Development	• National Nutrition Strategy (2017) • National Nutrition Mission/ POSHAN Abhiyan (2018) • Draft National Policy for Women, 2017 • National Plan of Action for Children 2016	• Integrated Child Development Scheme (ICDS) • Rajiv Gandhi Scheme for Empowerment of Adolescent Girls (SABLA) • Scheme for Adolescent Girls (SAG) • Balika Samridhi Yojana (BSY) • Beti Bachao Beti Padhao (BBBP) Scheme (2015)
Ministry of Human Resource Development	• Draft National Education Policy 2016 • National Policy of Information and Communication Technology (ICT) in Schools, 2012	• Sarv Shiksha Abhiyan (SSA) launched in 2001 • Rashtriya Madhyamik Shiksha Abhiyan (RMSA) • National Programme for Girls' Education at the Elementary Level (NPEGEL) • Kasturba Gandhi Balika Vidyalaya (KGBV) • National Scheme of Incentive to Girls for Secondary Education • Adolescence Education Programme (AEP) • Mahila Samakhya program
Ministry of Drinking Water and Sanitation		• Swach Bharat: Swach Vidyalaya
Ministry of Youth Affairs and Sports (MoYAS)/ Department of Youth Affairs.	• National Youth Policy 2014	• National Programme for Youth and Adolescent Development (NPYAD) • Nehru Yuva Kendra Sangathan (NYKS)
Ministry of Electronics & Information Technology, Government of India	• National Cyber Security Policy, 2013	

Laws	
THEME	LAWS
Nutrition	• National Food Security Act 2013
Education, life skills and skill development	• Right of Children to Free and Compulsory Education (RTE) Act of 2010
Child marriage	• Prohibition of Child Marriage Act, 2006
Age of consent	• Indian Penal Code (IPC) (Section 375)
Child rights and protection, child labor	• Child and Adolescent Labour (Prohibition and Regulation) Act, 1986 • Factories Act, Mines Act, and Plantations Labour Act • Protection of Children from Sexual Offences Act, 2012 (POCSO) • Immoral Traffic (Prevention) Act, 1956 • Trafficking of Persons (Prevention, Protection and Rehabilitation) Bill 2017 • Child Labour Act 1986
Protection of children online	• Information Technology Act, 2000 • Protection of Children from Sexual Offences Act, 2012 (POCSO) • Indecent Representation of Women (Prohibition) Act, 1986
Women's empowerment and gender equity	• Prohibition of Child Marriage Act 2006 • Preconception and Pre-Natal Diagnostics Techniques (PC&PNDT) Act (1994) • Medical Termination of Pregnancy (MTP) Act of 1971 (and the 2002 amendments to the Act)
Substance abuse	• Cigarettes and Other Tobacco Products Act, 2003 (COTPA)

Rashtriya Kishor Swasthya Karyakram (Rksk)

4

Adolescents constitute about one fifth of India's population. This population has a great demographic dividend with the potential to contribute to India's economic growth and development. Adolescence is a time of transition from childhood to adulthood. The adolescent goes through rapid physical, physiological and psychosocial changes. It is a critical time of formative growth to achieve human potential. It is considered the healthiest phase in life and health of this age group is a key determinant of India's overall health, mortality, morbidity and population growth scenario. 70% of the mortality in adulthood is linked to habits picked up during adolescence. Many adolescents die prematurely due to various reasons that are either preventable or treatable and many more suffer from chronic ill health and disability. Therefore, there is a pressing need to influence health-seeking behavior of adolescents. The country data suggests that:

ABOUT RASHTRIYA KISHOR SWASTHYA KARYAKRAM (RKSK)

Adolescents have fewer needs than those in early childhood or adulthood and thus have attracted little interest and investment in global health policy. Adolescent often do not have the autonomy or the agency to make their own decision. RKSK takes cognizance of this and involves parents and community.

In response to the health and development needs of adolescents, Ministry of Health and Family Welfare (MoHFW) under National Health Mission (NHM) in 2014, launched the 'Rashtriya Kishor Swasthya Karyakram' (RKSK), a comprehensive programme to reach out to the adolescents in India.

Key principle of RKSK:
Adolescent participation, leadership, equity and inclusion, strategic partnerships with other sectors and stakeholders adopting a combination of prevention, health promotion and healthy development strategies across a continuum of care.

Vision
All adolescents in India are able to realize their full potential by making informed and responsible decisions related to their health and well-being

Improve Nutrition: Reduce prevalence of malnutrition and iron deficiency anemia

Enable Sexual and Reproductive Health: • Improve knowledge, attitude and behaviour in relation to SRH including Menstrual Hygiene • Reduce teenage pregnancies • Improve birth preparedness and complication rediness. Provide early parenting support for adolescent parents

Enhance Mental Health: Improved knowledge and skills on mental health issues of adolescents among the health care providers

Prevent injuries and violence: Promote favorable behavior and attitudes for preventing injuries and violence (including Gender-Based Violence-(GBV) among adolescents

Prevent Substance Abuse: Increase adolescents awareness of the adverse effects and consequences of substance misuse

Address non-communicable diseases: Promote behavior change in adolescents to prevent NCDs such as hypertension, stroke, cardio-vascular diseases and diabetes

KEY RKSK STRATEGIES/INTERVENTIONS

The strategy is a paradigm shift, and realigns the existing clinic-based curative approaches to focus on a more holistic model, It goes beyond traditional understanding of adolescent health, confined to sexual and reproductive health, to include important dimensions like mental health, nutrition, substance misuse, gender based violence and risk factors for non-communicable diseases. A continuum of care approach is adopted for adolescent health and development needs, where, apart from the facility based curative care, it emphasizes community and school-based health promotion and preventive care. It includes provision of information, commodities and referral linkages through the public health system.

Facility Based Approach

Adolescent Friendly Health Clinics (AFHCs) providing counselling and clinical services

Adolescent Health Resource Centre at District Hospital

Community Based Approach

Weekly Iron Folic Acid Supplementation (WIFS) Programme

Deworming during National Deworming Day (NDD)

Provision of sanitary napkins

Peer Educator (Saathiya) programme for out of school/ vulnerable adolescent groups

Quarterly Adolescent Health Day (AHD)

Adolescent Friendly Clubs (AFCs)

School Based Approach

Screening of Adolescents for 4 Ds (RBSK)

Weekly Iron Folic Acid 0Supplementation (WIFS) Programme

Deworming during National Deworming Day (NDD)

Provision of sanitary napkins

Peer Educator (Saathiya) programme

Health promotion and prevention activities

Overview of adolescent-focused interventions of NGOs, autonomous institutions, multilateral organizations, donors and corporates

5

Introduction

The number of agencies working on adolescent health in India is vast. There are several players including international and Indian NGOs, foundations and autonomous institutions, multilateral organizations, donors and corporates working in various sub-sectors of adolescent health and development.

Many NGOs implement multi-pronged programs spanning SRH, health promotion, developing gender egalitarian attitudes, addressing issues of violence including gender-based violence, building agency, leadership, and life skills. These agencies' interventions are funded by a variety of donors, including government, UN and bilateral donor agencies, and agencies from for-profit and non-profit sectors. Further, such programs are often implemented in partnership with one or more agencies, including some that provide technical support. Several NGO projects have been implemented in collaboration with and within the framework of government programs, with a view to foster replication and scale-up.[i] Many NGO projects have yielded valuable learning, and some have contributed to the design of current interventions.

Donor agencies and several corporates are among important stakeholders that contribute to the adolescent health and development sector in the country. Several private- and public-sector companies support various initiatives for adolescent health and wellbeing, primarily through their Corporate Social Responsibility (CSR) programs, often in partnership with NGOs. Corporates' interventions focus on various areas, including, among others, SRHR, nutrition, life skills and empowerment, and improving employability. The interventions are implemented through various platforms, including among others, schools, NGOs, communities and families. CSR initiatives range from very small-scale to larger-scale ones that are implemented in multiple states. The agencies' support for RKSK as well as for other interventions aimed at adolescent health and development shall be discussed in this chapter.

This chapter does a brief analysis of the work of selected agencies, focusing more on those that work with government. The purpose is to facilitate program managers seeking to with different partners in specific geographies and on specific themes.

For each of the selected agencies, this chapter highlights the following aspects:

- Geographic Coverage/ focus states
- Intervention Level/ Platform (government, schools, family, community, health systems)
- For NGOs: RKSK thematic areas in which the agency works (SRHR, nutrition, mental health, gender issues & violence, substance abuse, and non-communicable diseases)

Highlights of work of selected NGOs

Classified by geography, site and target audiences

Sl. No.	Name of organization	Website	Geographical coverage/ focus states	Intervention Level				Thematic Areas					
				Schools	Facility	Community (including families)	Govt	SRHR	Nutrition	NCDs	Substance Abuse	Mental Health	Gender Issues & Violence
1	Abt Associates	https://www.abtassociates.com/	Pan India				■	■					
2	Agents of Ishq	agentsofishq.com/en/	Pan India			■		■				■	■
3	Angan Trust	aanganindia.org/	Assam, West Bengal, Rajasthan, Odisha, Uttar Pradesh, Bihar, Maharashtra			■	■	■					■
4	Arpan	www.arpan.org.in/	Maharashtra	■		■						■	■
5	BBC Action Media	https://www.bbc.co.uk/mediaaction/where-we-work/asia/india	Northern states	■		■		■	■			■	■
6	Breakthrough	https://inbreakthrough.tv/	Bihar, Haryana, Jharkhand, Uttar Pradesh, Delhi	■		■	■						■
7	C3	www.c3india.org/	Bihar, Jharkhand, Delhi	■		■	■	■	■	■	■	■	■

Sl. No.	Name of organization	Website	Geographical coverage/ focus states	Intervention Level				Thematic Areas					
				Schools	Facility	Community (including families)	Govt	SRHR	Nutrition	NCDs	Substance Abuse	Mental Health	Gender Issues & Violence
8	CARE	https://www.care-india.org/	Rajasthan, Haryana, Delhi, Uttar Pradesh, Maharashtra, Madhya Pradesh, Chhattisgarh, West Bengal, Odisha, Jharkhand, Bihar										
9	Centre for Enquiry into Health and Allied Themes (CEHAT)	www.cehat.org/	Maharashtra										
10	CHETNA	chetnaindia.org/	Gujarat, Rajasthan										
11	CINI	www.cini-india.org/	Assam, Jharkhand, West Bengal										
12	Comprehensive Rural Health Project (CRHP), Jamkhed, Maharashtra	jamkhed.org/	Maharashtra										
13	CORO	coroindia.org/	Maharashtra										
14	Corstone	https://corstone.org/	Pan-India/ Bihar, Surat										
15	CREA	www.creaworld.org/	Bihar, Jharkhand, Uttar Pradesh										
16	Dasra	https://www.dasra.org/	Pan-India										
17	Ekjut	www.ekjutindia.org/	Jharkhand , Orissa										
18	Engender Health	https://www.engender-health.org/our-countries/asia-near-east/india/	Pan-India/ Jharkhand, Bihar										

Sl. No.	Name of organization	Website	Geographical coverage/ focus states	Intervention Level				Thematic Areas					
				Schools	Facility	Community (including families)	Govt	SRHR	Nutrition	NCDs	Substance Abuse	Mental Health	Gender Issues & Violence
19	ETASHA Society	www.etashasociety.org/	Delhi	■		■						■	
20	FPAI	www.thefpai.net/	Pan-India	■		■		■					■
21	Global Health Strategies	global-healthstrategies.com/	Delhi, Mumbai, Patna			■		■					
22	Going to School	https://www.goingtoschool.com/	Bihar, Delhi, Jharkhand, Maharashtra										
23	Gramalaya	www.gramalaya.in/	Tamil Nadu			■		■					
24	Himalayan Institute Hospital Trust-Leap Project	hihtindia.org/projects/	Pan-India			■		■	■			■	■
25	HLFPPT India	https://hlfppt.org/	Uttar Pradesh, Bihar, Madhya Pradesh	■		■		■	■	■	■	■	■
26	Human Touch Foundation	human-touchfoundation.com/	Goa	■		■		■			■		
27	ICRW	https://www.icrw.org/	Pan-India	■		■		■					■
28	Institute of Health Management Pachod	https://www.ihmp.org/	Maharashtra			■		■					■
29	IPE Global	www.ipeglobal.com/	Jharkhand, Uttarakhand, Haryana, Himachal Pradesh, Delhi				■	■	■		■		
30	Jatan Sansthan	jatansansthan.org/	Rajasthan	■		■		■	■	■	■	■	■
31	Kherwadi Social Welfare Association- Yuva Parivartan	https://www.yuvaparivartan.org/	Maharashtra			■							
32	Love Matters	https://lovematters.in/en	Pan-India			■		■					■

Sl. No.	Name of organization	Website	Geographical coverage/ focus states	Intervention Level				Thematic Areas					
				Schools	Facility	Community (including families)	Govt	SRHR	Nutrition	NCDs	Substance Abuse	Mental Health	Gender Issues & Violence
33	Magic Bus	magicbus.org/	Maharashtra, Delhi, Andhra, Karnataka West Bengal, Assam, and Tamil Nadu										
34	Mamta	mamta-himc.org/	Pan-India										
35	Muktangan	https://www.muktanganedu.org/	Maharashtra										
36	Pathfinder	https://www.pathfinder.org › Countries	New Delhi, Bihar, Haryana, Rajasthan, Madhya Pradesh										
37	PFI	www.populationfoundation.in/	Pan-India										
38	PHFI	https://phfi.org/	Pan-India										
39	Pop Council	https://www.popcouncil.org/	Pan-India										
40	Pravah	commutiny.in/cyc-forum/pravah/	NCR, Bihar, West Bengal, MP, UP, Jharkhand, Rajasthan, Maharashtra, Telangana, NE region										
41	PSI	https://www.psi.org/	Pan-India										
42	Restless Development	restlessdevelopment.org/india	Delhi, Bihar, Jharkhand										
43	Saarathi Trust	http://www.saarthitrust.com/	Rajasthan										
44	Sahayog	http://www.sahayogindia.org/	UP, Uttarakhand										
45	Salaam Baalak Trust	www.salaambaalaktrust.com/	Delhi										
46	Samarthan	samarthan.info/	MP, Chhattisgarh										

