NSOU SPONSORED RESEARCH PROJECT

EFFECTIVENESS OF ROLE OF ADOLESCENT FRIENDLY HEALTH COUNSELLOR (ANWESHA COUNSELLOR) IN CONTRIBUTING WELL-BEING OF ADOLESCENTS: A STUDY IN BIRBHUM DISTRICT OF WEST BENGAL

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DECLARATION

I, Mr. Monojit Garai, Assistant Professor of Social Work, Department of Social Work under School of Professional Studies of Netaji Subhas Open University is hereby declare that the research study titled **"EFFECTIVENESS OF ROLE OF ADOLESCENT FRIENDLY HEALTH COUNSELLOR (ANWESHA COUNSELLOR) IN CONTRIBUTING WELL-BEING OF ADOLESCENTS: A STUDY IN BIRBHUM DISTRICT OF WEST BENGAL"** is carried out with the financial assistance from the Netaji Subhas Open University, Kolkata. The research study has been conducted under the NSOU Sponsored Research Project in Birbhum District by following rules and regulations of the university in connection with the research study.

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LIST OF ABBREVIATIONS

AFHC - Adolescent Friendly Health Clinic

RCH - Reproductive and Child Health

RKSK - Rastriya Kishor Swasthya Karyakaram

SRH - Sexual and Reproductive Health

NFHS - National Family Health Survey

ICMR - Indian Council for Medical Research

ARSH – Adolescent Sexual and Reproductive Health

MOHFW – Ministry of Health and Family Welfare

BPHC - Block Primary Health Centre

RH – Rural Hospital

MO - Medical Officer

NHM – National Health Mission

CMOH – Chief Medical Officer of Health

RTI / STI Clinic - Reproductive Tract Infections / Sexually Transmitted Infection

OPD – Out-patient Department

IFA - Iron and Folic Acid

ASHA - Accredited Social Health Activist

ANM - Auxiliary Nursing Midwifery

AWW - Anganwari Worker

IEC - Information Education Communication

AHD - Adolescent Health Day

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EXECUTIVE SUMMARY

The present study was conducted in Birbhum Health District and Rampurhat Health District under the jurisdiction of Birbhum District of West Bengal. The District has relatively very robust and extensive experience in providing adolescent friendly health services (AFHS) for adolescents both in rural and urban areas in some extend. The two Health District is now included under the RKSK Block/District.

For conducting the research study both qualitative and quantitate data was collected from the sample respondents i.e. adolescents girls and boys in the age group of 10-19 years as per the programme of RKSK. There is also some data was collected from the AFHC Counsellor to know the perception and experiences of them about the AFHC.

Out-reach programmes were conducted to know the awareness about the AFHC in the community and utilization of services of AFHC by the adolescents. A regional level seminar was organized to know about the present research on adolescent

It is found from the study that there is significant changes in the health and overall development aspects of the adolescents after being taking counselling services from the competent and trained AFHC Counsellor. There is significant changes in the information about health practices, knowledge, attitudes and belief among the adolescents and in the community especially in the RKSK Block (Earlier there was selected BPHC/RH was included under RKSK Block, now all AFHC located in BPHC/RH covered under the RKSK Block). In case of gender based counselling there is still preference for gender specific counsellor among the adolescents' respondents in few clinics. They feel uncomfortable and hesitation to share their problems to the opposite gender counsellor specially about their menstruation and related health issues.

The AFHC counsellor shared that they satisfied with the ice breaking attitudes of the community was achieved to least aware them about the existence of AFHC and a wide ranges of services are provide specially to the adolescents girls and boys in the age group of 10-19 years of age without any cost. There is a dedicated clinic named as Anwesha Clinic (AFHC) for the adolescents only. Peer Education is also an important component of the programme (RKSK) for giving training to the adolescent on health issues and formation of Teem Club with the adolescents including both male and female.

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INTRODUCTION

Adolescence is the phase of life between childhood and adulthood, from ages 10 to 19. It is a unique stage of human development and an important time for laying the foundations of good health. Adolescents experience rapid physical, cognitive and psychosocial growth. This affects how they feel, think, make decisions, and interact with the world around them. Despite being thought of as a healthy stage of life, there is significant death, illness and injury in the adolescent years. Much of this is preventable or treatable. During this phase, adolescents establish patterns of behaviour – for instance, related to diet, physical activity, substance use, and sexual activity – that can protect their health and the health of others around them, or put their health at risk now and in the future.

To grow and develop in good health, adolescents need information, including age-appropriate comprehensive sexuality education; opportunities to develop life skills; health services that are acceptable, equitable, appropriate and effective; and safe and supportive environments. They also need opportunities to meaningfully participate in the design and delivery of interventions to improve and maintain their health. Expanding such opportunities is key to responding to adolescents' specific needs and rights.

Adolescent is a phase of both opportunities and risks. They are the future drivers of developments. One in five persons in the world is an adolescent, totalling 1.2 billion people ages 10- 19 years globally. In Indian context, the adolescents (10 to 19 years) constitute almost a fifth of India's population as per Indian Census 2011. If the age group is widened to include the young people (10 to 24 years), the incidence changes to almost a third of the population of India. The state of their health is important for their lives now and in the future. Adolescents face numerous challenges as they transition from childhood to adulthood. These challenges are linked to physiological and psychological maturation as well as evolving interpersonal and social equations.

Adolescence is a period of life with specific health and developmental needs and rights. It is also a time to develop knowledge and skills, learn to manage emotions and relationships, and acquire attributes and abilities that will be important for enjoying the adolescent years and assuming adult roles. Age is a convenient way to define adolescence, but it is only one

characteristic that delineates this period of development. Age is often more appropriate for assessing and comparing biological changes (e.g. puberty), which are fairly universal, than the social transitions, which vary more with the socio-cultural environment.Adolescence is one of the most rapid phases of human development. Although the order of many of the changes appears to be universal, their timing and the speed of change vary among and even within individuals. Both the characteristics of an individual (e.g. sex) and external factors (e.g. inadequate nutrition, an abusive environment) influence these changes.Linked to the hormonal and neurodevelopmental changes of adolescence are psychosocial and emotional changes and increasing cognitive and intellectual capacities. Over the course of the second decade, adolescents develop stronger reasoning skills, logical and moral thinking, and become more capable of abstract thinking and making rational judgements. Changes in the adolescent's environment both affect and are affected by the internal changes of adolescence. These external influences, which differ among cultures and societies, include social values and norms and the changing roles, responsibilities, relationships and expectations of this period of life.

In many ways adolescent development drives the changes in the disease burden between childhood to adulthood – for example, the increase with age in sexual and reproductive health problems, mental illness and injuries. The appearance of certain health problems in adolescence, including substance use disorders, mental disorders and injuries, likely reflects both the biological changes of puberty and the social context in which young people are growing up. Other conditions, such as the increased incidence of certain infectious diseases, for example, schistosomiasis, may simply result from the daily activities of adolescents during this period of their lives. Many of the health-related behaviours that arise during adolescence have implications for both present and future health and development. For example, alcohol use and obesity in early adolescence not only compromise adolescent development, but they also predict health-compromising alcohol use and obesity in later life, with serious implications for public health.

The changes that take place during adolescence suggest nine observations with implications for health policies and programmes.

- adolescents need explicit attention;
- adolescents are not all the same,
- some adolescents are particularly vulnerable,

- adolescent development has implications for adolescent health;
- adolescent development has health implications throughout life;
- the changes during adolescence affect how adolescents think and act;
- adolescents need to understand the processes taking place during adolescence;
- to contribute positively, adults need to understand the processes taking place during adolescence, and
- public health and human rights converge around concepts of adolescent development.

All societies recognize that there is a difference between being a child and becoming an adult. How this transition from childhood to adulthood is defined and recognized differs between cultures and over time. In the past it has often been relatively rapid, and in some societies it still is. In many countries, however, this is changing.

There are more adolescents in the world than ever before: 1.2 billion, totalling one sixth of the global population. This number is expected to rise through 2050, particularly in low- and middle-income countries where close to 90% of 10 to 19 years old live. An estimated 1.1 million adolescents die each year. The leading causes are road traffic injuries, suicide and interpersonal violence. Millions of adolescents also experience illness and injury. Causes of mortality and morbidity among adolescents differ by sex and age, and also by geographic region. For 10-14 years old, the leading risks for health are related to water, hygiene and sanitation. Risks for 15-19 years old are more often related to behaviours, such as alcohol use and unsafe sex. Poor diet and low physical activity are additional challenges which begin in childhood and adolescence, as does sexual abuse. Older adolescent girls are disproportionately affected by intimate partner violence. Pregnancy complications and unsafe abortions are the leading causes of death among 15-19 years old girls. Most adolescent mortality and morbidity is preventable or treatable, but adolescents face specific barriers in accessing health information and services. Restrictive laws and policies, parental or partner control, limited knowledge, distance, cost, lack of confidentiality, and provider bias can all restrict adolescents from getting the care they need to grow and develop in good health.