Sl. No.	Name of organization	Website	Geographical coverage/ focus states	Intervention Level				Thematic Areas					
				Schools	Facility	Community (including families)	Govt	SRHR	Nutrition	NCDs	Substance Abuse	Mental Health	Gender Issues & Violence
47	Sangath	https://www.sangath.in/	Goa										
48	Save the Children	https://www.savethechildren.in/	Pan-India										
49	SEWA Bharat	sewabharat.org	Rajasthan, Bihar, Delhi, Uttarakhand, West Bengal, Gujarat, Kerala, MP										
50	SNEHA	snehamumbai.org/	Maharashtra										
51	Swasti	swasti.org/	Delhi, Tamil Nadu, Karnataka										
52	TARSHI	www.tarshi.net/	Delhi										
53	Vacha	www.vacha.org.in/	Maharashtra										
54	Vatsalya	https://vatsalya.org.in/	UP										
55	VHAI	www.vhai.org/	Punjab, Odisha, Kerala, UP										
56	WaterAid	wateraidindia.in/	Odisha, MP, Telangana, UP										
57	Young Lives India	https://www.young-lives-india.org/	Andhra, Telangana										
58	YP Foundation	www.theypfoundation.org/	Rajasthan, Bihar, Delhi, UP,										

Adolescent-focused interventions of United Nations agencies

UNICEF	**Geographical coverage** Andhra Pradesh, Assam, Bihar, Chhattisgarh, Gujarat, Jharkhand, Karnataka, Madhya Pradesh, Maharashtra, Odisha, Rajasthan, Tamil Nadu, Telangana, Uttar Pradesh and West Bengal. **Support to RKSK** • Support to disseminate and implement the Adolescent Health Strategy • Support to develop the Adolescent Health Communication strategy • Support to the universal roll-out of WIFS program in 14 major states • During 2018-2022, technical assistance for rolling out Anemia-Mukt Bharat program with focus on adolescents.
	Other adolescent-focused interventions • Swabhimaan program: Partnership between UNICEF, National Rural Livelihood Mission (NRLM), MoHFW's maternal health division and MoWCD to demonstrate the effectiveness of delivery of a package of nutrition interventions focusing on adolescent girls and women in Bihar, Chhattisgarh and Jharkhand. • Menstrual hygiene management (MHM) program: UNICEF's menstrual hygiene management (MHM) program supports clean, safe menstrual management practices for adolescent girls from marginalized communities in Uttar Pradesh, Jharkhand and Bihar.
UNFPA	**Geographical coverage** Bihar, Madhya Pradesh, Maharashtra, Odisha and Rajasthan. **Support to RKSK** • Technical support for district level trainings across the 6 National Training Partners under RKSK • Training of counsellors in collaboration with the Himalayan Institute Hospital Trust. • UNFPA and Population Foundation of India contributed to development of the 'Saathiya' Resource Kit and 'Saathiya Salah' mobile app for adolescents—these were launched by GoI in 2017. The 'Saathiya Salah' mobile app acts as a ready information source for adolescents in case they are unable to interact with peer educators. **Other adolescent-focused interventions** • Adolescence Education Programme (AEP): UNFPA supports MHRD with implementing of AEP. The program is coordinated by the National Council of Educational Research and Training (NCERT). • The AEP covers 1120 Kendriya Vidyalaya Sangathan (KVS) schools and 585 Navodaya Vidyalaya Samiti (NVS) schools; overall 6,80,000 adolescents in the age group of 14-16 years.

UNESCO	**Geographical coverage** Delhi, Gujarat **Support to RKSK** ● Part of the Technical Resource Group for development of curriculum and training material for School Health Programme under Ayushman Bharat ● Life skills, sexual and reproductive health and HIV-related content ● Eliminating school violence and bullying including school-related gender-based violence; ● Preventing health- and gender-related discrimination
WHO	**Geographical coverage** Pan-India **Support to RKSK** ● Technical and capacity building support to strengthen and scale up the RKSK. WHO will work with selected states for this purpose, support will have district focus. ● Focus on gender-awareness approach, and addressing issues relating to, among others, nutrition, early marriage and improving gender equality.

UN agencies' partnership with central and state governments to develop 10 districts as model districts for strengthening adolescent health approaches:
WHO, UNICEF and UNFPA will among them take up 10 districts to be developed as model districts for strengthening adolescent health approaches.

Support by donor agencies

United States Agency for International Development (USAID)

USAID strengthens family planning service provision and expands the range of family planning methods available. This includes increasing the awareness of reproductive health with youth, particularly adolescent girls.[xi] Among USAID's key focus areas is adolescent SRHR. While USAID will continue to provide assistance for SRHR interventions, it is now transitioning to a new strategic approach which involves considerable focus on multi-stakeholder cooperation. Under the new approach, USAID will engage more directly with local partners, co-financing instead of fully funding agreements on its own. [xii] In line with this approach, USAID, Kiawah Trust and Dasra launched a new initiative in 2017 aimed at empowering more than five million adolescent boys and girls in the country by 2021. Titled '10 to 19: Dasra Adolescents Collaborative' is targeted at girls and boys between the ages of 10-19 years and will work directly with them to help girls stay in school, delay their age at marriage, improve their nutritional status, promote menstrual hygiene, promote reproductive rights, build awareness about gender-based violence, improve decision-making skills and increase employment opportunities.[xiii]

The Children's Investment Fund Foundation (CIFF)

CIFF is the world's largest philanthropy focusing specifically on improving children's lives. CIFF's areas of work include children and adolescents' health and nutrition, child protection and early learning. CIFF works with a wide range of partners including governments, non-governmental organizations, other philanthropies, businesses, among others. In India, CIFF has a portfolio of multi-year grants covering a range of issues. Key interventions supported by CIFF are outlined below:

- Technical support for the Government of India's school-based deworming program.
- Partnership with Government of Rajasthan to support several investments directed at children and adolescents. This includes a grant to support India's first government-led community

management of acute malnutrition program, delivered through the public health system. It is envisaged that the state government will take this program to scale.

- More recently, CIFF has begun focusing on support to end child slavery and commercial sexual exploitation. [xiv]

The David and Lucile Packard Foundation

The Packard Foundation primarily works in the areas of population stabilization, to expand reproductive health options among the world's poor, and to support reproductive rights. The Foundation makes grants to non-profit organizations and supports efforts to expand and strengthen the quality of comprehensive sexuality education, voluntary family planning and contraception. The Foundation's India program supports the government's policy to delay marriage and childbearing among young people and to enable them to make informed decisions about their reproductive health. The Foundation's investments in India are focused on women and girls from marginalized communities in Bihar and Uttar Pradesh, who bear an immense burden of poor sexual and reproductive health and rights, due to their disadvantaged and marginalized status. The Foundation's investments have contributed to improving access to services, mobilizing political and financial commitment, and increasing women and girls' agency in decision-making. [xv],[xiv]

Support by Corporates

Azim Premji Philanthropic Initiatives (APPI)

APPI supports interventions that work towards ensuring greater participation of girls in schools and delaying the age of marriage and childbirth for adolescent girls. Key activities include:

- Creating a conducive environment, at the individual, collective and civil society level
- Raising awareness on reproductive and sexual health,
- Peer education, sensitization on violence and gender issues,
- Enhancing access to existing government schemes

APPI works through NGOs to implement its program for adolescent girls. The program is being

Nestle

Nestle aims to foster healthy behaviors in children and families through three projects, each with a specific focus. Of the three projects listed below, the first two are primarily directed at adolescents, while the third focuses on adolescent parents.

These projects are operational in

Rajasthan, Karnataka, Maharashtra, Chandigarh, Odisha, Uttar Pradesh, Bihar and Delhi.

Project Jaagriti encourages healthy nutrition and breastfeeding practices, as well as increases the uptake of public health services through community sessions.

Nestlé Healthy Kids Programme is dedicated to empowering teachers and children with nutrition education and promoting healthy lifestyles in the school environment.

Nestlé Start Healthy Stay Healthy educates adolescent parents on the importance of nutrition in the first 1000 days of life.

implemented in Uttar Pradesh, Himachal Pradesh, Madhya Pradesh, Rajasthan, Uttar Pradesh, Karnataka, Andhra Pradesh, West Bengal, Odisha and Jharkhand.

Jindal Steel and Power Limited (JSPL)

As a part of their CSR initiative, JSPL launched, "Kishori Express", an innovative programme with the objective to improve the health of adolescent girls (would-be mothers) in Odisha. Under this specially targeted intervention, JSPL has launched two dedicated vehicles known as 'Kishori Express' to improve the health of adolescent girls (would-be mothers) through regular medical check-up, haemoglobin check-up, awareness creation, as well as nutrition supplementation.

Kishori Express is a customized mobile health vehicle that moves from village to village, disseminating information as well as conducting haemoglobin check-up among adolescent girls. The vehicle is equipped with an electronic, interactive Touch Screen enabled with a Health Quiz program. Adolescent girls walk into the van, participate in the quiz and test their basic knowledge about iron-centric food that they should be consuming, sanitation, better hygiene and lifestyle. Besides rendering the above services, Kishori Express also provides low cost sanitary napkins 'SSHODASHI' to households.

JK Lakshmi Cement

The company carries out its CSR work in Rajasthan, Gujarat and Haryana and Chhattisgarh.

'Mor Sangwari' literally translates to 'My Friend' in English—this project aims at extending a friendly hand to the women and young girls who are deprived of basic hygiene facilities like sanitary napkins. The company promotes use of low cost sanitary napkins among these women and girls to improve their health.

JKLC works in eight villages that surround its plant in Durg district of Chhattisgarh to spread awareness about menstrual hygiene. To begin with, the company set up low cost sanitary napkin manufacturing unit in Girhola village and formed a self-help group of six women to take care of the day to day functioning of this manufacturing unit. A sanitary napkin manufacturing machine was installed here and the raw material to produce the napkins is also provided by JKLC to the women.

The Department of Women and Child Development of Chhattisgarh government took note of the positive impact of the 'Mor Sangwari' project. The government adopted the project as a good model and replicated it in 261 government schools where it has installed sanitary napkin vending machines and incinerators. Chhattisgarh government plans to replicate the project in all government schools and government girls' hostels. Apart from that, JKLC also replicated its project at two other plant locations.

Conclusions

Notably, most of the NGOs profiled in this chapter are working on SRHR. Of these, many are also working on gender issues, gender-based violence, life skills and empowerment. Further, while many of the above-profiled NGOs are working on nutrition, few are working in the areas of substance misuse, NCDs and mental health. The few agencies that are working in all the RKSK thematic areas are mostly those that provide technical assistance and/or capacity building support to governments.

While the intervention areas of the NGOs profiled in this chapter cannot be said to represent the entire range of NGOs' adolescent health work in India, they do seem to reflect a broader pattern that was observed while reviewing literature for the current study. In turn, this broader pattern seems to reflect the evolving policy priorities of governments and funding agencies worldwide with respect to adolescent health programming, which initially focused on SRHR and related themes during the two decades following the International Conference on Population and Development (ICPD) in 1994. This trend has begun to change only during recent years, as a broader and deeper understanding of the multiple dimensions of adolescent health has begun emerging.

UNICEF, UNFPA, UNESCO and WHO have been working closely with various government agencies involved in adolescent health and development. All three agencies have provided support in various ways in the design and implementation of RKSK. UNICEF India has been a leading partner in supporting the universal roll-out of the WIFS in several states. Under its country program for 2018-2022, UNICEF will work with the Adolescent Health Division of MoHFW for rolling out of the Anemia-Mukt Bharat (anemia-free India) program with focus on adolescents. UNFPA has been working with GoI on the development and strengthening of the AEP for over two decades. Additionally, UNFPA is supporting training and other components under RKSK; UNFPA is also supporting the Adolescent Health and Development project through the NYKS in 5 states. In the coming years, WHO, which so far had provided advisory and policy support, will now provide technical and capacity building support to strengthen and scale up the RKSK. This will be part of a coordinated initiative wherein the three UN agencies—WHO, UNICEF and UNFPA—will among them take up 10 districts to be developed as model districts for strengthening adolescent health approaches.

Donor agencies support adolescent health initiatives in various ways, including, among others, technical assistance, financial assistance, full funding of grant component, co-financing with other donors. Often, donor agencies provide funding on limited scale—for instance for pilot or demonstration projects—with the understanding that the recipient agency will mobilize or leverage funds for expansion or scaling. Corporates support a variety of adolescent-focused initiatives, which are implemented through various platforms, including among others, schools, NGOs, communities and families. Corporate CSR initiatives range from very small-scale to larger-scale ones that are implemented in multiple states. In some cases, even small-scale interventions by companies can trigger replication on wider scale: one example being the 'Mor Sangwari' project of JK Lakshmi Cement which is being replicated by the Chhattisgarh government across government schools and government girls' hostels.

Ensuring effectiveness, sustainability and eventual scaling of the initiatives that they support is important for agencies that invest in projects. In this regard it would be useful to consider the following:

ACTIONS

1. ADOPT A MULTISECTOR APPROACH TO IMPROVING THE HEALTH AND WELLBEING OF WOMEN, CHILDREN AND ADOLESCENTS. Identify and incorporate policies and interventions led by different single sectors as core to national health strategies. Identify key structural forces that affect health and drive disparities, including gender-related structural and institutional biases. Enact broad-ranging cross-sector policies to advance shared goals and address challenges that lone sectors cannot resolve, driven by heads of government. Assess policies and interventions in different sectors to identify potential health risks.
2. BUILD GOVERNANCE AND CAPACITY TO FACILITATE MULTISECTOR ACTION AND CROSS-SECTOR COLLABORATION. Strengthen coordination, financing and accountability mechanisms to manage multisector action and cross sector collaboration and promote related accountability at all levels. Identify strategic areas for cross-sector collaboration and create incentives to expedite the work. Eliminate bureaucratic and financial disincentives and barriers to multisector action and cross-sector collaboration, not only in governments but also among international agencies, the private sector and non-governmental organizations.
3. MONITOR THE IMPACT OF MULTISECTOR ACTION AND CROSS-SECTOR COLLABORATION ON HEALTH AND SUSTAINABLE DEVELOPMENT. Enact joint monitoring of policies and interventions in different sectors that impact on health and consider and report on them as core health indicators. Promote shared monitoring of cross-sector action and impact across health and other sectors, as well as shared contributions towards achieving the SDGs.
4. PROMOTE MULTI-STAKEHOLDER ENGAGEMENT TO MONITOR, REVIEW AND ACT. Promote multi-stakeholder engagement and cross-sector collaboration for follow up actions at all levels. Health sector reviews involving all stakeholders can provide a platform for monitoring, review and action. Parliamentarians and civil society can monitor and hold governments accountable, thereby ensuring citizens' voices are heard. To ensure a transparent and independent review, an Independent Accountability Panel will prepare an annual report on the State of Women's, Children's and Adolescents' Health . The Partnership for Maternal, Newborn & Child Health will play a coordination role in the global Accountability Framework to ensure all stakeholders can act on recommendations.

6

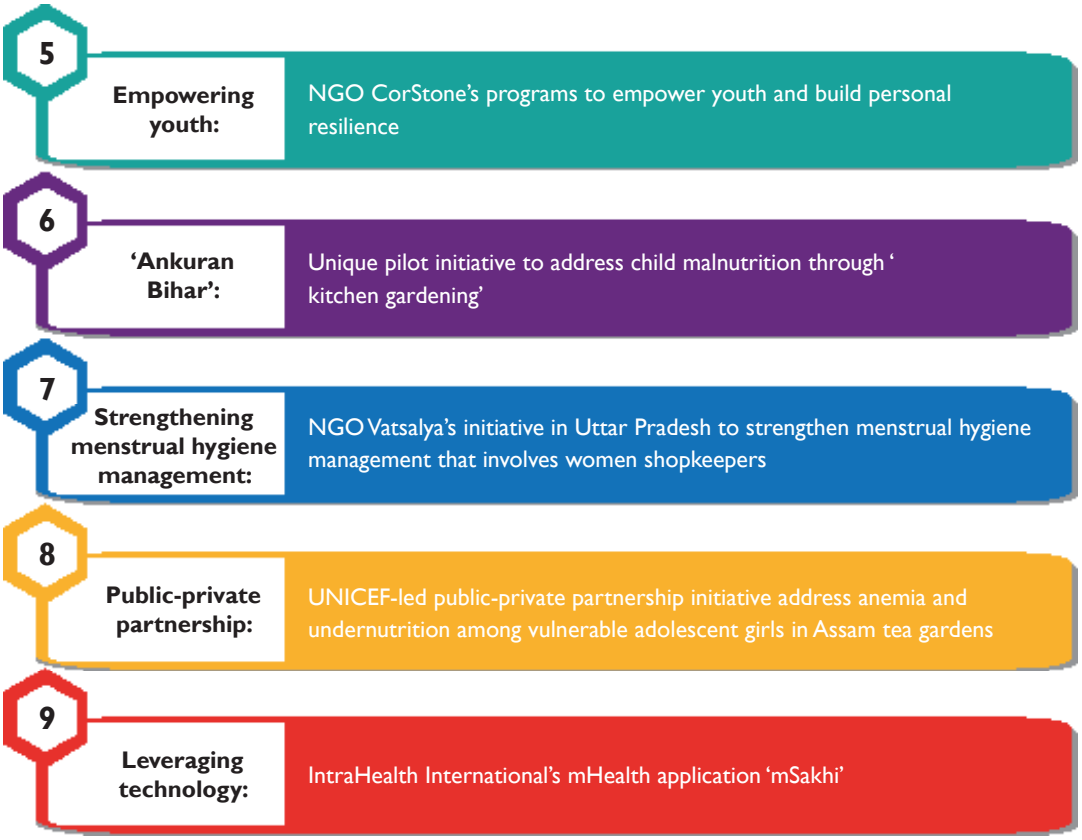
Innovative and replicable initiatives in adolescent health

Introduction

This chapter describes selected innovative and replicable initiatives in adolescent health and development that have been implemented in diverse settings and contexts.These provide useful models that can be adapted and used to strengthen and complement RKSK implementation efforts of health departments, including those in partnership with other stakeholder departments and NGOs.

The initiatives discussed in this chapter include:

1. **Systems strengthening and capacity building:** Intervention by Institute of Health Management, Pachod (IHMP) with marginalized communities in partnership with National Rural Health Mission, Maharashtra.
2. **Strengthening logistics and supply chain management:** Technical support by UNICEF to strengthen the WIFS Program in Uttar Pradesh.
3. **Convergence-based intervention at scale:** UDAAN Adolescence Education Program, a public-private partnership program in Jharkhand with technical assistance from Centre for Catalyzing Change.
4. **Reaching the marginalized and unreached:**
   - Pathfinder International's Sashakt Project to reach the extremely marginalized Mahadalit communities in Bihar.
   - Vacha's work to impart life skills and empower marginalized urban adolescents involving innovative use of technology and civic participation.



Interventions and programs

Systems strengthening and capacity building

Systems strengthening and capacity building

Institute of Health Management, Pachod (IHMP) intervention with marginalized communities in rural and urban Maharashtra to improve the sexual and reproductive health of girls and women involving training of frontline government health workers

Institute of Health Management, Pachod (IHMP) works with marginalized communities in rural and urban Maharashtra to improve the sexual and reproductive health (SRH) of girls and women.

IHMP runs an integrated program to empower adolescent girls and protect them from the consequences of early marriage. It works with unmarried adolescent girls, married adolescent girls and boys and young men. **IHMP's intervention involves training frontline government health workers to: (i) conduct monthly health needs assessments of married adolescent girls; (ii) provide needs-based counseling to married adolescent girls and their families; and (iii) actively link adolescent girls to government healthcare providers and health centers.**

IHMP has developed a monthly health needs assessment system to enable universal health coverage with services. **It has designed a needs-specific behavior change communication system—a paradigm shift in health communication.**

Among IHMP's partners are National Rural Health Mission, Government of Maharashtra and Global Giving.

Strengthening logistics and supply chain management

Strengthening logistics and supply chain management in the Weekly Iron Folic Acid Supplementation (WIFS) Program

Strengthening logistics and supply chain management in WIFS Program in Uttar Pradesh as part of technical support by UNICEF and NGO Vatsalya

UNICEF has been supporting implementation of the WIFS program in several states including Uttar Pradesh. As the delivery of program in Uttar Pradesh evolved during the period 2013–2017, multiple operational challenges were encountered. To scale up and strengthen the implementation of the program and to address the operational challenges, UNICEF entered into a partnership with the NGO Vatsalya.

One of the critical operational challenges was supply related issues, since successful implementation of WIFS program depends heavily on the availability of IFA tablets. Among the major reasons underlying the various logistical and managerial problems was the legacy of frequent changes in program delivery mechanisms and guidelines under the different programs that had administered WIFS over the previous years. This situation improved in 2014 with the issuance of WIFS program operational guidelines by MoHFW, GoI. However, there remained several challenges, including:

- Poorly defined budgetary and logistics management at state level, weak coordination amongst the state's Health, Education and ICDS departments, compounded by the enormous size of the state. These resulted in poor monitoring and inadequate coverage reporting.
- Problems in procurement and supply, delayed budget release, and time-consuming rate contract processes.

Several remedial steps were then taken:

- At the request of the state Health department, UNICEF supported a strategic intervention of developing an external monitoring and feedback loop mechanism to especially address the challenges faced by the government in WIFS monitoring and reporting.
- The procurement of IFA tablets was streamlined during the initial phase of the partnership with the state moving from one supplier to two suppliers for procurement of Iron tablets.
- Timely and adequate release of budget was streamlined in coordination with state Health department to maintain adequate annual supply of logistics including IFA tablets, registers, etc.
- A mechanism was established for movement of logistics through the Education and ICDS departments.

The above measures were accompanied by constant monitoring and the release of appropriate government orders and guidelines. As a result of these efforts, the availability of IFA tablets at district, block and community level improved from 71% to 96% at district level; 85% to 100% at block level and 17% to 43% at community level during the period July 2016 – September 2017. Efforts are ongoing to strengthen supply chain management, especially at the district level, for maintaining constant supply at schools and AWCs.[1]

Convergence-based intervention at scale

Convergence-based intervention at scale: UDAAN Adolescence Education Program, Jharkhand

UDAAN: In School, at Scale, Adolescence Education Program is a public-private partnership program between the State Department of Education, Government of Jharkhand, the Jharkhand State AIDS Control Society (JSACS) and Centre for Catalyzing Change, supported by the David and Lucile Packard Foundation.

Launched in 2006, *UDAAN* aims to promote adolescent development and establish a cadre of healthy and empowered youth. *UDAAN* strengthens the Adolescence Education Program (AEP) in all senior secondary schools in the state of Jharkhand. Centre for Catalyzing Change provides technical assistance to integrate life skills-based adolescent education in the state secondary education system by strengthening teacher training, developing teaching curriculum and developing and operationalizing a monitoring system for the Jharkhand state government.

From the very outset, the state government intended Udaan to cover all the secondary schools in all the 24 districts of the state. Over the years since its launch, the program was scaled up to cover all the state's secondary schools and then sustained. At a subsequent stage, it was extended to the state's upper primary schools.

The program, one of the largest interventions of its kind in north India, has over the past years reached out to over 500,000 adolescents through the *UDAAN* curricula in classes IX and XI in almost 1500 government secondary/senior secondary schools including *Kasturba Gandhi Balika Vidyalayas* (KGBVs) and around 20,000 students in classes 6, 7 and 8.

Udaan, which has been through a series of five evaluations, provides an example of a well-designed, implemented, evaluated and documented school based adolescent health program that has been operating at scale over a sustained period. UDAAN is recognized by national and state government (including National Aids Control Organization) as an at scale partnership program for replication in other states. **In August 2016, Udaan was also selected by the central Ministry of Health as a 'Good, Replicable Practice and Innovation in Public Health Care Systems'. Udaan was also chosen by the WHO Geneva as a 'first generation innovative adolescence program' with lessons for scaling, sustaining and replicating.**

Certain key factors contributed to Udaan's success:

First, the existence of a clear policy to implement a state-wide school-based adolescent education program, and the commitment of the state government to translate this policy into action.

Second, the continued technical support of the Centre for Catalyzing Change, which worked with counterparts in the state and district governments to design, implement, monitor and evaluate the program, and to foster its evolution into a truly state-wide program, using available opportunities and confronting challenges when they arose.

Third, the availability of funds for the scale up and sustainability of the program from the state government and for the Centre for Catalyzing Change from the Packard Foundation.

A commitment to constant improvement through evaluation.[2,3]

Reaching the marginalized and unreached

Reaching the marginalized and unreached

Pathfinder International's Sashakt Project (2015-present): Building on 12 years of experience and evidence to design a project to reach the extremely marginalized Mahadalit communities in Bihar.

Pathfinder International implemented the Promoting Change in Reproductive Behavior of Adolescents (PRACHAR) project from 2001 and 2012. The project, aimed at promoting Healthy Timing and Spacing of Pregnancy (HTSP), worked with local governments and community-based organizations to provide SRH counseling for young women and men, life skills education for adolescents, 'infotainment' programs for newlywed couples and behavioral change programs for the broader community. Evaluations of the PRACHAR program found a notable impact on the target groups' SRH behaviors and practices. **Based on evidence and the results of the PRACHAR project, Pathfinder designed the Sashakt project to reach the socio-economically marginalized Mahadalit communities with SRH information and services.** *(The term Mahadalits refers to the especially marginalized sections among the Scheduled Castes of Bihar).*

The Strengthening Adolescent and Youth Sexual and Reproductive Health (SASHAKT) project, initiated in 2015, equips two cadres of community health workers to reach young Mahadalits with sexual and reproductive health information and services in India's Bihar state. **Because very few programs have focused on this marginalized population, a key aim of Sashakt is to assess which approaches are most effective.**

Reaching the marginalized and unreached

Key activities include

Train community health workers to conduct home visits with young Mahadalits to discuss contraception, healthy timing and spacing of pregnancy, and life skills

Facilitate group meetings among young Mahadalits to increase knowledge and awareness of contraception and the risks of early pregnancy

Strengthen government capacity to deliver and sustain quality contraceptive services for Mahadalit youth[4]

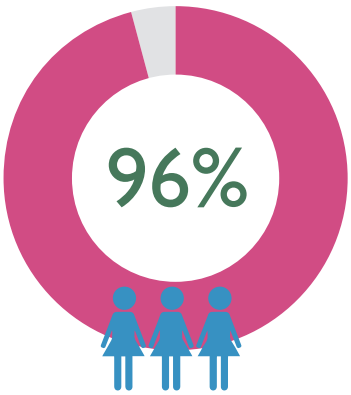
Reaching the marginalized and unreached

Vacha's work to impart life skills and empower marginalized urban adolescents in urban locations in Maharashtra.

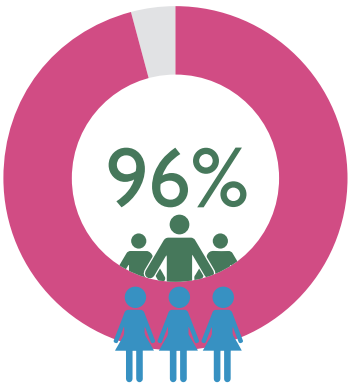
Vacha is a resource center for women and girls. It addresses issues faced by women and girls through educational programs, resource creation, research, training, campaigns and networking. It implements its programs in Maharashtra. Vacha implements two programs that work with marginalized adolescents in urban locations:

- **Urja:** Adolescent girls aged 10-18 attend sessions on health, gender, life skills such as communication, self-efficacy and negotiation as well as contemporary skills such as spoken English, computer literacy and photography. These skills enable girls' participation in civic life when combined with opportunities to speak in public, produce newsletters, advocate for their rights and organize community-based events.
- **Tejasvi:** Adolescent girls and boys aged 15-20 attend life skills sessions together, learning to work collaboratively and engage in civic issues. Participants in this program have initiated youth groups that address issues in their neighborhoods such as safety of girls and women.