Adolescents are the most dynamic, creative, productive and enthusiastic group of population but also the most neglected groups by our society and policy makers. The World Health Organization (WHO) promotes Adolescent Friendly Health Services to address these issues and make it easier for adolescents to obtain the required services. Viewing adolescents as a specific group with their own needs is a relatively recent practice, especially in the

developing world; India has identified adolescent reproductive and sexual health (ARSH) as a key strategy under the Reproductive and Child Health Programme Phase II (RCH-II) and the National Rural Health Mission (NRHM). Strategy for ARSH has been approved as part of the RCH-II. There are various programs available for adolescents and youths in different states. Initiative like "Adolescent Friendly Health Services (AFHS)" introduced in the schools is one of important efforts in this direction. Ministry of Health and Family Welfare (MoHF&W) has developed guidelines and training package for operationalizing AFHS. Haryana is one of the first states in the country to have launched a distinct Adolescent Reproductive and Sexual Health (ARSH) program providing AFHS at government health facilities. The National Program Implementation plan of the RCH-II has proposed to expand this program to 75 districts in the country. The AFHS project under RCH-II in Haryana employs an "Adolescent Action Group" (AAG) to plan interventions with clear targets and roles and responsibilities. ARSH was implemented in Haryana in 2008 in nine districts with the objective of providing adolescent friendly health services through the existing public sector health facilities. Reproductive Health Services under the public sector are more oriented towards adult married women, while unmarried adolescents hesitate to seek health services due to the fear that these services are not confidential, inability to pay, requirement of parents' approval and negative or insensitive attitude of health providers. For many adolescents who need sexual and reproductive health services, such as appropriate information, contraception and treatment for sexually transmitted infections, these are either not available or are provided in a way that makes adolescents feel unwelcome and embarrassed. Even married adolescent girls shy away from seeking healthcare due to sheer embarrassment and the taboo associated with reproductive and sexual health problems. This creates an "unmet need" for reproductive and sexual healthcare. This unmet need varies among married and unmarried adolescents Actions taken during adolescence can affect a person's life opportunities, behavioural patterns and health. Adolescent period is hazardous for adolescent health due to absence of proper guidance and counselling, which have not received proper attention and guidance because of which the need of Adolescent Friendly Health Services (AFHS) is emphasized. AFHS provides a broad range of preventive, promotive and curative services under one roof can help to ensure improved availability, accessibility and utilization of health services. According to WHO, Adolescent-Friendly Health Services (AFHS) are accessible, acceptable and appropriate in terms of right place, at the right time, and affordable. WHO promotes Adolescent Friendly Health Services to address these issues.There are several AFHI's undertaken by some NGOs in India such as Mamta, Nehru Yuva Kendra etc. MAMTA, an

NGO to establish a model of AFHS through the public health system in villages of Delhi, runs the clinic, called Friends' Clinic focusing the needs of the local youth population providing clinical and counselling services. Nehru Yuva Kendra acts as a health awareness unit through active participation of the young; Kishori Shakti Yojana is to improve the health and nutritional status of the girls; Balika SamridhiYojana is to delay the age of marriage; Mahila Samakhya Programme - stresses on equal access to education facility for adolescent girls and young women; school age education. Yadav et al (2009) observed that proportion of adolescent girls visiting the AFHCs in Delhi and Kolkata was higher whereas the situation was reverse in Chandigarh. Present study was undertaken with an objective of evaluating selected Adolescent Friendly Health Clinics (AFHC) with clients' perspectives.

Rationale of the study

The number of adolescents (age 10-19 years) comprises over one-fifth of the population in our country. They are contributors to demographic dividend. They are the future citizens and the productive workforce of tomorrow. Adolescents cannot be said to be a homogenous population group. A large number of them are out of school, many of them get married earlier than they are supposed to, there are some who work in vulnerable situations, many adolescents are likely to be sexually active and due to all this they become very vulnerable several health risks.

The number of adolescents (age 10-19 years) is increasing and comprises over one-fifth of the population in our country. They are not only in large numbers but are the future citizens and drivers of economic growth as the productive workers of tomorrow. Adolescents are not homogenous populations but exist in a variety of circumstances. A large number of them are out of school, get married early, work in vulnerable situations, are likely to be sexually active, and are exposed to several health risks. These have serious social, economic and public health implications for the nation. Their needs vary by their age, sex, stage of development, life circumstances, socio-economic status, marital status, class, region and cultural context. This calls for interventions that are flexible and responsive to their desperate needs. As the Indian Council for Medical Research (ICMR) acknowledges, despite 35 percent of the population being in the 10-24 age groups, the health needs of adolescents have neither been researched nor addressed adequately.

The health issues and the consequent implications have serious social, economic and public health impact for the nation. The needs of the adolescents vary by their age, gender, life conditions, socio-economic status, marital status, caste and class, religion and cultural contexts. There is a need for researched interventions that are flexible and responsive to their desperate needs. Thus there is a strong rationale to address the health issues of the adolescents through the institutional care that already exists in the countries of developing regions of the world.

Significant of the Study

The study will assess the level of awareness about the Anwesha Clinic (AFHC) in the study areas and explore the utilization of services of the clinics by the adolescents. The adolescent is the key focal point of the clinic set up with the objectives for overall development of adolescents both boys and girls. A wide spectrum of services like counselling, clinical, our-reach and referee services are provided through the AFHC under the RKSK programme to this entity for their growth and development. The study is very much significant in assessing the awareness, utilization of services of the AFHC in the study areas. As the programme is being implemented throughout the country so it is expected that the findings and outcome of the study will have some impact and significance. The study will suggest future scopes and areas for further and future research.

REVIEW OF LITERATURE

The relevant information from the literature review has been categorized in the following sections followed by the identified gaps:

1. **Status of Adolescent Health**

The adolescents are 253.2m according to Census 2011 in India. The proportion of adolescent population (10-19) to total population (%) is 19.6 which is the highest in the world.

Decadal growth of adolescent population is 12.5%

17.5% of adolescent populations are belonging to SCs and 9.2% are STs.

- Over 1.5 million adolescents and young adults aged 10–24 years died in 2020, nearly 5000 every day.
- Injuries (including road traffic injuries and drowning), violence, self-harm and maternal conditions are the leading causes of death among adolescents and young adults
- Early onset of substance use is associated with higher risks of developing dependence and other problems during adult life, and people of younger ages are disproportionately affected by substance use compared with people of older ages.

Source :(WHO, 2022; UNFPA & Census 2011; 2014)

2. Health Problems faced by Adolescents

The main health issues faced by the adolescents include: mental health problems, early pregnancy and childbirth, human immunodeficiency virus/sexually transmitted infection (HIV/STI) and other infectious diseases, violence, unintentional injuries, malnutrition and substance abuse.

Apart from physical health, a positive social health constitutes holistic health of the adolescents. Non-consensual sexual experiences and peer pressure are common in India (Jaya & Hindin, 2007; Bhave et al, 2011). Poor Engagement in Substance Use Treatment and HIV

Services among Adolescents and Young Adults Who Inject Drugs in India (Ganpathy et al, 2022)

In West Bengal a major problem regarding adolescents is early marriage and teenage pregnancy. Forty-two percent of women age 20-24 years got married before attaining the legal minimum age of 18. Among young women age 15-19 in West Bengal, 16 percent have already begun childbearing, that is, they have already had a live birth or are pregnant with their first child, the proportion who has started childbearing is much higher among young women who had no schooling (33%) than those with 12 or more years of schooling (7%).

Four of every ten adolescents have anaemia in India. 17 %of adolescent girls engage in unhygienic or unsafe menstrual practices (NFHS -4, Rimmelin et al, 2017).

Considering Body Mass Index, in 2016, 26.3 percent of adolescent boys and 14.2 percent of adolescent girls in India in the age group of 15-19 years were found to be moderately or severely thin between the ages of 10-19 years. Undernutrition in adolescents still stands at an alarming rate of 28.4 percent (Sivagurunathan, 2015; NFHS 4; NFHS 5; Mukherjee et al, 2020; Population Council, 2021).

3. Health Service Delivery Issues of Adolescents

• *Reproductive Health* – A qualitative systematic review of mixed methods studies to assess adolescent and provider views of barriers to seeking appropriate medical care for sexually transmitted infection (STI) services for adolescents was done by Newton-Levinson et al in 2016. They concluded that improving uptake may require efforts to address clinic systems and provider attitudes, including confidentiality issues. Moreover, addressing barriers to STI services may require addressing cultural norms related to adolescent sexuality. Establishment of a teen-centered, full-service clinic and working with youth-serving agencies to increase knowledge of the clinic's services are promising approaches to increasing teen access to reproductive health care (Sotolongo, 2016).

• *Counsellor Competency*- There is ultimately a mismatch between traditional office-based health services and the lived realities of adolescents. The need for flexibility and creativity in health care delivery is clear: school- and community-based health care, digital and social media, as well as mobile services in low resource settings and for marginalized groups are all

likely to be useful platforms in different places (Raymond et al, 2012; Patton et al, 2016). Outreach using arts to reduce stigma in relation to mental and sexual health may be useful (Gaiha& Salisbury, 2022). Provider and clinic staff training to improve routine communication with adolescents and their parents was suggested to reduce the gap between professional guidelines and practice (Sieving et al, 2020).

4. Review on assessment of RKSK

An impact assessment of the project 'Strengthening RKSK through Government Civil Society Partnership in West Bengal' reported that community sensitization efforts for parents and other stakeholders created a favourable environment for adolescents (CINI, 2016). A review of RKSK in Sitamarhi district, Bihar showed that whilst community engagement and operationalization of AFHCs at CHCs are notable strengths, the absence of dedicated counsellors and the lack of incentives for PEs were challenges for the programme (GoI, 2018). A research project entitled 'Understanding the lives of adolescents and young adults' in Uttar Pradesh highlighted programme challenges such as lack of timely procurement of supplies, difficulties with recruiting counsellors and PEs, insufficient training and support for frontline workers on how to respond to the needs of adolescents, and lack of disaggregated data to assess the quality and reach of services (Population Council, 2017). A study in two districts in Gujarat found that RKSK implementing officers required greater clarity on the content of the programme, and that RKSK was not a top priority for district officials (SAHAJ, 2016). A study on Gujarat found that financial resources for RKSK were not sufficient (Singh et al, 2016).

In 2016, in response to a request from the Government of India the World Health Organisation conducted a rapid programme review (RPR) of the ARSH & RKSK. Based on the findings and recommendations of this review, to assess the feasibility, the acceptability and effectiveness of implementing RKSK at scale, with quality and equity, and to understand how challenges and bottlenecks can be addressed in a practical and systematic manner, The Learning District initiative was launched by the MOHFW in July 2018 (Barua et al, 2020).

5. Covid-19 related issues

Income loss during the pandemic adversely affects food insecurity, household dynamics, healthcare-seeking behavior, and worsening adolescent depressive symptoms. With schools

reopening, adolescent mental health should be formally addressed, potentially through cash transfers and school or community-based psychosocial programming (Pinchoff, 2021). Acute alcohol intoxication in adolescents before, during and post pandemic lockdown, was studied by Pieaud (2021). A study in England with Covid-19 affected adolescents showed that a multi-component intervention will be required, and that mental and physical health symptom occurs concurrently, reflecting their close relationship (Stephenson, 2022). A collection of studies demonstrated that many adolescents experienced increased depressive symptoms, negative affect, and loneliness, and lower academic adjustment during the pandemic, particularly those that were already at risk before the pandemic (Branje, 2021). Effects of quarantining and other protective factors affect the emotion regulating skills of adolescents (Romm et al, 2021). Specific living arrangements, pandemic-related stressor accumulation, and a lack of adaptive coping strategies were associated with during-pandemic self-injury and domestic violence in adolescents (Steinhoff, 2021).