Vacha is innovative in its use of technology and civic participation to equip adolescent girls with the skills they need to negotiate restriction and patriarchy in their lives. Internal studies conducted by Vacha have found that:



of girls enrolled with Vacha have completed education till the 10th grade



96% of girls and boys enrolled with Vacha have been trained to use digital technology such as cameras and computers, as compared to 39% of their peers[5]

Empowering youth and building personal resilience

NGO CorStone's programs to empower youth and build personal resilience

CorStone, an international NGO, develops and provides personal resilience programs to improve well-being for youth throughout India, focusing on adolescent girls as critical change-agents in their communities. The agency has been conducting efficacy, effectiveness, and scalability trials of resilience-based interventions for at-risk youth in India since 2009.

CorStone's India programs include:

- **Girls First, Bihar: empowers marginalized adolescent girls in Bihar** with knowledge, skills and support to improve their personal resilience and physical health, and to self-advocate for their right to stay in school and delay marriage.
- **Girls First, Surat: empowers marginalized adolescent girls in the slums of Surat** with knowledge, skills and support to improve their personal resilience, physical health, academic achievement and self-sufficiency.
- **Girls First, KGBV Schools, India:** Girls will receive extensive training in topics such as character strengths, interpersonal communication, problem-solving, nutrition, reproductive health, and gender-based violence **by trained KGBV teachers.**
- **Youth First, India:** Based on the well-documented impacts of CorStone's Girls First program, Youth First fosters development 'from the inside out,' providing an integrated, school-based, resilience and adolescent health training program to improve health, school performance, self-advocacy and social skills among marginalized youth.[6]

Addressing child malnutrition through 'kitchen gardening'

Project Ankuran Bihar

Unique pilot initiative to address child malnutrition through 'kitchen gardening'

In 2016, Government of Bihar launched the pilot project 'Ankuran Bihar', in partnership with UNICEF, to address child malnourishment and anemia in 100 schools in Purnea district. This unique initiative is aimed at using 'kitchen gardening' to grow micronutrient-rich foods near anganwadi centers, schools which provide midday meals, and homes. Project partners include the state's agriculture, education, health and social welfare departments. Rajendra Agriculture University and UNICEF provide technical guidance and support to the project. Experts from Rajendra Agriculture University train teachers and students to develop the gardens. The project targets children aged 6-14 years old; the produce from the kitchen gardens is used in the preparation of mid-day meals for children.

Strengthening menstrual hygiene management (MHM)

NGO Vatsalya's initiative in Uttar Pradesh to strengthen menstrual hygiene management

Innovative approach to enhancing menstrual hygiene management (MHM) related awareness and distribution of sanitary napkins through women shopkeepers

The NGO Vatsalya works in communities and schools in Uttar Pradesh to increase the awareness of girls, women, boys, men and government workers on menstrual hygiene management (MHM) issues. Vatsalya helps women shopkeepers to become change agents that sell sanitary napkins and serve as MHM experts for girls, alongside public health workers.

The program aims to break the culture of shame and stigma that surrounds menstruation, which in part related to the ignorance and lack of involvement of men and boys. Vatsalya's mobilizers actively engage groups of men and adolescent boys to influence changes in attitudes around menstruation and MHM.

Studies by Vatsalya show that its programs have resulted in nearly 80% of girls reporting that the intervention has changed the way they manage menstruation and that there has been a substantial decrease in girls missing school due to menstruation among those who participated in the program.

Public-private partnership

Public-private partnership

UNICEF-led public-private partnership initiative address anemia and undernutrition among adolescent girls in Assam tea gardens

Adolescents are a valued segment of the tea plantation workforce, since their height is suitable for plucking the tea leaves and their work capacity helps generate excellent output. However, a large proportion of these adolescents are undernourished and anemic.

Since 2008, UNICEF India has had a partnership with Twinings Company's Corporate Social Responsibility, together with a federation of tea companies in Assam's Dibrugarh district, through which 158 adolescent girls' clubs have been established across 63 of the 273 tea gardens. **In 2011, to address the problem of anemia and undernutrition among adolescent girls in 15 tea gardens in Dibrugarh, Assam, UNICEF initiated an intervention in partnership with multiple stakeholders.**

The stakeholders' responsibilities were as follows:

The Assam Branch of the India Tea Association (ABITA) was the coordinating partner to influence the management decisions of the tea garden managers in providing various resources.

The state health department was responsible for the provision of supplies and for project monitoring through their health supervisors.

Academic institutions were responsible for evaluation of the impact of the program.

Twinings, the biggest buyer of tea from ABITA, provided the financial resources for the initial supplies and program expenses.

UNICEF, Assam was the initiator and convener of all these efforts.

The key features of the intervention were:

- Baseline survey (2011) of the girls' nutritional status, followed by weekly supervised iron folic acid (IFA) supplementation, biannual de-worming, and nutrition education woven into the peer sessions.
- The central strategy to deliver these interventions was first to train and mentor two peer monitors per tea garden to supervise the activities, and then to incorporate the interventions into the monthly meetings of the 45 adolescent girls' clubs. Visual aids, recipe demonstrations, and community and individual kitchens were used during the nutrition and health education sessions.
- Appropriate linkage was established with the state government to ensure that adequate supplies were provided, and government frontline and supervisory staff were trained and involved.
- Supervision of intervention by peer monitors per tea garden, field monitors and block monitors supervised intervention.

Two and one-half years after the project implementation, the endline survey showed a 14 per cent improvement in mean hemoglobin levels in the girls in the 15 tea gardens. The endline survey also showed that full consumption of weekly IFA supplementation (4 tablets per month) increased from 24 per cent in January 2011 to 96 per cent in March 2014.

Lessons from this public-private partnership can be adapted for reaching out to adolescent girls with anemia control interventions in similar programming environments (coffee, rubber plantations and self-contained mines).[7]

Leveraging technology

IntraHealth International's mHealth application 'mSakhi'

mSakhi is an open source Android application developed by IntraHealth International specifically for frontline health workers in India. It is an all-in-one job aid and electronic medical record system that replaces multiple paper-based tools and helps health workers gain access to the most up-to-date training and information in easy-to-understand, convenient formats that work for them.

mSakhi helps health workers such as ASHAs in a variety of ways, for example:

- ASHAs can use their smartphones to update skills and stay in touch with supervisors
- They can track and report crucial data about health issues in their communities
- They can impart knowledge and skills to community members—e.g., teaching new parents how to protect their babies from infection or dehydration, how to breastfeed, and how to identify symptoms of serious illness.
- If a mother or baby needs medical attention, an ASHA can use mSakhi to refer them to a doctor who can help

In 2015, mSakhi won the mBillionth Award from the Digital Empowerment Foundation for outstanding mobile content. Experience gained with mSakhi has helped inform a large-scale smartphone-based mHealth initiative led by the Government of Uttar Pradesh which reaches 12,000 frontline health workers in five districts—with a total population of 15 million.[8] mSakhi is also being made available to frontline health workers in Uttarakhand and Jharkhand. Frontline health workers in Jharkhand are now using the app to diagnose and manage noncommunicable diseases.

IntraHealth originally developed mSakhi with support from the Bill & Melinda Gates Foundation. The Margaret A. Cargill Foundation and Medtronic Foundation are currently supporting IntraHealth's mSakhi work.

Conclusions

The initiatives described in this chapter provide several useful takeaways:

Clear policy commitment by government backed by adequate funding, sustained technical support and commitment to constant improvement through process monitoring and evaluation are among crucial success factors in adolescent health interventions, especially when initiatives are sought to be scaled.

NGOs are critical stakeholders in adolescent health and development initiatives; NGOs also have the flexibility to try out innovative approaches and to foster convergent action by government agencies. NGOs and government can successfully work together to develop and implement innovative programs at scale.

Well-functioning logistics and supply chain management is crucial to effectiveness of health programs, not least a relatively new program like RKSK. Systematic and sustained efforts—including streamlining of funds flows and monitoring—are needed to strengthen logistics and supply chain management.

The UNICEF-led public-private partnership initiative in Assam tea gardens demonstrates how diverse stakeholders can collaborate to deploy their unique strengths and resources to target vulnerable adolescents who work in settings where it might not be easy to access government services.

Leveraging mass and digital media for reaching out to adolescents

7

Introduction

One of the key components of the RKSK strategy is to engage in effective communication with adolescents and on behalf of adolescents. The RKSK communication strategy envisages a 360-degree approach to social and behavior change communication—towards this end it strongly advocates harnessing both traditional communication methods as well as new age tools.

Effective communication strategies make use of multiple media platforms to expand reach and enhance impact of communication. Traditional media platforms include mass media, printed materials, audio-visual media, telephone helplines, and outdoor media. In recent years, mass media and digital media have rapidly evolved as platforms that provide innovative opportunities for engaging adolescents, including those who are disadvantaged and hard-to-reach. Unlike traditional media, digital media, which include social and interactive media, allow users to both consume and actively create content. According to the Lancet commission report on adolescent health, school-based promotion of services, mass media campaigns, and social media can all play potential roles to reduce barriers to accessing health care by promotion of health literacy and help-seeking. Partnerships with civil society and media professionals are very effective in exploiting the potential of these platforms.

The growth in mobile devices together with social networking and digital technologies provide tremendous opportunities for engagement with adolescents. While there exists substantial experience with use of mass media, there is, however, little consensus at present about the most effective strategies for using digital media to reach adolescents. This chapter discusses the levels of access to mobile phones and digital media in India and outlines key advantages of using digital media to reach out to adolescents. Further, this chapter describes a few communication interventions using various media platforms (including mass media, digital media and transmedia initiatives) that have been found effective in reaching out to adolescents and their communities.

Access to and advantages of digital media

Access to mobile phones and digital media

There has been a tremendous increase in mobile phone usage in India over the last decade. According to data from 2016, India has over 81 mobile phone connections per 100 citizens, up from over 37 connections per 100 citizens in 2009. Further, over 43% of mobile phone connections in 2016 were in rural areas. Also, mobile phones are increasingly being used to access the internet.

Although India's rate of internet access is still relatively low compared to that of other middle-income countries, it is growing rapidly. Most of the growth in internet access is driven by mobile internet use. There are 302 million internet subscribers in India of which 94% are mobile internet users and only 6% are wired internet users. Out of 400 million internet users in the country, 28 million are school-going children.[1]

However, major disparities exist in internet access due to socioeconomic differences, geographic coverage and gender. As many as 60 per cent of the urban population has access to the internet, compared to only 15 per cent in rural areas. Again, there is a huge digital divide between men and women. While in urban areas, women make up one third of internet users, in rural areas only 10 per cent of Internet users are female. Nearly all urban middle-class men of working age now have Internet access through smartphones, on the other hand almost all poor rural women remain offline. Many poorer and rural users continue to use basic feature phones for communication and entertainment. There are also substantial differences between rural and urban areas regarding reasons for accessing the internet. Urban users are increasingly going online for communication, social networking, shopping and travel booking, however rural use is still predominantly for entertainment.

The rapid growth in mobile use and internet access provide a huge opportunity to use digital media/ Information and Communications Technologies (ICT) for health communication. Digital media refers to digitized content that can be transmitted over the internet and can thus be accessed via computers and mobile phones. Information and Communications Technologies "encompasses all rapidly emerging, evolving, and converging computer, software, networking, telecommunications, Internet, programming, information systems and digital media technologies."

Advantages of using ICT/digital media

There are several advantages to using ICT/digital media platforms to engage with adolescents:

- These platforms provide an opportunity to share information, answer questions, stimulate discussion on health-related and other relevant topics
- They are an effective tool to disseminate accurate and relevant health-related information in an accessible and cost-effective way, which is especially useful in rural and otherwise inaccessible areas.
- They can be used to monitor health programs via frontline workers including tracking patient history and providing health-related information in rural and otherwise inaccessible areas.

  Traditional outreach mechanisms are often unable to reach vulnerable adolescents such as married girls, very young adolescents and out-of-school adolescents. ICTs can be leveraged to enhance reach amongst adolescents, including vulnerable adolescents. At the same time, however, disparities in access to and use of digital media amongst different sub-groups have to be factored in while developing communication strategies.
- Social media can be used to foster social inclusion or peer-to-peer connection among

adolescents who might otherwise feel excluded, for example, those with obesity or mental health issues.

- Social media and digital technology can be used to organize, enhance, and sustain public engagement around relevant causes and topics quite quickly and effectively, as groups share information and broaden their memberships.

Selected interventions using mass media and ICT/ digital media

A wide variety of media platforms and formats are used in communication interventions that have been found effective in reaching out to adolescents and their communities. By way of illustration, a few such interventions are discussed below.

Transmedia edutainment initiative 'Adhafull' developed by BBC Media Action in partnership with UNICEF.

A transmedia intervention has a range of outputs targeted at different segments and different age bands. The outputs address a very wide range of issues through varied formats and platforms, focussing on a unified overarching insight. AdhaFULL transmedia linkages adapts to the platform dramatic and nuanced on TV, direct and explicit on radio, playful on a mobile app, satirical on social media, simple yet engaging in the inter-personal toolkit. The initiative uses an entertainment-education approach for a range of media outputs, including a 78-episode 'whodunit' television drama series AdhaFULL (Hinglish for Half Full). The television series is supported by a 78-episode-long radio show called Full on Nikki, social media strategy, a mobile game and an interpersonal communication toolkit - each serving a strategic purpose in this unique initiative for adolescents.

Using drama and discussion, the project aims to break the silence surrounding sensitive issues affecting young people, challenge traditions that perpetuate gender stereotypes and boost the ability of teenagers to take action to improve their lives. Issues such as under-age marriage, nutrition, stereotyping of girls and boys, continuing education, peer pressure, school drop-outs and exam blues and gender-based violence are creatively depicted in the narrative. AdhaFULL episodes are telecast on Doordarshan National every Friday, Saturday and Sunday at 7:30 pm.[1]

AdhaFULL- TV series	Full on Nikki -Radio Show	'Nugget', an Android-based Game
– World's 3rd and India's 1st RCT for a media intervention – Strong engagement – Girls empathize with the narrative, and have expressed willingness to negotiate for their rights. – Amongst boys, significant difference between exposed and unexposed of recognition of gender stereotyping	– Platform to showcase voices from 13 states, 368 vox pops, 35 expert interviews, 45 real life champions, 32 celebrities, 7 music bands – 24 community radio stations across 7 Hindi-speaking states and the union territory of Chandigarh, – 11 private FM stations across 8 states – 8500 government schools in Madhya Pradesh, – 5500 government schools in Chhatisgarh, – 25 government schools in Jodhpur, – 20 private schools in Bihar, Uttar Pradesh, Rajasthan and Delhi.	– 116,000 downloads from Google Play Store – Need report

Edutainment television serial 'Main Kuch Bhi Kar Sakti Hoon'

During the period 2014 to 2016, Population Foundation of India (PFI), a Delhi-based population research and advocacy organization, collaborated with the public service television network Doordarshan to telecast a unique television serial 'Main Kuch Bhi Kar Sakti Hoon (I, a Woman, Can Achieve Anything)'. The project was funded by United Kingdom's Department for International Development (DfID) and the Gates Foundation and was supported by United Nations Population Fund.

The serial used entertainment as a means of education to positively entrenched social norms and to promote the health and agency of women. The serial focused on attitudes towards child marriage, sex selection, closely spaced pregnancies and nutrition, domestic violence, and on improving youth's access to contraception. The serial's design used the concept of "positive deviance", which involves nudging communities to rediscover traditional wisdom and act on it.

The serial ran for two seasons on Doordarshan from 2014 to 2016, and a survey showed that it was watched by 58 million viewers in its first season. According to Doordarshan, the two seasons and their reruns together reached over 400 million people.

Each episode ended with a message and a quiz and a number on which viewers could give a missed call. When called back, viewers could either answer the quiz or participate in a discussion. Overall its two-year period, the serial received 1.4 million calls from across the country. Both men and women called to share their opinions and vowed to change.

As an additional intervention, 'Sneha Clubs', where viewers discussed the issues raised, were formed with the help of 10 NGOs in Bihar and Madhya Pradesh. The show was also converted to radio, and broadcast on 230 All India Radio stations. Further, it was translated into 12 languages for regional telecast.

A PFI study in 2015 found that the serial managed to change attitudes to a significant degree. This is consistent with findings from other similar interventions where it has been seen that using edutainment to deliver critical social messages is both effective and efficient—it can reach and convince target audiences quite rapidly.

Taking note of the finding that as many as 40 percent of the serial's viewers were between 15 and 24 years of age, the MoHFW requested PFI to include discussions around the key themes of the RKSK in the show's second season. PFI then made eight films around the six key themes of the RKSK. Furthermore, PFI researchers created the name 'Saathiya', meaning friend, for the peer educators appointed under the RKSK. Compact discs of the episodes were made part of the kit distributed to peer educators.

Digital technology-based YouthLIFE program

Centre for Catalyzing Changes' YouthLIFE (Life Skills, Information and New Technologies, and Education) program aims to improve adolescent's knowledge and decision making around critical life choices that promote their reproductive health and rights—towards this end the programs uses education, information sharing, and new technologies. The program, which is supported by the MacArthur Foundation, is implemented in selected schools in Delhi and Jharkhand and reaches out to over 30,000 adolescents.

The special features of the YouthLIFE program include:

- YouthLIFE combines Centre for Catalyzing Changes' Life Skills and Reproductive Health

curriculum, with peer discussions and information sharing using new technology platforms. The program enhances adolescent girls' and boys' knowledge and guides informed decisions around their reproductive health to promote effective learning and ability to make healthy behavior choices.

- YouthLIFE uses a range of communication platforms, including classroom and computer learning, and reaching youth through technologies with updated education and digital methodologies.
- Through smart classes, portions of academic curricula are taught in a digital mode, using various visuals and animations.
- The digital curriculum is designed for young boys and girls aged 10-14 years (an age group that is widely acknowledged as largely neglected by adolescent health interventions). This self -learning program involves innovative ways of learning through edutainment and simulation games and exercises.

'Saathiya Salah' mobile app for adolescents

UNFPA and Population Foundation of India contributed to development of the 'Saathiya' Resource Kit and 'Saathiya Salah' mobile app for adolescents—these were launched by GoI in 2017. The 'Saathiya Salah' mobile app acts as a ready information source for adolescents in case they are unable to interact with peer educators or hesitate to discuss certain health issues with them.

Conclusions

The interventions discussed in this chapter use diverse media platforms and formats to influence the beliefs, behaviors and practices of adolescents and their communities. Many of these interventions use multiple channels to enhance reach and impact.

The media have a significant impact on adolescents' behavior and attitudes. There is a need for large-scale studies that explore media use patterns among adolescents including their media preferences, the context of media use, their interpretation of media content, and finally what messages they imbibe and act out in their daily lives. The aim of the research would be to enhance understanding of how various media platforms influence adolescents in their transition to a secure and healthy adulthood.

Further, in view of the rapid expansion in the use of media, agencies that design communication interventions need to track the reach of the various media in different geographies and among different target audiences and adjust their planning accordingly.

New media including social media and digital technologies are very promising, more so with the rapid growth in mobile phone use. However, as mentioned earlier, at present there is little consensus about the most effective strategies for their use with adolescents. Hence it is important that media strategies, especially strategies that employ new media, be strongly anchored in evidence regarding what works with adolescents.

Irrespective of the media used, for communication interventions to achieve the desired outcomes, it is imperative that, along with appropriate information, services and products be made available to adolescents. This implies that implementing agencies need to work on, among others, strengthening health worker training, product supply chain systems, and adolescent friendly facilities.

Convergence for RKSK: convergence plans, challenges and way forward

8

Introduction

The RKSK strategy recognizes that the diverse needs of adolescents cannot be addressed by the health sector alone, and hence that there is a clear need for pooling resources and harnessing collective strengths across multiple sectors working towards improving the health and well-being of adolescents. Hence RKSK has established a strategy and framework for implementing program interventions through convergent efforts at both intra-departmental and inter-departmental levels.

Ministry of Health and Family Welfare: Plans for RKSK convergence with other health programs

The RKSK proposes convergence with the following programs:

Strengthen existing linkages with NACO, Family Planning and Maternal Health divisions for information, including existing programs and schemes, counselling, services and commodities

Family planning: Provision of contraceptives and pregnancy kits to adolescents; capacity building of health functionaries regarding varied contraceptive needs of adolescents; incentivization of ASHAs for delaying first pregnancy in married adolescents.

Maternal health: Maternal health-tracking of adolescent pregnancy for birth preparedness and complications prevention; capacity building of health functionaries to manage adolescent pregnancy and its complications.

National Mental Health Programme: Well-defined linkages with the District Mental Health Programme and the psychiatric wings of medical colleges for referral care.

National Programme for prevention and control of cancer, diabetes, cardiovascular disease and stroke (NPCDCS): Linkages with NCD clinics at CHC and DH levels; inclusion of health promotion on NCD prevention in training modules of MOs, ANMs, staff nurses, teachers and peer educators

National Tobacco Control Programme (NTCP): Trigger behavior change to eliminate tobacco use among adolescents through peer educators, role models and school-based activities of NTCP

Rashtriya Bal Swasthya Karyakram (RBSK): make appropriate referrals to AFHCs and District Early Intervention Centres (DEICs); provide key health promoting messages through the block level mobile health teams.

This chapter outlines the convergence plans of RKSK, and relevant adolescent-focused policies and programs of other stakeholder ministries including Ministry of Women and Child Development (MoWCD), Ministry of Human Resource Development (MHRD), Ministry of Youth Affairs and Sports (MoYAS) and Ministry of Drinking Water and Sanitation (MDWS). The chapter then discusses challenges faced in achieving convergence and suggests ways for addressing them.

Convergence plans of RKSK

Ministry of Women and Child Development (MoWCD)	
RKSK's convergence plans	**Relevant provisions in MoWCD policies/programs**
• AWC to be the hub of activities for out of school girls (Scheme for Adolescent Girls (SAG)/Sabla and KSY to serve as platforms) • AWWs to select and mentor peer educators under Scheme for Adolescent Girls (SAG)/Sabla (to use Sakhi Saheli when possible) • Use of Scheme for Adolescent Girls (SAG)/Sabla module to train ANMs	Among the objectives of **National Nutrition Mission 2017** is to reduce the prevalence of anemia among women and adolescent girls in the age group of 15-49 years. The following three services under the **Scheme for Adolescent Girls (SAG)** will be provided (to out of school girls in the age group of 11-14 years) in convergence with the relevant schemes of the state Departments of Health & Family Welfare: • IFA supplementation, including supply of IFA tablets • Health check-up and referral services • Nutrition and Health Education

Ministry of Human Resource Development (MHRD)	
RKSK's convergence plans	**Relevant provisions in MHRD policies/programs**
• **Adolescence Education Programme (AEP)** to cover all the secondary and senior secondary schools of the country. AEP trained teachers from CBSE, Kendriya Vidyalayas (KVs), and Navodaya Vidyalaya Schools (NVS) and State Board schools, to provide health education on SRH, HIV/AIDS, and substance abuse • Teachers to select, and mentor peer educators—incentive-based activity • Inclusion of topics related to mental health, substance abuse, NCDs, nutrition and violence in the curricula of secondary and senior secondary schools • Using the platform of schools to increase awareness about facility-based health services for adolescents at Adolescent Health Clinics	**AEP**: Most of the strategic priorities in RKSK (nutrition, reproductive and sexual health, response to injuries and violence including GBV, mental health, preventing and managing substance misuse and non-communicable diseases) are also addressed in AEP. The **School Health Programme (under Ayushman Bharat)** is a joint initiative of Ministry of Health and Family Welfare and Department of School Education & Literacy, Ministry of Human Resource & Development. The Programme aims to implement preventive and promotive activities in schools. The Programme specifies inter-departmental coordination and joint working mechanisms. For reporting and recording purposes under the Programme, the indicators for all relevant health promotion activities in schools will be included in the existing Shalakosh-U DISE (Unified district information system) of the Education department.

Ministry of Youth Affairs and Sports (MoYAS)	
RKSK's convergence plans	**Relevant provisions in MoYAS policies/programs**
• Adolescents, who have undergone the 45-day training on 'life skills education' can form a cadre of peer-educators • Telephonic counselling under the National Programme for Youth and Adolescent Development (NPYAD) can be utilised to provide counselling services to adolescents • Trained District Youth Coordinators and Project Coordinators can be trained on adolescent health and development • NYKS has linkages with local NGOs, the capacity of which can be built through training provided by skilled personnel from the Health Department	The **National Youth Policy 2014** envisages implementation, through MoYAS's programs, of targeted health awareness programmes for youth and targeted disease control programmes for youth. The Policy recommends leveraging of NRHM, NACP and on-going NGO programmes to expand disease detection, control and awareness programmes. In addition to its own core programmes, **Nehru Yuva Kendra Sangathan (NYKS)** takes up programmes and schemes in convergence with various other central and state government agencies, UN organizations and other agencies. As such, these other departments and agencies can leverage the vast outreach of the NYKS (8.65 million youth enrolled in 623 districts).

Ministry of Drinking Water and Sanitation (MDWS)	
RKSK's convergence plans	**Relevant provisions in MDWS policies/programs**
Under the **Menstrual Hygiene Scheme (MHS)** and **RKSK, MoHFW's prime focus is on**: • Manufacture, procurement, storage and distribution of sanitary napkins • ASHA training for MHM education • MHM education activities	**MoDWS's Menstrual Hygiene Management (MHM) National Guidelines of 2015** are integrated into the national sanitation program (**Swach Bharat Mission**), they also highlight the roles of the other concerned ministries in improving MHM and recommend greater convergence amongst them, including consensus on the roles and responsibilities, and greater coordination. **MoDWS's prime focus is on**: • Building & maintaining toilets in schools, homes & communities • Establishing disposal mechanisms • Solid and liquid waste management

Challenges faced in achieving convergence

Available information indicates that achieving convergence under RKSK and its related schemes is challenging.

The Tenth Common Review Mission (CRM) under the National Health Mission conducted during 2016 observed that inter-departmental coordination between Departments of Health, Education and WCD had been a challenge and needed to be effectively addressed. The Mission further observed that many schemes such as WIFS, deworming program, among others, could be much more effective if there were better inter-departmental coordination and synergy of inputs. More specifically, such lack of convergence had, among others, led to poor reporting on IFA coverage and low awareness regarding the benefits of IFA tablet consumption among the beneficiaries in the States of Delhi, Kerala, Nagaland and Tripura. Discussions held with stakeholders during the landscape study too indicated that inter-departmental convergence for RKSK at state and district levels is inadequate.

Challenges faced in achieving convergence under the WIFS program are illustrative of challenges faced under other components of adolescent health as well. For instance, iron supplementation is generally seen as a health department intervention, therefore ownership of the program by the partner departments, namely, ICDS and Education is often a challenge. *The absence of a formal coordination mechanism and absence of clear lines of responsibility and reporting further compound the challenge.*

Endeavors to improve adolescent health through convergent efforts require good understanding of the synergistic dynamics of the actions of all concerned partners. *However, as a UNFPA study in 2017 noted, even at the state and district levels, there is limited understanding of how different RKSK components should work synergistically for optimizing benefits or young people.* According to the study, an important reason for this lack of clarity is that "patchy implementation of different RKSK components in sub-district geographies…limits ownership and impedes a holistic understanding."