Gaps in the existing studies and Review of Literature

- There is no such studies on the well-being of adolescent health in West Bengal
- There is less and limited region-based studies in India
- There is probably no research studies on Anwesha clinics in West Bengal

OBJECTIVES

a) To assess the present health status of adolescents.
b) To assess the perceptions, level of awareness, accessibility and utilization of services of the Anwesha Clinic by the stakeholders.
c) To analyze role of Anwesha Counsellor in contributing well-being of adolescents.
d) To find out the challenges and enabling environment in the existing health services delivery in Anwesha Clinics.

RESEARCH METHODOLOGY

Research Setting

Birbhum is one of the socio-economically backward and marginal district of West Bengal with an unmet need of health services.Overall health scenario in this district is not very satisfactory as per the report of the government. There has been no such study on Anwesha clinics focusing on the well-being of adolescents in Birbhum so far.

Research Design

Mixed Methods (Eclectic research) involving Quantitative and Qualitative aspects in data collection and analysis

Sample

- Quantitative & Qualitative Data has been collected from 6 functioning Anwesha clinics (AFHC) located in rural areas in Birbhum recognized as Rural Hospital and /or Block Primary Health Centers (BPHC).
- The study has included a survey from the male (6) and female (6) counselors in the Anwesha clinics.
- A purposive sample of 50 adolescent clients have been selected across the clinics and structured interviews conducted on them.
- FGD was conducted with involving the AFHC Counsellor (16 Participants) to their perception about the AFHC and the adolescents.
- Four out-reach programme was organized with the AFHC Counsellor and Sub-Centre level Health Workers (ANM,ASHA,AWW) to know the awareness and utilization of services of the AFHC.
- A Project Seminar was organized at Regional Level to know the present research and development from the practitioner and professional working on adolescent health.

Operational definitions

Adolescents– Boys and girls in the age group of 10 to 19 years (NHM, GoI).

Anwesha Clinics – The Adolescent Friendly Health Clinics (AFHCs) are known as Anwesha Clinics in West Bengal situated at the Block Primary Health Centres (BPHCs).

- Inclusion Criteria for adolescents– walk-in & referred by the counsellor.

Data Analysis Matrix

Data Analysis Matrix				
Sections	**Topics**	**Type of Analysis**	**Tools used**	**Data collected from**
Part-1	Adolescent Client responses on health delivery in Anwesha clinics	Quantitative (Descriptive Statistics)	Interview Schedule	Adolescent clients
Part 1	Responses by Anwesha clinic counsellors on existing service delivery issues	Quantitative (Descriptive Statistics)	Interview Schedule	Counsellors
Part 3	Outreach Programme	Qualitative (Thematic)	Discussion Guide list (unstructured)	Community People& Others
Part 4	FGD	Qualitative (Thematic)	Discussion Guide list (structured)	Counsellors
Part 5	Project Seminar	Qualitative (Thematic)	Interview Schedule (un-structured)	Practitioners & Professionals

Ethical norms followed

- Permission from Health Department for data collection
- Informed consent from counsellors, clients.
- Privacy and Confidentiality maintained
- Interaction in a harmless and dignified manner

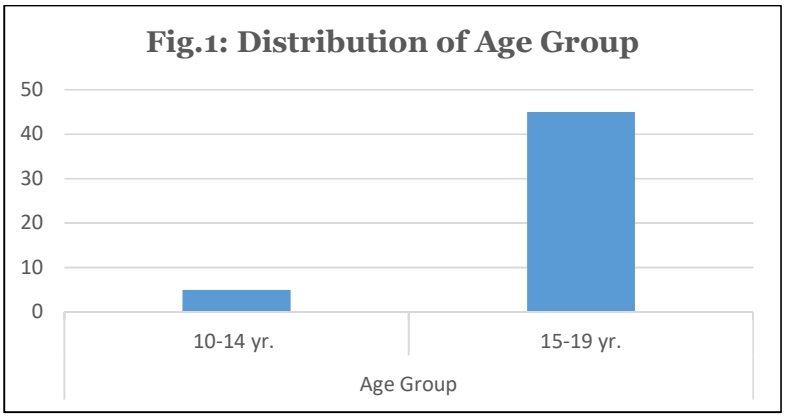
Time line of the Study

This study was undertaken during November 2022 to April, 2023 at two health districts of Birbhum, in West Bengal namely Rampurhat Health District and Birbhum Health District. Existing patterns of Adolescent Friendly Health Services (AFHS) provision and mode of delivery were evaluated based on clients' interviews in selected health facilities and clinics of the study areas. Interviews of adolescents both male and female (clients) from selected AFHC were conducted regarding their perceptions, attitudes, services offered and satisfaction thereof. Evaluation of AFHC was done based on its desired characteristics of availability, accessibility, and acceptability. Prior permissions from concerned authorities were taken for conducting the study. Exist interviews were taken only of clients willing of participating in the study and confidentiality of their responses was ensured following the ethical considerations. Because of some time, financial and time constraints, study could not be extended further in terms of inclusion of more AFHC's in other area of the district.

DATA ANALYSIS

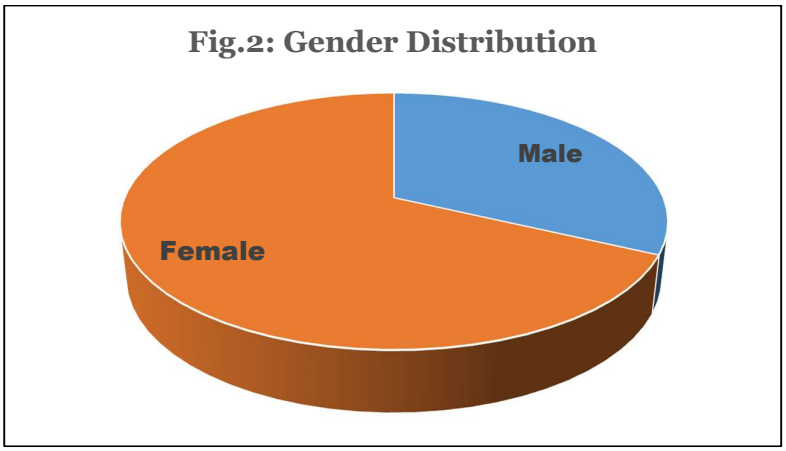
PART-A (CLIENT RESPONSES)

Table.1: Age Group	
10-14 yr.	15-19 yr.
5	45



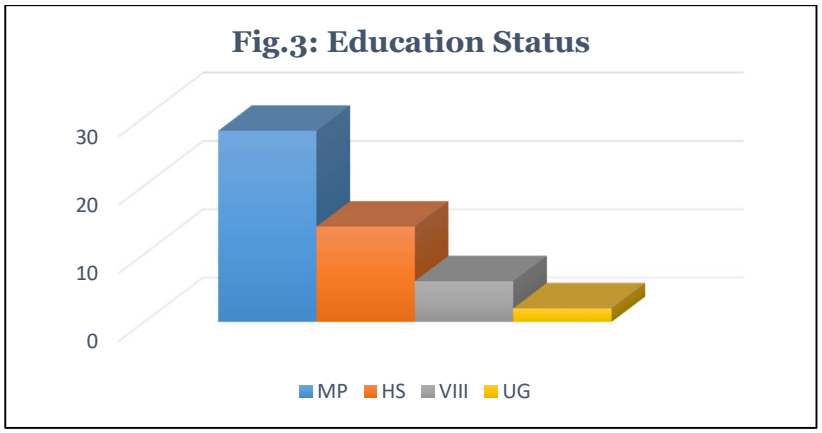
Interpretation: The above table and figure indicates that 90% of the respondents are from 15-19 years of age group across the gender. There is around 10% of the respondent are from the 10-14 years of age group. It is to assume that the higher age group has more awareness and/or accessibility of the clinic in term of service utilization of the clinic.

Table-2: Gender	
Male	Female
16	34



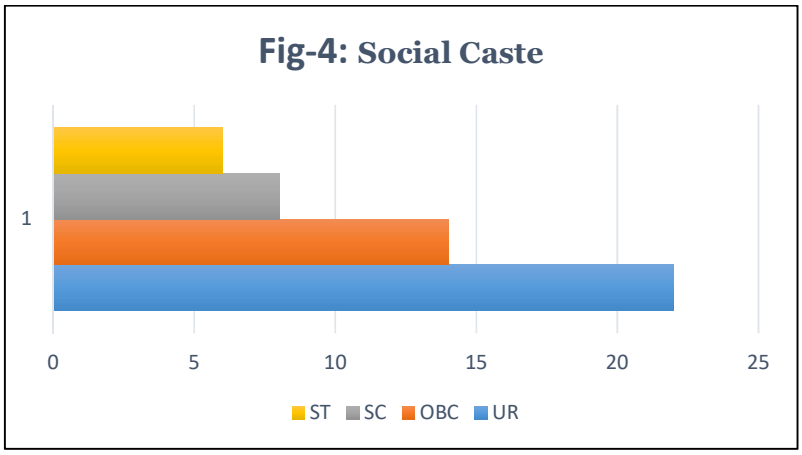
Interpretation: Respondents are mainly from the female category who visited the clinic most for addressing their health and other issues. 68% of the Female client accessed their services from the AFHC. Only 32% of the male respondent availed health and counselling services from the clinic.

Table-3: Education Status			
MP	HS	VIII	UG
28	14	6	2



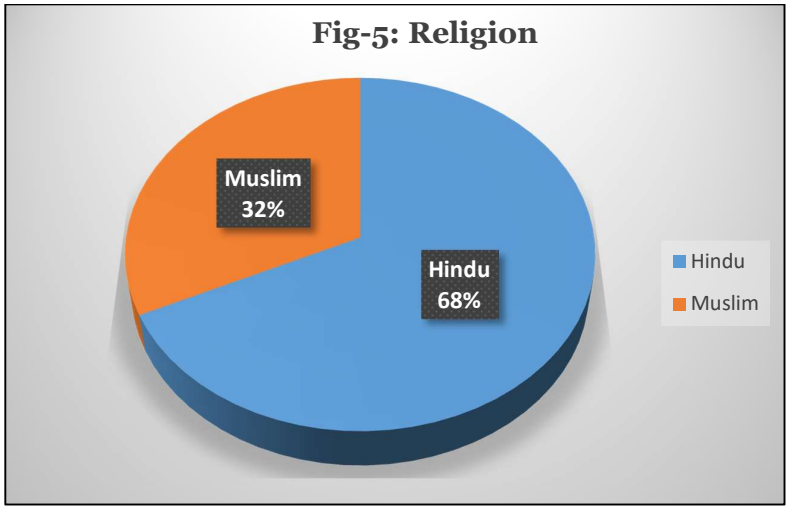
Interpretation: In term of the educational status of respondents it is found that majority of them are studying in secondary level (MP) and higher secondary level (HS) of 56% and 28% of the total respondents of adolescents of 10-19 years of age group in the study areas. Few adolescents studied in UG level which is 4% of the total sample population.

Table-4: Social Caste			
UR	OBC	SC	ST
22	14	8	6



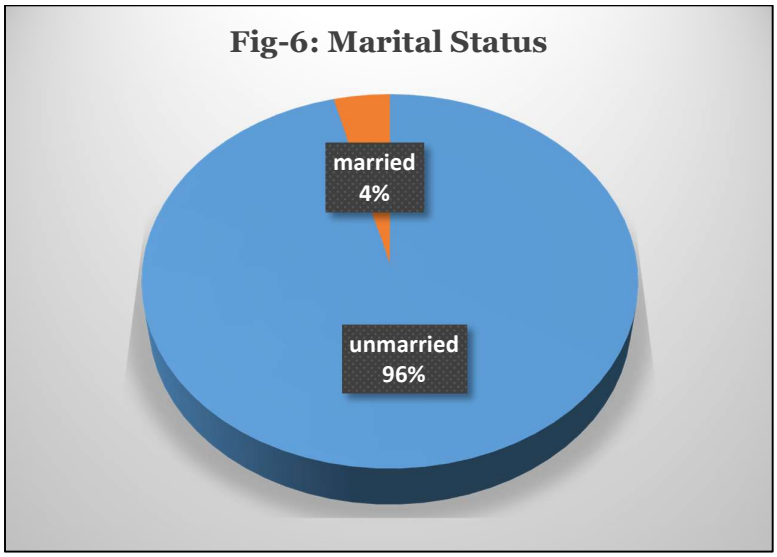
Interpretation: The social caste of the respondents are mainly general caste and other backward class category, in percentage it is 44% and 28% respectively. There is also few respondents who belongs from Scheduled Caste (16%) and Scheduled Tribes (12%) in the select study areas. Though the no. of actual respondents in this category is lass due to the limited no of sample size of the respondents.

Table-5: Religion	
Hindu	Muslim
34	16



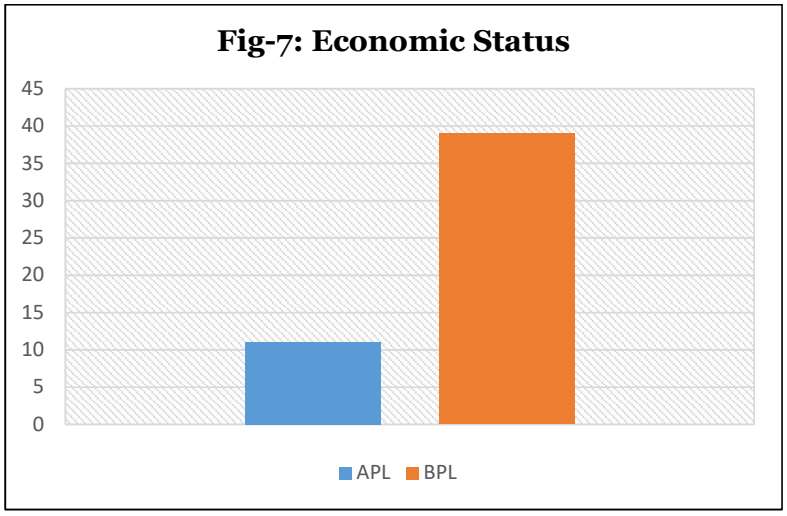
Interpretation: The Religion of respondents are mostly Hindu (68%) and Muslim (32%) in the study areas. It is significant that adolescents from the Muslim family/ community visited and availed the services of AFHC (Anwesha Clinic). Though there is need of more awareness about the services of AFHC particularly in the Muslim dominated areas.

Table-6: Marital Status	
Married	Unmarried
2	48



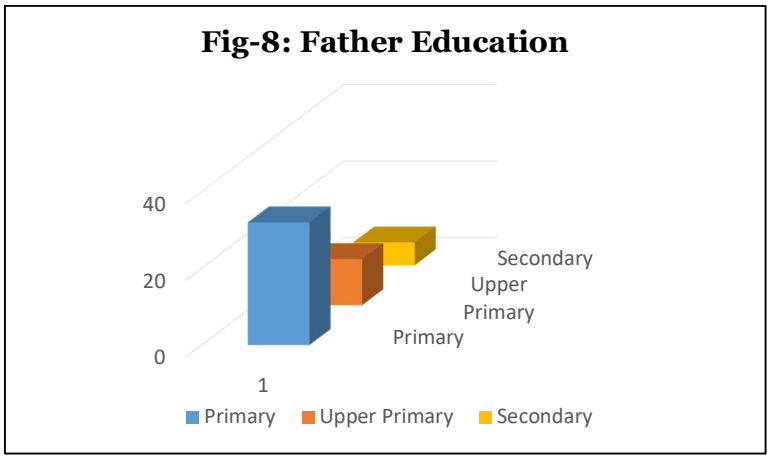
Interpretation: The respondents are most unmarried (96%) in the age group of 10-19 years in the study areas. But there is very few found that they were married (4%) in the age group of 15-19 years of age group.

Table-7: Economic Status	
APL	BPL
11	39



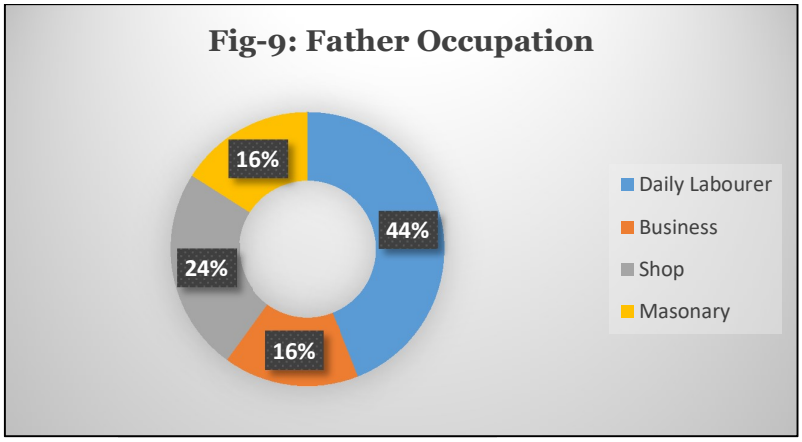
Interpretation: The economic status of the sample respondents are APL (Above Poverty Line) and BPL (Below Poverty Line) which are 78% and 22% respectively of the sample respondents. So, most of the adolescents are belong from poor and backward families as per their economic status in the study areas.

Table-8: Father Education		
Primary	Upper Primary	Secondary
32	12	6



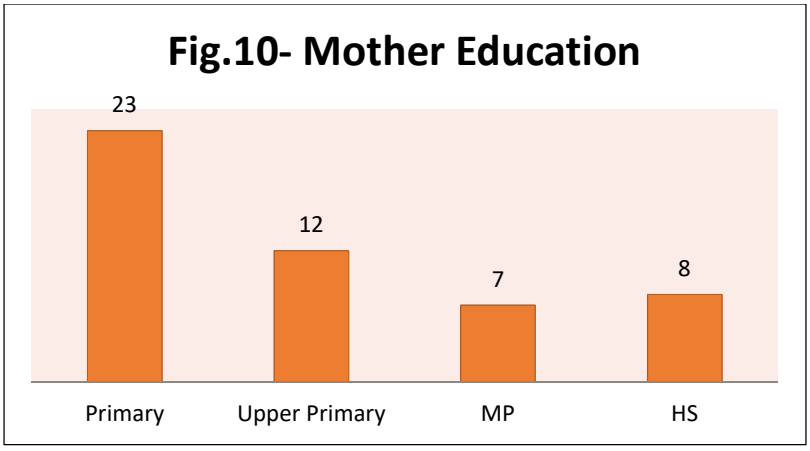
Interpretation: Father Education of the sample respondents are primary level (64%) and upper primary level (24%). There is few no. of fathers of the adolescents who studied up to secondary level (12%) in the study areas.

Table-9: Father Occupation			
Daily Labourer	Business	Shop	Mason
22	8	12	8



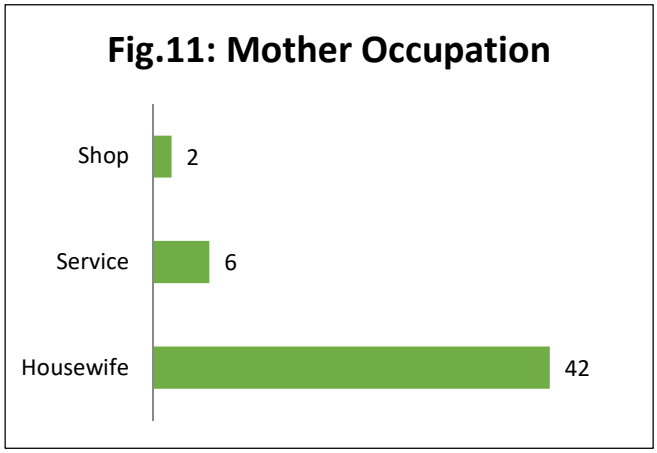
Interpretation: In the distribution of father occupation, it is observed that the father of the respondents are mostly daily labourers (44%) and shop keepers (24%). There is also few fathers of respondents have their own Small Business (16%) and doing Masonry (16%) work in the study areas.