Conclusions and way forward

While most strategy and program frameworks for adolescent development programs emphasize the criticality of convergence for successful outcomes, and specify guidelines and mechanisms for operationalizing convergence, achieving convergence in practice is challenging, both in terms of interdepartmental coordination at national and state levels and convergence at the operational/ field levels. Nevertheless, some adolescent-focused programs have had significant success in achieving convergence at scale (a notable example is the UDAAN program in Bihar, which is discussed in the next chapter).

Based on insights garnered from the literature and discussions with stakeholders, some ways forward are suggested for promoting convergence and addressing the challenges to it:

- The element of **oversight and accountability for convergence, including regular monitoring**, should be part of convergence mechanisms. In the case of RKSK, **at the national level** such oversight could be exercised by the Prime Minister's Office, either directly or via NITI Aayog.
- **Elevating RKSK's profile to be on par with programs such as nutrition and NACP**, with the aim to strengthen both convergence and advocacy efforts. Establishing a national youth council could be among the steps in this direction.
- **At the state level, a systematic approach should be evolved to coordinate the efforts of key departments responsible for program implementation**—within the health department to begin with, and then with partner departments. This should include the formation of an interdepartmental convergence committee with a key mandate for continuous advocacy for interdepartmental convergence through, among others, regular reviews. Further, this forum should be formalized.
- **The responsibilities of officials of the concerned partner departments should be clearly delineated**, including responsibilities for recording and reporting, and there should be effective monitoring of their compliance with their designated roles.
- **The convergence effort must have a clear anchor in the health department**, which should coordinate with partner departments to evolve a shared vision of all partners as contributing to achieving the larger goals of the state. Towards this end:
    - Nodal officers should be identified in each collaborating department
    - It should be ensured that program managers from the collaborating departments participate in each other's state level review meetings to exchange information on themes relevant to convergence.
- **It is crucial that proposals for Interdepartmental convergence percolate down the line** to functionaries at district and block level.
- **At the district and field levels**, accountabilities should be fixed for the implementation of convergence efforts, and the process should be closely monitored. To enable this, the district collector/magistrate may be made responsible for facilitating and monitoring convergence efforts.
- **Technical support** (for instance, by UN agencies and NGOs) can be helpful in promoting convergence.
- **NGO partners can facilitate government initiatives for convergence** since many NGOs have experience of implementing multi-sectoral initiatives, and, in so doing, gain experience in coordinating with various government agencies and where needed, facilitating convergence amongst them.

Adolescent-focused interventions: evidence and recommendations for programming and research

9

Introduction

Over the years, a wide variety of interventions and programs aimed at fostering adolescent health and development have been implemented across the world. Many of these interventions have been extensively studied and in respect of some interventions, there is now a body of evidence regarding their effectiveness or lack of it. Successful outcomes are often associated with specific contexts—for example, some interventions have been shown to work in high income countries only, while others have been successful in low and middle-income countries as well. There are yet other interventions that are viewed as promising but remain to be backed by adequate evidence.

Most of the research on adolescent health interventions, both in India and globally, has focused more on sexual and reproductive health than on mental health, non-communicable diseases, violence, and substance misuse. Also, several aspects of sexual and reproductive health itself have not been adequately studied.[1] Overall, there is a scarcity of published literature on the effectiveness of interventions for adolescents and young adults.[2]

This chapter reviews and synthesizes study findings and evidence on certain key themes relating to adolescent health programming. **The purpose of this chapter is to inform the design and implementation of interventions to be undertaken under RKSK by health department and other stakeholder ministries, as well as adolescent-focused interventions by NGOs working as government partners or independently.**

The discussion in this chapter spans the following three themes:

- **Theme 1:** Synthesis of findings on the evidence for certain promising interventions and recommendations for programming and research
- **Theme 2:** Critical lacunae in how interventions are planned and implemented, thereby impacting their effectiveness
- **Theme 3:** Prevention science, an emerging frontier in adolescent health, for which there is a growing research base worldwide and which seeks to substantially reduce morbidity and mortality.

Synthesis of findings on the evidence for promising interventions and recommendations for programming and research

This study focused on nine interventions—from health and other sectors—which are viewed as promising for their influence on adolescent health, and therefore worth planners to consider investing in.

The interventions discussed herein include:

The scopes of some the above interventions overlap; also, there are major synergies between programs focused on achieving reproductive health outcomes and those intended to build life and leadership skills and enhance the agency of adolescents. Indeed, many reviews emphasize the need for multi-pronged and multi-component programs, implemented at community, school and health service levels, and adapted to sociocultural contexts. In fact, several programs—especially those implemented by NGOs—frequently aim to address many of the above themes simultaneously.[3]

Some of the above interventions are backed by evidence (albeit of varying degrees), some have not been adequately studied, and some have so far been implemented only on limited scale. Hence further research may be needed on some of these before they can be implemented. These interventions are implemented by both government and non-government actors. This study reviewed and synthesized study findings on the existing evidence (global and Indian) for these interventions, recommendations for programming and further research, and, where such information was available, implementation challenges.

A synthesis of findings is given below:

Adolescent-focused interventions: evidence, recommendations for programming and research, challenges

Highlights of the work of selected NGOs

Intervention	Evidence	Recommendations for programming/ research	Implementation challenges
Comprehensive Sexuality Education (CSE) *CSE programs are also referred to as family life education, sex education or adolescent education programs.*	**Global evidence:** There is a **substantial body of evidence on comprehensive sexuality education: it has been shown to improve adolescent SRH knowledge, attitudes, and behaviors when well implemented.**[4] Evidence from several countries points to positive effects of sexuality education on knowledge and attitudes, on condom use, number of sexual partners, sexual debut and risky sexual behavior. Further, there is no evidence that sexuality education promotes premature sexual activity. Some studies found that combining sexuality education with contraceptive promotion significantly reduced unintended pregnancy. There is robust evidence that abstinence-only education programs have no effect on reducing infection and unintended pregnancy.[5] **In 2009, UNESCO and other UN partners issued technical guidance on the development and implementation of quality CSE.** The document identified 18 characteristics of quality CSE; 12 of these characteristics are related to the development, content, and delivery of sexuality education. According to the guidance, participatory teaching methodologies are essential to ensure the development of skills and self-efficacy to act on information.	• Develop common understanding of curriculum content of Comprehensive Sexuality Education (CSE) but allow for customization to local contexts • It is essential to identify 'must-include' content elements of CSE in view of the persistent stigma attached to certain topics in the curriculum • Develop age-appropriate models, evaluate their effectiveness, and then consider scaling up. For this, review international experiences to inform curriculum modification • Incorporate additional components beyond sexuality education, including, among others, gender norms, nutrition, mental health and substance abuse.[9], [10]	Many teachers are very uncomfortable teaching about sexuality and are often inadequately prepared; some lack the skills to give such instruction. [11] To effectively engage with adolescents on sensitive topics, it is essential to involve community gatekeepers and frontline health workers. In practice, this is a challenge in view of pervasive social stigma attached to sexual matters. NGOs have found it fruitful to contextualize curricula to local cultural norms. But to do this on scale is challenging, since adaptation of curriculum to multiple contexts requires substantial resources. It is crucial that stakeholders collectively determine universal standards for CSE programs, but there is no forum in India that could facilitate this. Hence the curricula of many SRHR education programs in the country lack certain critical elements. [12]

Intervention	Evidence	Recommendations for programming/ research	Implementation challenges
Peer education	A recent study highlighted the importance of incorporating an empowerment approach emphasizing gender and rights in improving reproductive health outcomes. **Studies show, however, that implementation of school-based CSE programs often does not exhibit these characteristics.** Studies also show that curriculum content is often inadequate, and the problem is compounded by weak delivery. [6] **<u>India evidence:</u> Sexuality education programs in India are not truly comprehensive, and there are few reliable evaluations. An evaluation of the Adolescence Education Programme (AEP) was conducted in 2010-11 in selected schools in five states.** The evaluation showed modest positive effects of the program on awareness of physical maturation, nutrition and anemia, HIV/AIDS and modes of transmission, and substance misuse. Modest effects were also visible in students' agency as well as their gender role attitudes. The evidence also showed positive influence of AEP on awareness of and attitudes about delaying marriage and childbearing. The evaluation highlighted the need to strengthen teacher training and methods of transacting the curriculum.[7] Accordingly, certain changes were made to strengthen the program. In 2016-17, an assessment of the AEP was undertaken across 100 schools in the country. Findings clearly showed that AEP is recognized as an important priority in school education. The assessment made certain recommendations aimed at consolidating the gains in the program (training and resource materials, trained human resources, monitoring protocols, mechanisms to engage young people, a virtual platform) and institutionalizing it.[8]		

Intervention	Evidence	Recommendations for programming/ research	Implementation challenges
Adolescent-friendly health services	**<u>Global evidence</u>: There is evidence, although of moderate quality, suggesting positive effects of adolescent friendly health service interventions** that provide information and counselling, contraceptives, pregnancy related care, abortion care, treatment and prevention of STIs, HIV testing, and counselling and care for sexual and gender-based violence. Such services improve both the uptake of these services and contraceptive knowledge and practice.[13] **However, studies show that most programs deliver adolescent-friendly services ineffectively. Several evaluations have shown that adolescent use of SRH services can be increased, especially when the following 4 complementary approaches are implemented together:** 1. Providers are trained and supported to be non-judgmental and friendly to adolescent clients. 2. Health facilities are welcoming and appealing. 3. Communication and outreach activities are used to inform adolescents about services and encourage them to make use of services. 4. Community members are supportive of the importance of providing health services to adolescents.[14] **<u>India evidence</u>: A scoping review of 2016 of about 30 studies published between 2000 and 2014 that evaluated Adolescent Friendly Health Services (AFHS) initiatives** made the following findings: • There are some weaknesses across study designs, and lack of comparability between intervention and comparison groups.	While RKSK includes a strong focus on the need for the provision of adolescent friendly health services and Adolescent-Friendly Health Clinics would be established across the country, substantial work is needed to establish appropriate design, reach and effectiveness in the Indian setting—for this purpose various modified models may need to be tested. There is a need to test whether currently implemented models are feasible, and how to establish optimal linkages between clinic-based services and outreach in schools and communities, drawing on any existing NGO experiences.[16] Further, additional strategies for delivering services to adolescents should be explored: for instance, establishing a wider provider base in the public and private sectors and demand-generation through social marketing.[17]	Facilitating access to products and services does not necessarily lead to actual service utilization. Often services and products are not acceptable or affordable. Further, service providers are sometimes rude or judgmental, and while there are affordable public services that are free or low cost, people often prefer private providers whom they consider to be safe or confidential sources.[18]

Intervention	Evidence	Recommendations for programming/ research	Implementation challenges
	• That said, findings do suggest that these programs resulted in increased knowledge about SRH matters, both among providers and adolescents, and increased contraceptive practice and use of sanitary napkins; a couple also demonstrated an effect on raising age at first birth at the community level. • Efforts to spread information about the availability of services have, however, been inadequate. Consequently, there was limited awareness and use of available services, in particular those offered by Adolescent Friendly Health Clinics (AFHCs).[15]		
Peer education	**Global evidence:** Several studies including five meta-analyses of peer education programs implemented in widely different contexts over many years have concluded that while these programs result in information sharing, on their own, they have very limited effects in promoting healthy behaviors and improving health outcomes among target groups.[19] However, there is moderate quality evidence to suggest that peer education programs, despite being largely unsuccessful in high income countries, may have an effect in low and middle-income countries, particularly on safe-sex behaviors and use of health services. *The Lancet* Commission labels peer education programs as promising for low and middle-income countries but recommends further research to identify the nature and effect of these programs. **Evidence from India:** There are **no evaluations of peer led interventions in India.**[20]	Peer education might be more effective if it is integrated in holistic interventions and if the role of peer educators is redefined in a way that makes them more of a source of sensitization and referral to experts and services.[21] **Additionally, there is need for:** • Monitoring/concurrent assessment of peer educators' role in the field to identify effective ways of utilizing them to promote use of health services. • Developing and testing contextually appropriate models in different parts of the country, drawing on NGO experiences with peer-based programs.[22,23]	**NGOs implementing peer-based programs point to the following issues:** • It is challenging to identify and recruit motivated and mature adolescents with the requisite skills to discuss SRHR issues. peer leaders often lack leadership, communication skills and the capacity to promote social change in the local communities. • Peer leaders may be perceived as being favored by teachers or program staff members, and this in turn may impact trust levels within peer groups. Such programs involve high costs since there is rapid turnover as peer leaders grow older, hence there is a constant need to train new recruits. Also, peer leaders require more support in terms of training and mentoring than adults—this also entails higher costs for the program.