Table-10: Mother Education			
Primary	Upper Primary	MP	HS
23	12	7	8



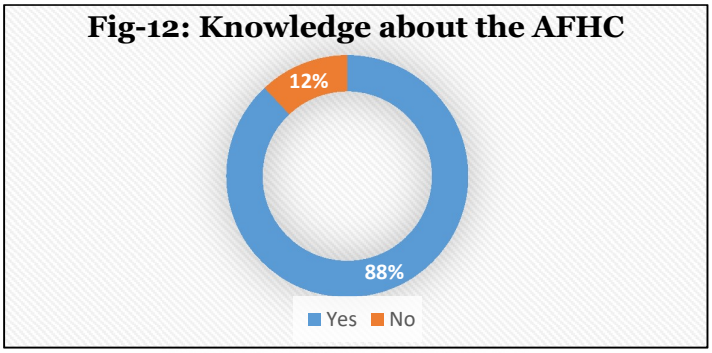
Interpretation: The study found in case mother education of the respondents that most of the mothers education fall within the primary and upper primary level/standard vis-à-vis 46% and 24% respectively. There is also some mothers of the adolescents studied up to the standard of secondary (MP) and higher secondary (HS) level which account around 14% and 16% of the total sample population. So, the mother's education is quite good in comparison with the father education.

Table-11: Mother Occupation		
Housewife	Service	Shop
42	6	2



Interpretation: Occupation of the respondent's mothers are mainly housewife which is 84% of total sample. The other occupations of the respondent's mothers are service (12%) and have their own shop (4%) at their home. So, it is observed that though the mother education is quite higher than the father of the respondent, majority of the mothers are housewife. Though very few mothers do some business and service.

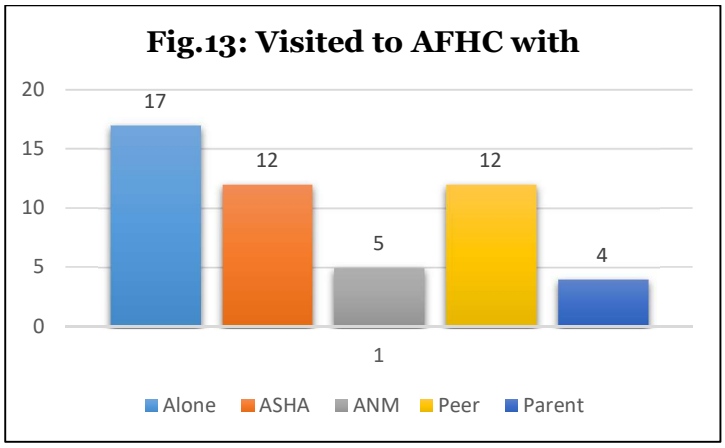
Table-12: Knowledge about AFHC	
Yes	No
44	6



Interpretation: Regarding the knowledge about the Anwesha Clinic or AFHC the adolescents know the center about 88% of the studied sample population in the areas. They have good knowledge and information about the center. They perceived it as their own center.

They preferred to visit the center than going to doctor or private clinicif they any problem with their health. Though it was found that 12 % of the respondents did not know about the clinic.

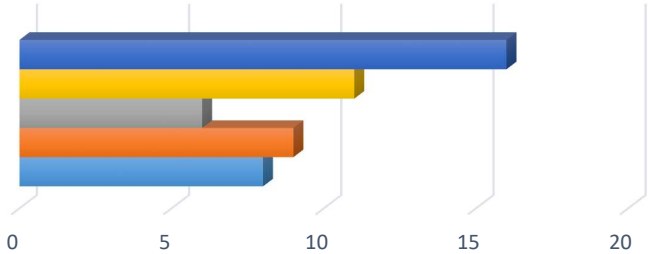
Table-13: Visited to AFHC with				
Alone	ASHA	ANM	Peer	Parent
17	12	5	12	4



Interpretation: It is reported by the adolescent's respondents that they preferred to visit the clinic mostly by alone (34%), with peer (24%), ASHA (24%), ANM (10%) and with parent (8%) of the total interview respondents in the study areas of Birbhum District. They also told that they used to visit the clinic generally in group of their peers but due to the distance constraints they could not able to visit the clinic frequently.

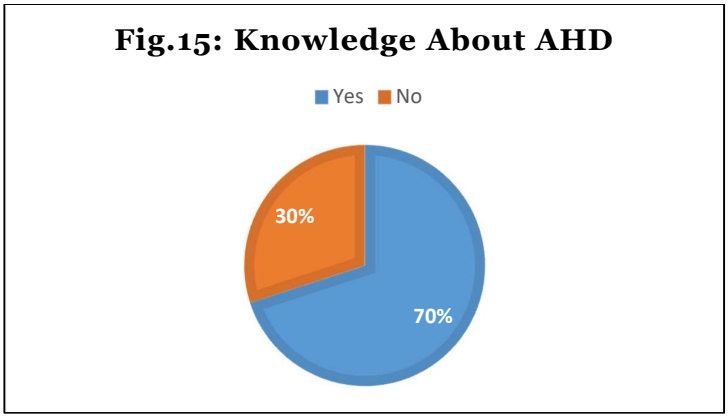
Table-14: Distance of AFHC from home				
0-1KM	1-2KM	3-4KM	4-5KM	5KM+
8	9	6	11	16

Fig.14: Distance of AFHC



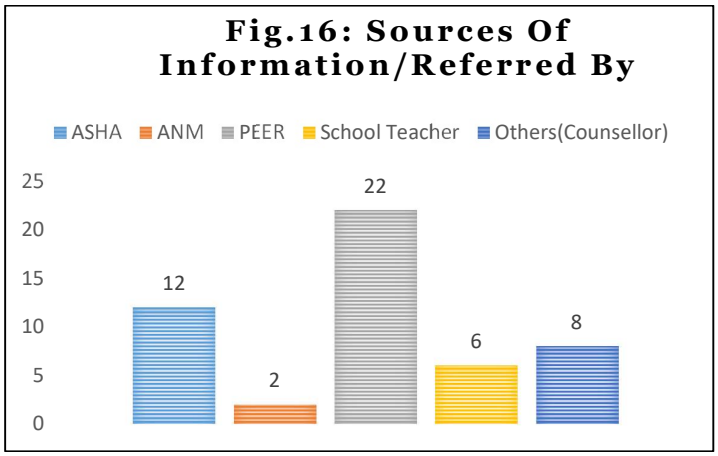
Interpretation: The respondents of adolescents during the interaction said that the location and distance of the clinic is too far from their residence. They reported that the distance of the clinic is more than 5 kms which is about 32% and in between 4-5 kms which is about 22% of the total adolescents interviewed. But in some cases the distance of the clinic fall within 1 km which is 16% and in between 1-2 kms is 18%.

Table-15: Knowledge about Adolescent Health Day (AHD)	
Yes	No
35	15



Interpretation: The adolescents have the knowledge (70%) about the Adolescent Health Day (AHD) which is observed quarterly in the community level organized by the ASHA with the adolescents, for the adolescents for discussion about health practices of adolescents. Still 30% of the total interviewed adolescents did not have awareness about the AHD.

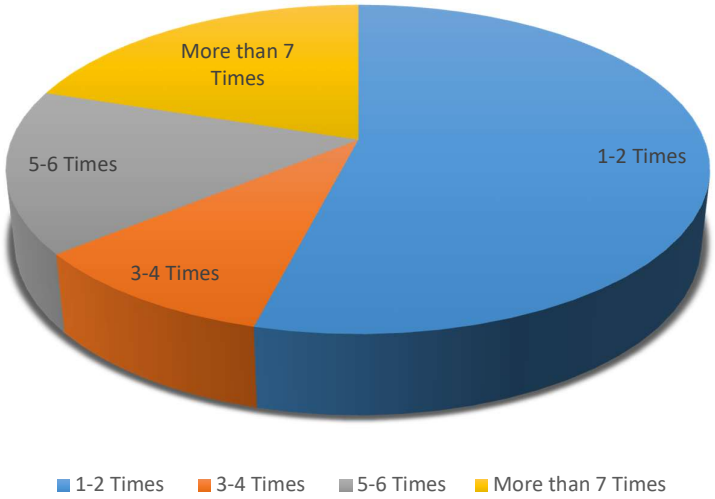
Table-16: Source of information/ Referred by				
ASHA	ANM	PEER	School Teacher	Others(Counsellor)
12	2	22	6	8



Interpretation: Regarding the sources of information about the AFHC Clinic they reported that they received information or referred mostly by the Peer (44%), ASHA (24%), and Counsellor (16%). School Teachers (12%) also referred the school going adolescents to the clinic for their health and related problems.

Table-17: Frequency of visit to AFHC			
1-2 times	3-4 times	5-6 times	More than 7 times
27	5	8	10

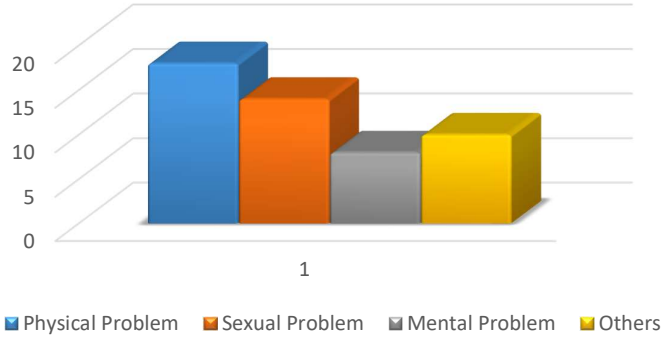
Fig.17: Frequency of visit to AFHC



Interpretation: Regarding the frequency of visit to the Anwesha Clinic (AFHC) most of the respondents reported that they visit the clinic most of the cases that is 1-2 times which is 54%, and more than 7 times which is 20%. They also reported that they also visited the clinic 5-6 times which is 16% and 3-4 times which is 10% as per the data collected from them. So, adolescents visited the clinic in most of the cases having being it's the location of the clinic is far from their home which is very encouraging and motivating from the perspective of the clinic and for the counsellor of the clinic.