Intervention	Evidence	Recommendations for programming/ research	Implementation challenges
Gender transformative life skills education programs	**Global Evidence: Gender transformative life skills education has been found to be effective in the global literature in promoting safer entry into sexual life, delaying marriage and childbearing and developing adolescents' agency.** Life skills education programs are also promising in terms of a reduction in intimate partner violence. **India evidence:** Several gender transformative life skills education projects have been implemented in India by NGOs, using different designs and curricula. **While these projects appear promising, there have been few evaluations. Existing evaluations indicate that these interventions are promising in terms of raising awareness, changing gender role attitudes, and building adolescent agency.** A few have demonstrated positive effects on behaviors such as delaying marriage and childbearing, promoting birth spacing or reducing the perpetration of violence against women and girls. A few programs have also shown success in modifying the attitudes of boys. [24]	Investment is needed in adapting appropriate gender transformative life skills education models from among those discussed in the global literature, ensuring that content is age-appropriate and comprehensive. Since the risk profile of boys differs from that of girls in terms of alcohol and substance abuse, injuries from road accidents and interpersonal violence, effort should be made to develop and test models that establish how to incorporate these elements in programs.[25] Several national programs, including the RKSK, SABLA, NYKS programs, and the AEP, include a focus on empowerment, life skills, changing gender norms, and equipping adolescents to make informed choices. Hence there is potential to incorporate gender transformative life skills education in these programs.	
Programs focusing on married girls	**Specific vulnerabilities of married girls:** Although married adolescent girls constitute the largest group of sexually experienced adolescents in this country, they are very hard to reach through adolescent-focused programs. They are often pulled out of school, unable to access communal spaces and have their social networks limited to their immediate family. Therefore, it is likely that the specific needs of married adolescents are neither addressed in services for married women nor in interventions aimed at adolescents in general.[26],[27]	In view of married girls' vulnerability and numbers, it would be appropriate to review, adapt and then scale the NGO-implemented projects in India to sub-district level in states with high rates of child marriage. While gender transformative life skills education programs are typically implemented among unmarried adolescents, there is a need to orient programs to support married girls, who despite the decline in child marriage, continue to comprise millions of adolescents.[29]	

Intervention	Evidence	Recommendations for programming/ research	Implementation challenges
	Global evidence: A systematic review was conducted of 14 community based reproductive health interventions, of which five were from India. The review highlighted that multi-layered community-based interventions that target married young women as well as their husband, their family and their community can improve reproductive health services among the young, but recognized the difficulties in changing norms at the family and community level. **Evidence from India: A few NGO-implemented projects in India have focused exclusively on married girls and their evaluations suggest that such a focus has potential to improve pregnancy care and child spacing outcomes.** The evaluation of one such project showed a significant, independent effect on indicators reflecting married young women's autonomy, social support networks, partner communication and support, knowledge of sexual and reproductive health, use of contraceptives to delay the first birth, antenatal care, delivery preparedness, routine postpartum check-ups, and adherence to recommended breastfeeding practices. **In the case of another project, a longer- term evaluation found that the intervention was not only associated with increased contraceptive knowledge and use in the short term, but also that the short-term gains were sustained years later.** [28]		
Programs directed at very young adolescents	**Global evidence:** Very young adolescents are a neglected segment both nationally and globally. It is increasingly understood that gender roles are established at a young age, and that early adolescence and puberty intensify traditional gender role attitudes and widen differences in socially acceptable behaviours between girls and boys.	Very young adolescents (VYAs) are in a formative period in their lives and experience a variety of transitions on the way to adulthood. It is important for programs to equip VYAs with, among others, life skills, comprehensive sexuality education and information that helps them identify and address violence.[32]	**Challenges in reaching Very Young Adolescents:** • It is often controversial to work with this age group in the Indian context, especially due to the stigma surrounding SRHR issues. VYAs are considered too young to engage on topics such sex, contraception and violence.

Intervention	Evidence	Recommendations for programming/ research	Implementation challenges
	However, few programs globally target very young adolescents and even fewer have been robustly evaluated. Designing and testing programs aimed to change attitudes and behaviours among very young adolescents, for example age-appropriate comprehensive sexuality education, puberty education and programs that engage young adolescents through sports or ICT, would fill a crucial gap in the global and Indian evidence on what works. [30] **Evidence from India:** While few such programs have been implemented in India, there is **evidence from at least two studies focused on young boys that used sports as a vehicle to provide gender transformative life skills education. Both studies showed an increase in equitable attitudes expressed by young adolescent boys.** Indeed, one of them showed that changes were more significant among younger than older adolescents. [31]	Very young adolescents are recognized as a neglected group, and research is needed that explores acceptable ways of reaching this group, apprising them about physiological maturation and instilling in them new notions of masculinity and femininity.[33]	• There are systemic challenges in reaching VYAs and imparting knowledge to them. For instance, teachers, Aanganwadi workers, and other frontline workers are untrained and/or overburdened and hence unable to handle this additional responsibility. • Many gatekeepers do not acknowledge the necessity to provide SRH information and services to this age group. • The most vulnerable segments among VYAs, including those from Scheduled Castes, Scheduled Tribes, or disabled adolescents, those out-of-school, are not easily reached through mainstream programming.
Targeted interventions that aim to engage parents and modify parenting practices	**Global evidence: Although the role of parents as key socializers of adolescents is repeatedly acknowledged, there are hardly any interventions in India or other low- and middle-income countries that have aimed to modify parenting practices,** encourage parents to adopt more gender- egalitarian socialization practices, and play a supportive role in the transitions to adulthood faced by their sons and daughters. Parents are rarely the primary target group of programs conducted in LMIC. Rather, programs that aim to change young people's knowledge, attitudes and practices may also engage parents and communities on the advantages of delaying marriage, ranging from one-on-one counselling sessions to group and community education programs. Among such programs, very few have been evaluated.	**There is a need to develop, test and evaluate interventions that involve and engage parents** through schools, as well as through livelihood training and health programs for adolescents, using forums that are acceptable to and convenient for parents (such as school committees, AFHCs, etc.), including fathers, and evaluate program effects on both parents and adolescents. Such interventions should, among others, aim to transmit information on adolescent health and gender-egalitarian attitudes towards sons and daughters.[35]	

Intervention	Evidence	Recommendations for programming/ research	Implementation challenges
	Despite the sparse, moderate quality and often inconclusive evidence from low- and middle-income countries, available reviews call for the inclusion of a strong focus on family and community in multi-component interventions that aim to change social norms and practices. **Parenting-focused programs are more common in high-income countries, and evaluations measuring effects on adolescents have found promising results.** **Evidence from India: Most programs have acknowledged the role of parents, but have traditionally included them only peripherally in life skills and other programs,** for example by conveying the benefits of enrolling their adolescent in a program and seeking their consent and cooperation. [34]		
Use of media (mass media and digital media)	In recent years, communication, information technology, and mass media have rapidly evolved into a platform that provides innovative opportunities for engaging youth, including disadvantaged and hard-to-reach youth and those turned off by traditional health education approaches.[36] **Mass media:** Health-care services for adolescents depend on adolescent help-seeking. School-based promotion of services, mass media campaigns, and social media can all play potential roles to reduce barriers to accessing health care by promotion of health literacy and help-seeking. **Web-based or other technologies might improve help-seeking, although a recent systematic review found little evidence to date.** Merely establishing stand-alone adolescent health services is not effective. The most effective strategies use a combination of approaches, including health-worker training, adolescent-friendly facility improvements,		

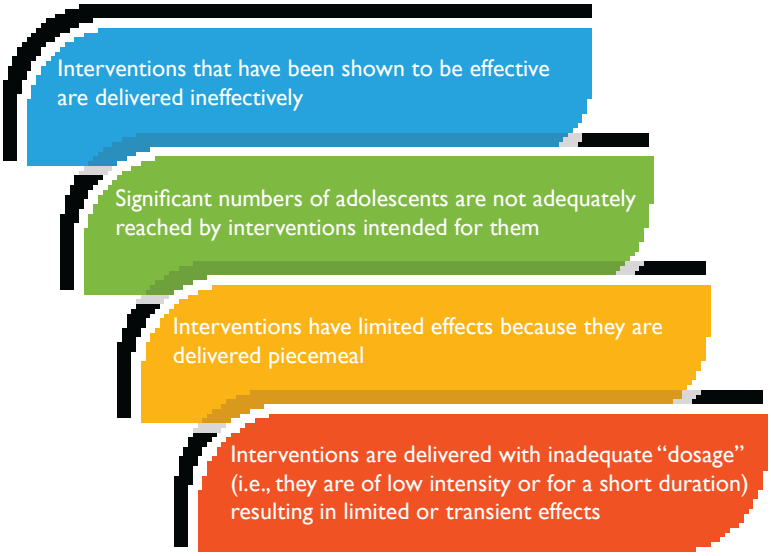
Intervention	Evidence	Recommendations for programming/ research	Implementation challenges
	and information dissemination though the community, schools, and mass media to drive demand. **Social marketing and mass media approaches should not only target the attitudes and values of adolescents and young adults but also their families and broader communities.** Partnerships with civil society and media professionals are very effective in exploiting the potential of these platforms.[37] Based on **evidence on substance abuse** it appears that among tobacco-related interventions, school-based prevention programs and family-based interventions are effective in reducing smoking; **mass media campaigns are also effective provided these are of adequate intensity over extensive periods of time.**[38] **Digital media:** Social media holds potential to reach diverse groups including geographically and socially marginalized adolescents. The growth of new media/technologies can enable a sustainable environment for young people to engage around their health. **The growth in mobile devices together with social networking and digital technologies provide huge opportunities for engagement. However, at present there is little consensus about the most effective strategies for use with adolescents. Evidence on effectiveness is also very limited both in terms of longer term benefits and concrete health outcomes.** Even so, many global organizations including, among others, WHO, UNFPA, and the Lancet Commission are using online technologies, including social media and surveys, to gather information about health priorities directly from young people to inform strategies and policies.[39]		

Intervention	Evidence	Recommendations for programming/ research	Implementation challenges
	Young adults affirm the benefits of seeking health information online and through social media and find these channels to be useful in supplementing information obtained from health care visits. **Social media may be used to promote health and wellness and advocate healthy behaviors, such as abstaining from smoking and a balanced diet. Unfortunately, however, there are also innumerable web sites and social networks that promote unhealthy behaviors.**[40]		
Conditional cash transfer (CCT) programs	**Global evidence: Successful CCT programs and other entitlement-based programs in other countries** have focused on improving schooling outcomes and have had short time horizons with payments made monthly or annually conditional on regular attendance. **Such programs have been shown to positively influence not only schooling outcomes but delayed marriage and childbearing as well.** There is also moderate quality evidence for the impact of schooling-linked unconditional and conditional cash transfers on improving safe sex practices, as well as on reducing STI and HIV prevalence. Economic incentives were also identified as a promising approach in a review of evaluations of interventions aimed at reducing STIs or high-risk behaviours among the young. **A systematic review** of interventions and evaluations to reduce unintended and repeat pregnancy among young people (including unmarried youth) in low and middle-income countries **found that conditional cash transfer programs were more likely to have positive effects on unintended and repeat**	**There is a need to reshape CCT programs in India**, drawing on successful international models, and test models for immediate as well as long-term impacts.[42]	

Intervention	Evidence	Recommendations for programming/ research	Implementation challenges
	pregnancy than programs focused on peer education and life skills education, contraceptive counselling and supplies, and use of mass media. **Evidence from India:** CCT programs in India were **aimed at countering adverse sex ratios at birth and the practice of gender-biased sex selection** and not schooling outcomes. Hence these **programs generally have very long-term pay-out horizons** (for example when the child turns 18 and is unmarried, or when she achieves such milestones as full immunization) and **few have been robustly evaluated.**[41]		

Critical lacunae in how interventions are planned and implemented

Many studies point out that although certain interventions are backed by strong evidence, there are serious deficiencies in the way they are planned and/or implemented, thereby compromising their effectiveness. This section discusses four such prevalent lacunae, namely:



Lack of fidelity: interventions that have been shown to be effective are delivered ineffectively

Studies highlight that adolescent health interventions are often poorly implemented, lacking fidelity to the critical elements of the interventions that make them effective in the first place, or picking and choosing from among a few approaches rather than implementing them together as a whole. For instance, although CSE and AFHS have been shown to be effective, there are often various lacunae in their implementation which compromise their effectiveness.[43] Among the commonly encountered lacunae are: field-level program implementers may lack capacity and commitment, program delivery may be compromised if health care providers skip issues that make them uncomfortable or do not ensure participant engagement and reflection. To ensure fidelity of implementation, studies recommend establishing stronger program monitoring mechanisms, and undertaking process documentation that would help track fidelity and facilitate making mid-course corrections.[44]

Adolescents are not adequately reached by interventions intended for them

For an intervention to influence adolescents' knowledge, attitudes, beliefs, and behavior, it must first be able to reach them. **Studies suggest that many adolescents, especially those with the most pressing health/SRH needs or who are most marginalized or vulnerable, are not being reached by interventions as intended by program planners.**[45] Many programs make inadequate, if any, efforts to ensure that the most vulnerable adolescents are reached. Unless specific measures are taken to identify and ensure the inclusion of the most vulnerable—for instance, by caste, household poverty, sex and marital status—interventions may well overlook the neediest adolescents.[46] **In fact, findings on interventions implemented in several countries in various settings show that without dedicated outreach for specific subgroups of vulnerable adolescents (such as very young adolescents or married adolescents), the more advantaged (e.g., older and unmarried adolescents and youth) are more likely to be reached by traditional youth programs.**

Case study from India

A recent evaluation of the TARUNYA Project, which supported the Government of Jharkhand State, India, to implement its ASRH Program, found that community-education sessions conducted by trained community volunteers over a period of 5 years reached around 1 in 4 girls aged 10–14, compared with 1 in 3 girls aged 15–19. Among the 1,288 girls surveyed, the project was predominantly reaching older, unmarried and literate adolescent girls. Even in a part of the state where levels of community education were high, they reached only 1 in 5 boys aged 18–19, out of 210 boys surveyed. [47]

Piecemeal delivery of interventions

Interventions have limited effects because they are delivered piecemeal, instead of in coordinated and complementary fashion. Adolescents' health outcomes are determined by

various factors which operate at different levels and are interrelated in complex ways. Adolescents make choices to engage in specific behaviors based on what they know, believe, and can do—within contexts, where in fact many, especially girls, have limited agency. To improve the health of adolescents, action is needed at each of these levels, often by sectors other than health. Yet in many places, interventions are implemented in an uncoordinated and piecemeal fashion, and hence do not result in positive outcomes. Sometimes, the fragmented implementation of interventions can even have negative effects.

Case study from England

Convincing evidence of the importance of implementing coordinated and complementary interventions comes from a 2014 review of England's multi-year effort to reduce teenage pregnancies.

Beginning in 1999, the Government of the United Kingdom established a 10-year strategy to reduce teenage pregnancy rates. One of the 4 key themes of the strategy was to ensure coordinated action of better prevention activities for boys and girls, which included providing comprehensive sexuality and relationship education through a variety of channels, improving access to contraception through a variety of means, supporting a communication campaign to reach young people and their parents, and strengthening support for young parents.