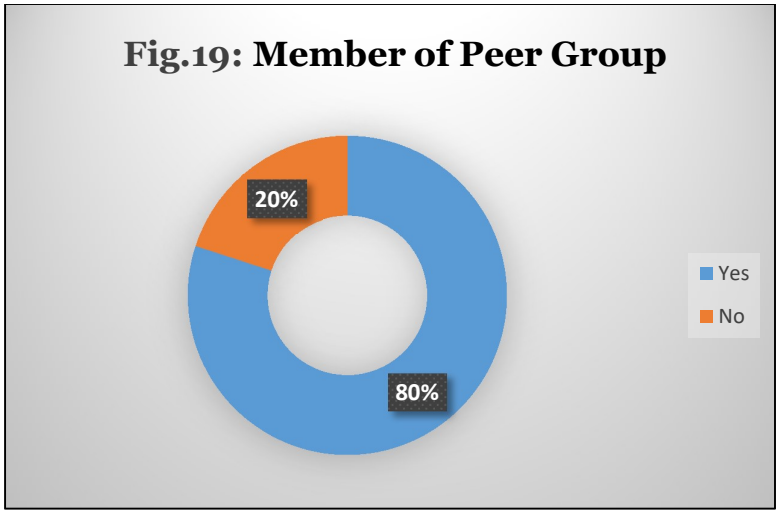
Table-18: Reason for visit to AFHC			
Physical Problem	Sexual Problem	Mental Problem	Others
18	14	8	10

Fig.18: Reason for visit to AFHC



Interpretation: The adolescents reported that they attend the clinic with various reasons or problems mostly Physical Problems (36%) and Sexual Problem (28%). Some other reasons for visiting the clinic are Menstrual Problems (16%) and Others Problems (20%).

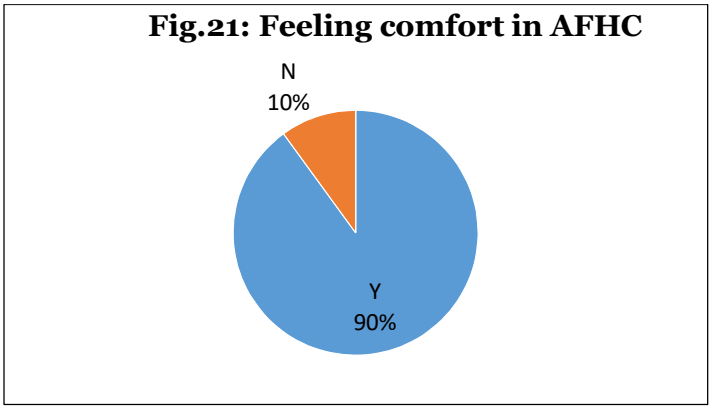
Table-19: Member of Peer Group	
Yes	No
40	10



Interpretation: Regarding membership of Peer Group of adolescents it is found the most of adolescent boys and girls are the member of the Peer Group (80%). Though around 20% of the total adolescent boys and girls are the member of any Peer Group in the study areas.

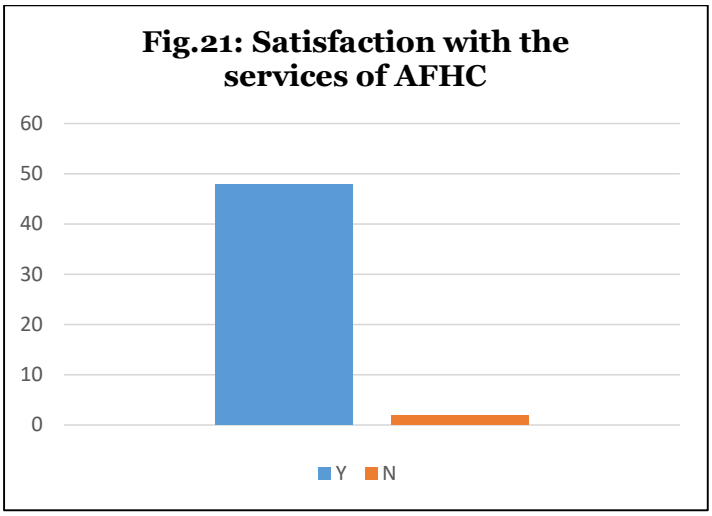
Table-20: Feeling comfort in AFHC	
Yes	No
45	5

Fig.21: Feeling comfort in AFHC



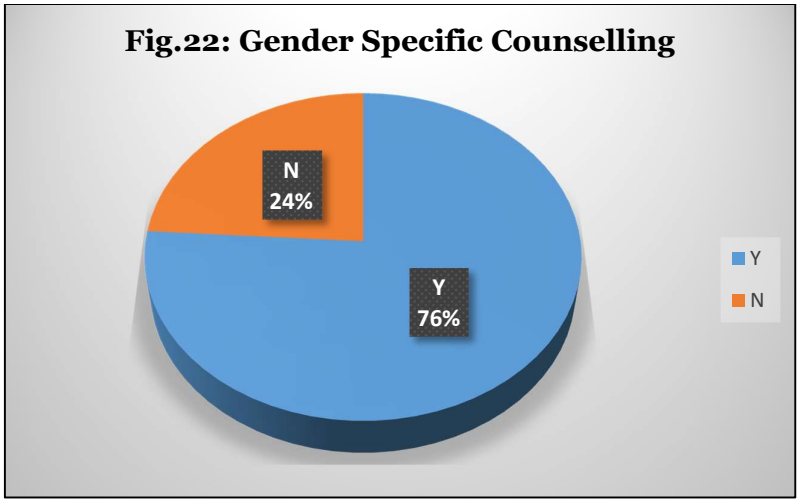
Interpretation: Feeling of comfortness in AFHC is an important component of the study. Both the adolescent's girls and boys reported their comfort around 90% while attending or visiting the clinic. Only 10% respondents reported they are not satisfied with the clinic because of many reasons like lack of toilet, waiting room, and other infrastructures, distance etc.

Table-21: Satisfaction with the services of AFHC	
Y	N
48	2



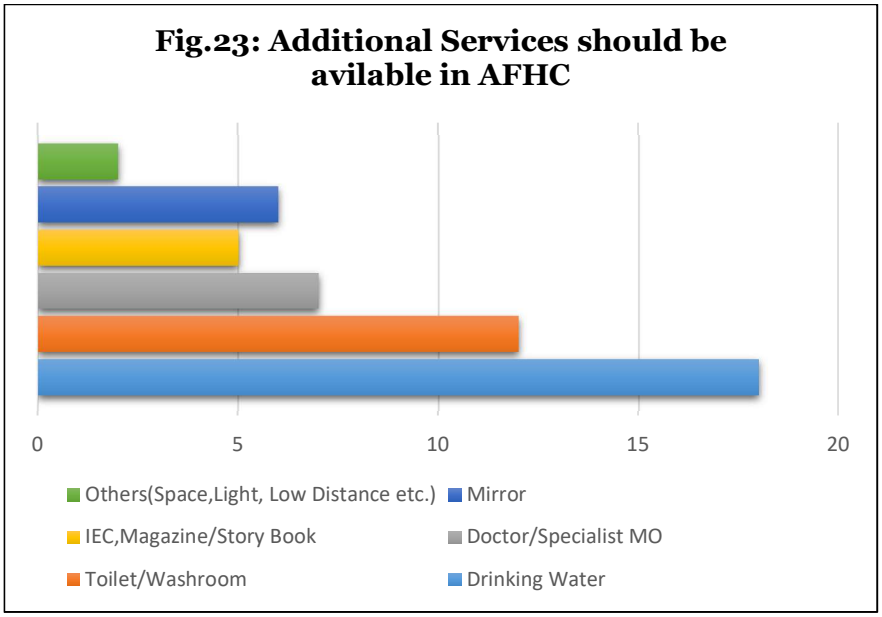
Interpretation: Adolescents are satisfied (96%) with the services of the Anwesha Clinic / AFHC in the study areas. They are very much happy with the behavior of the counsellor of the clinic. They received desirable services from the counsellor and the clinic.

Table-22: Gender Specific Counselling in AFHC	
Yes	No
38	12



Interpretation: As per their preference, adolescent's girls and boys counselled by the gender specific counsellor means girl clients are counselled by female counsellor and boys are counselled by the male counsellor in the clinic. They reported that 76% of the client (Adolescents) are counselled by the gender specific counsellor and 24% are reported not.

Table-23: Additional Services should be available in AFHC					
Drinking Water	Toilet/ Washroom	Doctor/ Specialist MO	IEC/Magazine/ Story Book	Mirror	Others (Space, Lght, Distance)
18	12	7	5	6	2

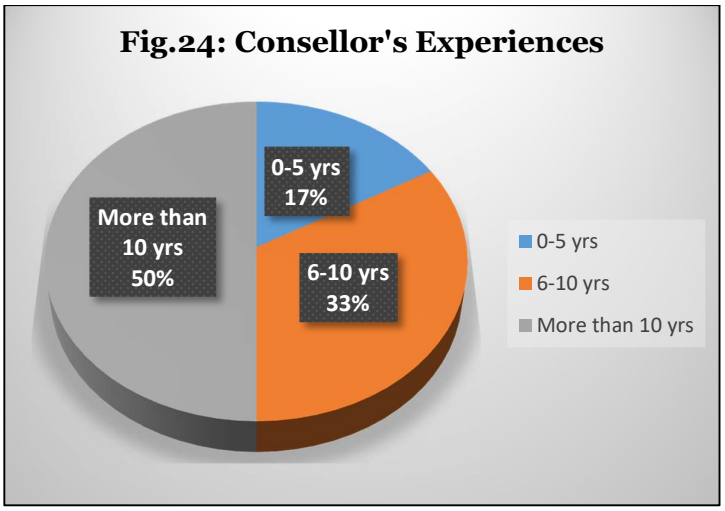


Interpretation: Regarding the additional services should be available in the clinic/AFHC, adolescents' respondents suggested as per their ranking asdrinking water (36%), Toilet/Washroom (24%), Specialist MO (14%), Mirror (12%), Magazine/Story Book (10%) and Space, Light in the indoor of the clinic (4%).

DATA ANALYSIS

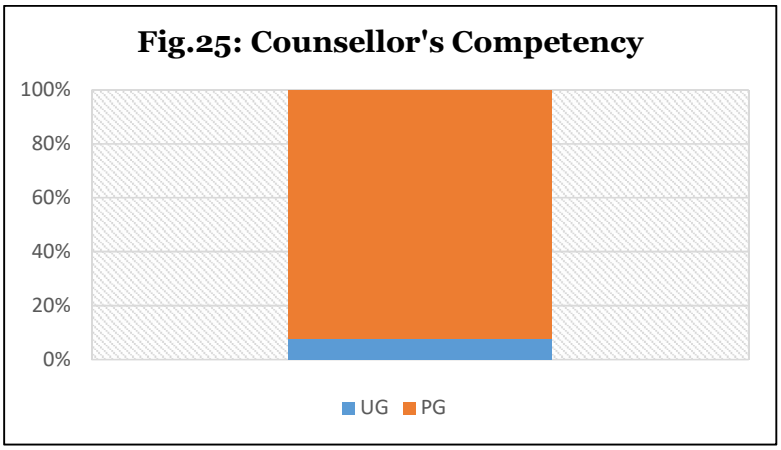
PART-B (COUNSELLOR'S RESPONSES)

Table-24: Counsellor Experiences		
0-5 yrs	6-10 yrs	More than 10 yrs
2	4	6



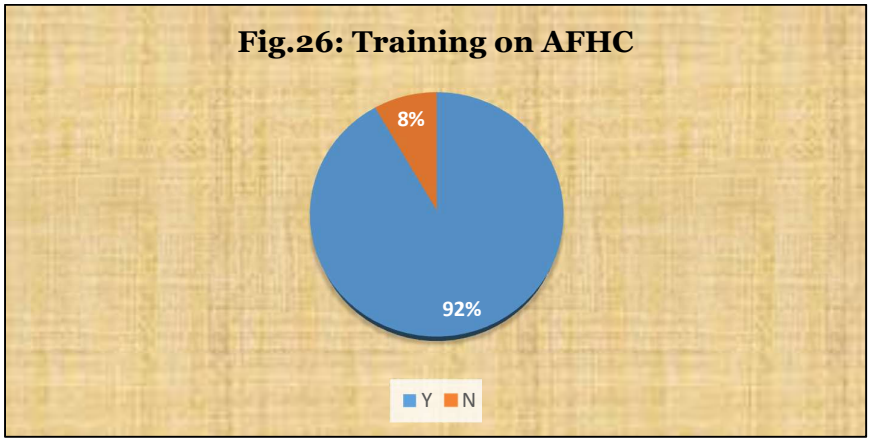
Interpretation: Regarding AFHC Counsellor's experiences most of them have more than 10 years of experiences that 50% (6 Nos). In between 6-10 years of experiences (33%) and very few (16%) have 0-5 years of experience as AFHC Counsellor in the study areas. So, most of the AFHC are experienced counsellor.

Table-25: Counsellor Competency	
UG	PG
1	11



Interpretation: Majority (92%) of the AFHC Counsellor completed Post-Graduation Degreemostly in Social Work (MSW) subjects from Visva-Bharati. They are competence enough for proving services through the AFHC Clinic.

Table-26: Training on AFHC	
Yes	No
11	1



Interpretation: AFHC Counsellor received training (92%) on Adolescent Health (AH) and overall development of adolescents as found in the study areas. So, they are called trained counsellor in contributing good health and wee-being of the adolescent's girls and boys.

Data received from AFHC Counsellor (Male/Female)									
Sl. No	Name of the BPHC	Training on AH	Awareness Program on AH	Need for training on AH	Parents Meeting on AH	Awareness of AFHC	Changes among Adolescents	Challenges	Suggestions
1	Md. Bazar (Rural)	Yes	No	Yes	Yes	not enough	all	Not desirable change in knowledge belief, attitude, education, health	Problems in community intervention with backwards, muslin women and rapport building
2	Md. Bazar (Rural)	Yes	Yes	Yes	No	Far Enough	Positive change	infrastructure, crowded room, space problems	infrastructure Development
3	Sultanpur BPHC (Rural)	Nill	Yes	Yes	Yes	Pretty much more aware	Nil	Outreach activities to stop child marriage and child line help	Due to infrastructure problems counselling service is to be difficult to provide to the clients
4	Sultanpur BPHC (Urban)	Yes	Yes	Yes	Yes	Better	Nill	Damage room, not computer service, toilet maintenance problem	Caste based problem
5	Nalhati BPHC-I	Yes	No	Yes	No	Not aware at all	Risk taking behavior	Migration labour, droup out, mobile and drug addiction	Sub Centre level meetings and grassroots level engagement are necessary
6	Baswa/Rampurhat-II (Rural)	Yes	Yes	Yes	Yes	Need much awareness on adolescents and parents counselling	Positive change	Shortage of fund, infrastructure	Mental health workshop, infrastructure, computer accessebility
7	Baswa/Rampurhat-II (Urban)	Yes	Yes	Yes	No	Need more intervention	Positive change	Treatment, counseling	Nill
8	Bolpur BPHC	Yes	Yes	Yes	Yes	Infrastructure	Positive change	awareness	Nill

DATA ANALYSIS

PART-C (FGD WITH AFHC COUNSELLOR)

One day Focused Group Discussion on Evidence Based Practice in AFHC organized at Annapurna Society for Urban and Rural Community Development (A Study Centre under the SVS, NSOU) in Bolpur Birbhum on 09/04/2023. The FGD was conducted by divided the participants who are the AFHC Counsellor both male and female into four groups. Total participants were 16 and divided them into 4 different groups. Thematic discussion and interaction were held between the group members. Analysis of the FGD given below.

Group – A

As per the team members of Group A Many people came to them with skin problems, R.T.I, S.T.I. Complainants about ringworm, white discharge are very common, Counselor ask the counselee whether there is a bad smell or there is some change in color. Counsellor guides the adolescent girls that white discharge is a normal phenomenon. Then comes the inferiority complex…..many come with this problem. Come and say, my boyfriend said I'm a little black, how can I be fair? I am a little thin, my breast is small, and so my boyfriend is not satisfied, what can be done? Again, many boys come and say, what can be done to make my penis a little large? Many people come to us with this problem of inferiority complex.

Parents also come with a negative attitude. They came and said my son can't do anything, what will happen in the future exam? He is Very low confidence. But sometimes it's seen that parentsare demotivating their children that's why they are felling low or under-confident. The role of Counselor is to believe in positive thinking and boost that confidence in the clients.

Techniques use in counseling – Individual interview Parents counselling, peer counselling, group counseling by going to some field like going to school to provide knowledge to children,

Couple counseling / family counselling….it has increased tremendously now a days. Because of teenage pregnancy, here we try to convince the boys to not to get babies before the age 23-25, don't have kids so soon. Many think counselor means local Political leader, people need

to understand what is counseling. They came with some expectation that IFA medicine, protection will be available there.

Counsellors also conduct outreach activities like School visit, sub- centre visit, VHND, NGO, CBO, SHG, Panchayat, Anganwadi, club, home visit etc. Also deal with Peer education formation – It is done through ANM, Aspirants… they act as a communicator. They act as a bridge between Anwesha clinics and peer members. The Anwesha clinic and RKSK program is very important for the adolescent, it is a platform to talk about adolescence. That is, RKSK program for the adolescence, by the adolescence, of the adolescence.

Group – B

Previously people specially adolescence girls or boys had issues with interpersonal relationships with their parents and friends also after successfully established this Anwesha clinic now this problem has been cleared and doing some awareness programs we have successfully promoted this clinic and people start coming in this clinic to discuss over their difficulties After successfully established this clinic people started discussing their problems such as menstruation, nightfall, addiction etc. with their family in guidance of the counselors like Anwesha Clinic's counselors. Society has developed by reduce the rate of child marriage unwanted pregnancy etc. with the help of them Unwanted pregnancy, white discharge, menstruation, skin problem, psychological issues are the problems of adolescence. Counseling technique applied by the counselor first the counselor have to create a good relationship and build a rapport with the client to get information to specify their cause of the problems. He must be maintain confidentiality he should be nonjudgmental. The counselor will give the way to solve client's problem without being impatient he have to listen Outreach panchayat, school, health center, sub center are already working on problems such as attitude, knowledge, believe, parents and community. Peer educators are teamed by Asha activists to conduct adolescence meeting also some innovative model can use this technique to occasionally conduct meeting over google meet.

Group – C

If you follow the point, we can be seen those type of people who is full of fear, shame and unprepared also .I am there for them and when he comes it is important to accept him and build a rapport and create an environment in which he is assure a sense of "We Feeling" where he can talk about his problems. By using the listening and observing skill of the

counselor the problem solving way will be provided to those people. Counseling is not a one day process, the client will come again very soon..

Outreach: Group counseling, individual counseling happened when we visit the school to discuss about the adolescence problems.

NHM: Many adolescent mother bring their children to us to discuss about their and child's hygiene.

Innovative practice – Kishore Mela, bring them together to give the awareness about the issues. Stage drama can illustrate the problems which the young pregnant women may experience than young pregnant women at the right time.

Group – D

Although the mixed problem has arrived, the school students are given tablets of anemia but they don't eat because of this the adolescence are facing malnutrition, underweight and over nutrition. We have to choose questions which can open up herself when she is sitting quietly.

Attitude: Many people are thinking to come to the AFHC Clinic who are suffering from cold or fever and they desire to get medicine and

Advice: Many people come who are suffering from the problem of their son's mobile addiction; the reduction of mobile usage of the parents can be fixed this problem effectively.

Peer selection: 2males and 2 females are decided as the advisor of Adolescent in the community level.

Village Health Sanitation and Nutrition Committee: make awareness about the AFHC among the community people.

RKSK- The program needs to be increased and need more effective and every kind of service must be increased to aware the people.

Summary: It may be summarized from the above discussion that no doubt that there is increased in the visit and attending to AFHC by the adolescents for solving their various health issues like physical, mental, social, sexual and many others. The AFHC counselors expressed that they really did hard work for convincing the adolescents and community people toward accepting and recognizing the need and importance of Anwesha Clinic (AFHC) for adolescent health and development in the society.

DATA ANALYSIS

PART-D (OUTREACH PROGRAMME IN COMMUNITY LEVEL)

There are total three out-reach programmmes was organized at the community level for the project to know regarding the perception and knowledge about the AFHC and its service utilization. This activity is also a part of the survey or research work of the study.

- There is strong Peer Educators/ Peer Networks in the RKSK Blocks.
- Knowledge and awareness about the AFHC is comparatively more in the RKSK Block than the non RKSK Blocks.
- In non-RKSK Blocks, majority of the adolescents/clients were not knew the exact name of the Clinic but somehow they have knowledge about the clinic.
- In many of the AFHCs there is a friendly atmosphere / environment with proper ventilation in their clinic/settings.
- All AFHCs ensured to have maintain confidentiality in all cases except the exceptional cases.
- There is only two BPHC/RH have the proper infrastructure for separate sitting for Male and Female Counsellor.
- Few AHFCs have attached toilet facilities for AFHC counselor.
- There is no such drinking water facility especially for the clients of AFHC. There is Drinking Water facilities for all/general public.
- Four AFHCs have convergence with Kanyashree Program/Scheme, SAG-KP, SisuSathi, CINI, and Child Line for effective implementation of the program.