A midcourse review in 2005 showed that while overall the under-18 conception rate had declined by 11%, there was wide variation in results across other areas. This prompted an in-depth review: 3 local government areas where under-18 conception rates declined since 1998 were compared with 3 areas with similar demographics but where conception rates were static or increasing. **The review found that areas with better reduction rates were implementing all aspects of the strategy whereby all relevant agencies were involved to create a "whole systems" approach.** Strong leadership was also an important factor. In areas with little progress, only some aspects of the strategy were being implemented, even though considerable effort was being made. As a result of the 2005 review, the Government identified and disseminated nationwide 10 "must-do" activities, and it established a system for self-assessment and external assessment. Teenage pregnancy rates began to decline in all 150 local government areas of the country, and the decline continues to this day.[48]

Interventions are delivered in a low "dosage" and are not sustained

"Dosage" here refers to how intensively and/or how long an intervention or a package of interventions is delivered. In practical terms this means a program that reaches young people with complementary messages using a variety of delivery mechanisms (e.g., teaching sessions in school, hoardings, and radio or television chat shows), has a higher "dosage" than another program that uses fewer and less-intensive approaches. An outreach worker who conducts monthly discussion sessions with a youth group over a period of 12 months also delivers an intervention with "higher dosage" than another who only conducts a single session. **Studies show, however, that interventions are often delivered with inadequate dosage resulting in limited or transient effects.**

For programs to improve and change knowledge, understanding, attitudes, beliefs, and behaviors over the long term and at the community level, programs must be delivered regularly, consistently, and with intensity over a sustained period. However, further research is needed to determine what level of intensity and/or duration is optimal.[49] Process documentation and regular monitoring could help to determine the optimal dosage for various types of interventions, including the optimal level of saturation of a specific target group to achieve desired outcomes. [50]

Case study from China: **A striking example [of the importance of dosage] comes from a 20-month comprehensive community-based sex education and reproductive health service project in Shanghai, China.** At the end of the project, the endline survey indicated the project had had a positive effect on contraceptive use among unmarried youth who had been exposed to the intervention. However, a little over 2 years after the end of the project, a follow-up survey found that without the consistent and sustained dosage from the intervention, young people appeared to revert to behaviors seen at baseline. [51]

Emergence of prevention science as a basis for holistic preventive interventions

Prevention science is an emerging frontier in public health, for which there is a growing research base worldwide and which seeks to substantially reduce morbidity and mortality.

Prevention science focuses on empirically verifiable precursors that influence the probability of undesired health outcomes. Precursors include various contextual and individual risk factors that predict an increased likelihood of problem behaviors, and various protective factors that either operate directly or mitigate the influence of risk factors. Studies show that some risk factors are problem specific and some are more general, predicting multiple outcomes, for instance across alcohol, tobacco, and other drug misuse, unsafe sex, violence, school dropout, among others. The commonality in risk factors suggests that preventive interventions that address precursors of multiple problems are an efficient approach. Moreover, preventive interventions that effectively reduce risk and enhance protective factors can have the reverse effect and make healthy development more probable.[52]

The standard approaches to improving adolescent health have usually focused on health promotion, prevention, and treatment of problem behaviors often with a focus on a single behavior. **Prevention science goes beyond single-focus prevention interventions and advocates greater understanding of the co-occurrence of problem behaviors and of the overlap in predictors across many behaviors, as a basis for developing holistic preventive interventions.** Over recent decades, evidence has been growing that preventive and promotive approaches can be both effective at reducing adolescent problem behaviors and improving health. Increasingly in high-income countries, the adolescent health field is adopting the prevention science approach. [53]

Longitudinal studies have shown that risks cluster across development to produce early accumulation of risk in childhood and more pervasive risk in adolescence. This understanding has led to the formulation of appropriate prevention policies and programs that have shown short-term and long-term reductions in these adolescent problem behaviors. Some experts suggest that reducing

a small amount of risk in the general population might be epidemiologically more beneficial than reducing larger amounts of risk in the smaller, high-risk, segment of society.

Experts recommend greater focus on the adaptation of evidence-based prevention science approaches that simultaneously address risk and protective factors, for adolescents in lower- and middle-income countries. **The research base that has been developed in high-income countries has recently begun to be applied to low- and middle-income countries by translating existing approaches and developing and testing new preventive interventions in lower-income contexts**. Experts advocate applying the growing research base for prevention science worldwide to substantially reduce morbidity and mortality. They also recommend the creation of a database that documents best and promising practices in prevention science and adolescent health. [54],[55]

Conclusions

There is now a substantial body of evidence regarding the effectiveness of many adolescent health interventions that are considered promising. Studies have identified the crucial factors underlying successful outcomes; studies have also repeatedly shown that lack of fidelity to such factors in programming can seriously compromise outcomes.

Program planners should draw upon the existing knowledge base to modify existing programs where needed and while designing new programs. Planners should also consider expanding the scope of both existing and proposed programs to address relatively neglected and vulnerable groups such as married girls and very young adolescents.

Despite the substantial knowledge base, there remain huge gaps in our understanding of what works in adolescent health programming, especially at scale. Hence there is need to identify and define these gaps and address them through appropriate means—for instance, by developing and testing suitable models in different contexts; by reviewing, adapting and then scaling some of the existing promising projects; and, by conducting further research where indicated. For this, there needs to be effective collaboration amongst key stakeholders, including government agencies and NGOs, especially since convergent, multi-sectoral approaches are needed to ensure better adolescent health outcomes.

Furthermore, planners should consider adopting evidence-based prevention science approaches in policy development and programming for adolescent health. For this, there is need to review good and promising practices in prevention science and adapt and implement those practices that would be relevant to the Indian context. A potentially useful platform for implementing prevention science approaches is available in the form of the newly launched School Health Programme (part of the Ayushman Bharat Programme). At an appropriate stage, this program could be leveraged to make concerted early prevention interventions (including among primary and middle school

students) for better adolescent health outcomes. Table #: details the evidence, challenges and recommendations for Adolescent-focused interventions.

Notably, most of the NGOs profiled in this chapter are working on SRHR. Of these, many are also working on gender issues, gender-based violence, life skills and empowerment. Further, while many of the above-profiled NGOs are working on nutrition, few are working in the areas of substance misuse, NCDs and mental health. The few agencies that are working in all the RKSK thematic areas are mostly those that provide technical assistance and/or capacity building support to governments.

While the intervention areas of the NGOs profiled in this chapter cannot be said to represent the entire range of NGOs' adolescent health work in India, they do seem to reflect a broader pattern that was observed while reviewing literature for the current study. In turn, this broader pattern seems to reflect the evolving policy priorities of governments and funding agencies worldwide with respect to adolescent health programming, which initially focused on SRHR and related themes during the two decades following the International Conference on Population and Development (ICPD) in 1994. This trend has begun to change only during recent years, as a broader and deeper understanding of the multiple dimensions of adolescent health has begun emerging.

10

Conclusions and Way Forward

Introduction

Mapping the landscape of a subject as vast as adolescent health will be, and should be, a work-in-progress. As current and future interventions and studies generate new learning and evidence, stakeholders will need to continue to analyze and collate such knowledge as is needed to support policy planning, programming and implementation. This landscape report marks a stage in that journey—it is envisaged that it will serve as a resource, as well as a base and reference point from which to proceed with further knowledge-gathering.

This report covers diverse topics, and its chapters set out conclusions and suggested ways forward as appropriate. Those conclusions and suggestions are best reviewed within the context of their respective chapters. This concluding chapter focuses on summing up key findings, especially those relating to evidence, programming, NGOs' role, role of media, and promoting convergence. The chapter also makes broad suggestions for the way forward in these areas.

Gaps in evidence

Observations: Current evidence on what works and what does not work for adolescent health is still very limited. Furthermore, most of the research on adolescent health interventions, both in India and globally, has focused more on sexual and reproductive health than on mental health, non-communicable diseases, violence, and substance misuse. Even within the area of sexual and reproductive health, several aspects have not been adequately studied. Overall, there is a scarcity of published literature on the effectiveness of interventions for adolescents and young adults.

Way forward: There is need for better understanding of what types of interventions would be effective for males and females, for different age groups of adolescents and for vulnerable and marginalized groups. Experts suggest that researchers, academics, national governments and the international development community need to work together to generate more robust evidence to inform policy and programming.

Programming for adolescent health

Observations: Studies have repeatedly highlighted certain critical and pervasive lacunae in how adolescent health programs are planned and implemented:

- Interventions are often poorly implemented, lacking fidelity to the critical elements of the interventions that make them effective in the first place, or picking and choosing from among a few approaches rather than implementing them together as a whole.
- Many adolescents, especially those with the most pressing health/SRH needs or who are most marginalized or vulnerable, are not being reached by interventions as intended by program planners.
- Interventions have limited effects because they are delivered piecemeal, instead of in coordinated and complementary fashion.
- Interventions are often delivered with inadequate 'dosage' resulting in limited or transient effects. 'Dosage' here refers to how intensively and/or how long an intervention or a package of interventions is delivered.

The following approaches and strategies may be considered for addressing the above lacunae:

- Program planners should review the evidence base for proposed interventions and ensure that critical ingredients/success factors are incorporated into program design. Additionally, strong program monitoring mechanisms and process documentation would help track fidelity and facilitate making mid-course corrections during implementation.
- Specific measures should be taken to identify and ensure the inclusion of the most vulnerable—for instance, by caste, household poverty, sex and marital status—otherwise interventions may well overlook the neediest adolescents. Among the vulnerable groups, two very large groups that are neglected and hard to reach are married adolescent girls and very young adolescents.
- Intervention strategies should be comprehensive, ensuring that all relevant agencies are involved to create a 'whole systems' approach. Convergence plans and implementation mechanisms should ensure that programs are implemented in coordinated and complementary fashion, implementing all aspects of the strategy.
- For programs to improve and change knowledge, attitudes and behaviors over the long term and at the community level, programs must be delivered regularly, consistently, and with intensity over a sustained period. Process documentation and regular monitoring could help to determine the optimal 'dosage' for various types of interventions.

Additionally, program planners should consider the following lessons from the interventions reviewed in this study:

- Clear policy commitment by government backed by adequate funding, sustained technical support and commitment to constant improvement through process monitoring and evaluation are among crucial success factors in adolescent health interventions, especially when initiatives are sought to be scaled.

- NGOs are critical stakeholders in adolescent health and development initiatives; NGOs also have the flexibility to try out innovative approaches and to foster convergent action by government agencies. NGOs and government can successfully work together to develop and implement innovative programs at scale.

Furthermore, planners should consider adopting evidence-based prevention science approaches in policy development and programming for adolescent health. For this, there is need to review promising practices in prevention science and adapt, test and implement those practices that are considered appropriate for the Indian context. The recently launched School Health Programme (part of the Ayushman Bharat Programme) could be leveraged as a platform to make concerted early prevention science-based interventions for adolescent health.

NGOs' roles in adolescent health interventions

Observations: There are several NGOs working on adolescent health and development in India. Many such NGOs implement programs spanning multiple themes, to address not just health issues but to also build agency and promote empowerment. Further, many NGOs use mass media and digital media in creative ways to influence socio-cultural attitudes that impact adolescent health. NGOs also work in collaboration with and within the framework of government programs, the aim being to foster replication and scale-up.

NGOs can support government in implementing the RKSK in several ways:

- Providing technical support at state and district levels
- Collaborating with government at national, state or district levels to train government health staff
- Exploring ways to promote the RKSK's themes in any school-based programs implemented by NGOs
- Incorporating RKSK themes into their own programs for adolescents and youth
- Supporting convergence of government agencies under RKSK at district, local government and community levels
- Promoting RKSK and connecting adolescents to RKSK services via any mass media or digital media-based projects that they implement

Role of media including digital media

Observations: New media including social media and digital technologies are promising, more so with the rapid growth in mobile phone use. However, at present there is little consensus about the most effective strategies for their use with adolescents. There are, though, several examples from India where communication interventions using various media platforms have been effective in reaching out to adolescents and their communities. These interventions use diverse media platforms and formats, some use multiple channels to enhance reach and impact.

Some key considerations that should inform communications interventions directed at adolescents are:

- It is important that media strategies be strongly anchored in evidence regarding what works with adolescents, including evidence on longer term benefits and concrete health outcomes.
- In view of the rapid expansion in the use of media, agencies that design communication interventions need to track the reach of the various media in different geographies and among different target audiences and adjust their planning accordingly.
- Social marketing and mass media approaches should not only target the attitudes and values of adolescents and young adults but also their families and broader communities.
- Irrespective of the media used, for communication interventions to achieve the desired broader outcomes, it is imperative that, along with appropriate information, services and products be made available to adolescents.

Promoting convergent approaches for adolescent health

Observations: While most strategy and program frameworks for adolescent development programs emphasize the criticality of convergence for successful outcomes, and specify guidelines and mechanisms for operationalizing convergence, achieving convergence in practice is challenging, both in terms of interdepartmental coordination at national and state levels and convergence at the operational/ field levels.

Certain considerations for promoting convergence under the RKSK are outlined below:

- The element of oversight and accountability for convergence, including regular monitoring, should be part of convergence mechanisms. In the case of RKSK, at the national level such oversight could be exercised by the Prime Minister's Office, either directly or via NITI Aayog.
- Elevating RKSK's profile to be on par with programs such as nutrition and NACP, with the aim to strengthen both convergence and advocacy efforts. Establishing a national youth council could be among the steps in this direction.
- At the state level, a systematic approach should be evolved to coordinate the efforts of key departments responsible for program implementation—within the health department to begin with, and then with partner departments.
- At the district and field levels, accountabilities should be fixed for the implementation of convergence efforts, and the process should be closely monitored. To enable this, the district collector/magistrate may be made responsible for facilitating and monitoring convergence efforts.
- The responsibilities of officials of the concerned partner departments should be clearly delineated, including responsibilities for recording and reporting, and there should be effective monitoring of compliance with their designated roles.
- Technical support (for instance, by UN agencies and NGOs) can be helpful in promoting convergence.