Few Non-RKSK BPHCs have already formed Peer Educators/ Teen Clubs in non-formal way without any financial support from the program**.**

DATA ANALYSIS

PART-E (PROJECT SEMINAR)

The one-day regional level seminar on Adolescent Health and Development sought to offer a space for stakeholders from many sectors to address and resolve crucial problems facing adolescent health and development. The seminar focused on the government response, non-governmental organizations (NGOs), civil society, and the role of social work professionals in supporting the well-being of adolescents. The objective of the seminar is to raise awareness of the significance of adolescent health and development. To comprehend the duties and responsibilities tasks of various stakeholders in dealing with Adolescent health problems. To discuss the current initiatives and programmes being implemented by the government, non-governmental organisations (NGOs), and civil society organisations. To investigate the role of social workers in fostering teenage well-being. Identifying difficulties and proposing solutions to improve adolescent health and development.

Smoking among adolescents has far-reaching social implications that can harm individuals, families, and communities. For starters, smoking throughout youth raises the chance of acquiring a variety of health issues later in life, including respiratory ailments, cardiovascular disorders, and several forms of cancer. These health difficulties not only burden individuals, but also put a strain on healthcare systems, affecting society's general well-being.

Furthermore, teenage smoking might result in a variety of social and behavioural issues. Young smokers are more prone to engage in hazardous behaviours such as substance addiction, which can worsen health issues and contribute to social instability. Smoking can also impair academic performance, resulting in lower educational achievement and fewer future possibilities for those who smoke.

Life skill workshops are extremely important in improving adolescent health and development. Adolescence is a vital transitional stage marked by physical, emotional, and social changes. Adolescents encounter several difficulties and decisions throughout this stage that might have long-term consequences for their well-being. Life skill workshops offer teenagers with an organised and supportive setting in which to gain vital skills and information that can benefit their health and overall development.

Physical health promotion is a key implication of life skill workshops. Adolescents are encouraged to develop healthy behaviours such as frequent physical activity, good diet, and personal cleanliness. They learn the value of a healthy diet, the dangers of substance misuse, and the advantages of physical activity.

The synthesis of numerous efforts and programmes to meet tribal teenage girls' special health requirements entails the convergence of Indian government policies for the well-being of tribal adolescent girls' health. The government recognizes the specific issues that tribal teenage girls confront and intends to provide extensive support and services to them.

There is an emphasis on convergence across different departments and ministries to facilitate successful implementation and cooperation. Collaboration between the Ministries of Health and Family Welfare, Women and Child Development, Tribal Affairs, Education, and others is an example of this. This convergence enables coordinated planning, execution, and monitoring of tribal teenage girls' health programmes. Mental health issues are frequent among Indian teens, with a significant percentage of them displaying signs of anxiety, sadness, stress, and behavioural disorders. Stigma and a lack of mental health knowledge are common societal and cultural issues that exacerbate these problems. The study proposes a number of strategies for boosting adolescent mental health in schools. These include mental health education and awareness campaigns, the implementation of peer support programmes, the availability of mental health services in the school, and the promotion of healthy school settings. The study emphasises the significance of a comprehensive and holistic approach to mental health promotion in schools that takes into account individual, social, and cultural factors that influence mental health. Finally, the study emphasizes the need of teenage mental health treatment.

RESULTS (KEY FINDINGS)

Unmarried adolescent girls are using AFHCs. Global evidence indicates that integrating adolescent friendly services into existing health delivery systems is more effective than establishing separate or stand-alone youth and/or adolescent health centers or clinics. The findings from this study support this, as it appears that AFHCs (which are integrated into existing facilities) are reaching unmarried adolescent girls with a range of health services, both general and SRH-related, through established health facilities. It is also noteworthy that significantly few adolescent boys use the AFHCs and, when they did, service statistics indicate that they did so for general illness, rather than SRH services. Further exploration is needed to understand the reasons behind boys' lower attendance at AFHCs.

AFHC users expressed satisfaction with AFHC service providers. The adolescent girls who received services from AFHCs were generally satisfied with how service providers treated them. This is especially noteworthy, given the social stigma associated with unmarried girls seeking services from facilities that are often seen as 'family planning clinics' by parents and other community members.

Variation in the physical set-up of AFHCs impacts client access and privacy. There were some variations observed in the physical set-up of AFHCs at BPHCs and UHFWCs. In the BPHCs, each AFHC had a separate room or designated physical space. Ensuring that a separate physical space is allotted for all AFHCs is important, since ensuring privacy and confidentiality for adolescent services and counselling is a critical aspect of quality adolescent friendly health services. This was noted by a number of respondents as a challenge, and some respondents and service providers also suggested separate waiting rooms for boys and girls, to further ensure privacy for adolescent clients.

Awareness of AFHCs is limited. Adolescents and parents had limited awareness of AFHCs. This may be because the AFHCs had just been recently launched at the time this study was conducted. However, more publicity and generating awareness about the centres in the community is recommended. Awareness-raising efforts provide a unique opportunity to 'relook' how adolescent friendly centres are viewed — as sources of prevention and

counselling services, and not just as treatment centres. These centres have the potential to be seen and serve as important 'information and counselling hubs' to serve a wide range of adolescent health and counselling needs.

AFHC users experienced challenges. While generally happy with the way AFHC service providers treated them, AFHC users described several limitations in accessing services at AFHCs. Like distance and location is a challenging factor to them to visit the clinic.

Shortages of space and lack of privacy are the major challenges identified by the adolescent respondents. The demand for separate waiting rooms for adolescents was also strongly emphasized by the respondents. Concerns were raised by both clients and AFHC service providers regarding the **lack of Behaviour Change Communication (BCC) / Health Educational Materials** available in the AFHCs. These should include posters, booklets, and leaflets, and should address an expanded range of issues of concern to adolescents – e.g. mental health, substance abuse, early marriage prevention, and domestic violence. Afternoon service hours once a week or opening for weekend service hours could effectively create an enabling environment and maximize outreach to adolescents. Service providers who are assigned to AFHCs face difficulty operating in multiple places throughout their day – outdoor service points to serve mothers and children and AFHCs to serve adolescents. The AFHS-trained providers talked about the additional demands created by their new responsibilities for serving adolescents, while continuing to meet the needs of their regular clients (mothers and children). This increased workload and the need to choose when to be in the AFHC was stressful for some providers.

Most service providers in BPHCs used outdoor service points to serve adolescent clients rather than using the designated AFHC, due to their workload. Service providers should be supported and motivated to use the AFHCs, so that adolescents can be confident that the service provider will be available when they come to the AFHC. It is also recommended that more service providers be trained in AFHS to increase availability of AFHS and to prevent service provider burnout. To address the challenge of service providers being required to deliver services in two different locations, it may be beneficial to examine clinic flow to identify additional opportunities to integrate AFHC into existing spaces, while ensuring privacy and confidentiality.

DISCUSSIONS

Addressing adolescents provide not only health benefits in terms of delaying age at marriage, reducing incidence of teenage pregnancy, prevention and management of obstetric complications including access to early and safe abortion services and reduction of unsafe sexual behavior etc. but also economic and other benefits due to improved productivity and will help in protection of human rights. Health services have to be sensitive to the needs and developmental attributes of adolescents to be able to attract them. More young people now need reproductive health care, especially prevention services. These arguments strongly advocate the need of establishing AFHC. It is a known fact that adolescents first approach their peers for advice on sexual or reproductive issues. In the present study, majority of respondents were self-motivated to attend these clinics mostly without any prior appointment and mostly had to wait 30-60 min to consult the doctor. There may be several reasons why the present health services are not accepted well by adolescents such as lack of knowledge regarding availability and accessibility of services, cultural reasons, lack of confidentiality, long way away or expensive services, lack of friendliness services, poorly trained staff, physical or logistical restrictions, gender barriers, and peer pressure etc. as observed in the present study also. Seventy two percent girls and 56% boys reported health problems during survey. only 43% girls and 35% boys reported to the clinic voluntarily to seek help and only one fifth the amount of problems were reported at the clinic in comparison to the quantum of problems reported in survey, which probably reflects a poor health seeking behavior by Joshi et al (2006). No counseling was done in the most of the cases and most of them were not availing contraceptive service as observed in the present evaluation. They received all relevant information up to a satisfaction level. Confidentiality and the quality of care are major concerns among adolescents. Present study reported that confidentiality was also maintained in most of the cases. Utilization of AFHC could be improved by intensive information, education and communication (IEC) strategies raising awareness on reproductive health and gender related issues. Overall satisfaction rates were found very satisfactory among AFHC clients. They were of the opinion that there should be opportunity of separate discussions with doctors in privacy. No earlier study is available on evaluation of AFHC in Indian set-up.

CONCLUSIONS AND SUGGESTIONS

Existing services were found to be lacking in terms of infrastructure for maintain privacy of clients. Adolescents felt need some improvements in AFHC. More users friendly AFHS need to be established and extended with desired characteristics of availability, accessibility, and acceptability. Further insight should be given to understand problems of adolescents attending AFHC and for evaluation of AFHS in a better way. Adolescent Friendly Health Initiatives (AFHI) should be developed and monitored at different levels as ongoing efforts.

- Older (15-19yrs) unmarried girls formed a greater part of the client group. This is an achievement and focus should also be put on younger girls and boys.
- Performance across the clinics was relatively uniform though there were best practices scattered among them. This could be replicated through knowledge dissemination workshops.
- A lack of basic Infrastructural facilities was pointed out by all the service providers. Accessibility & visibility of the clinics was important for increasing walk-ins.
- Outreach activities with schools, clubs and communities, career counselling and formation of peer groups may be significant in the future to enhance the service delivery.
- The enabling aspects of service delivery of the counsellors were the 'friendly' environment that they maintained and some innovative efforts that they put in. For this, training of the counsellors in latest issues necessary. The convergence with NGOs and government youth schemes also significant in the success of Anwesha clinics.

Limitations of Research

- Limited AFHC included and cover only one district for the study.
- May cover more district for the study.

Scope of Further Research

- May be replicated in other districts/regions with AFHCs
- Scope for develop an evaluative model/assessment scale for AFHCs.

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Appendix-1

Interview Guide for AFHC Counsellor (Male & Female Separately)

1. Name of the AFHC

2. Location of the AFHC (Rural/Urban)

3. Name of the AFHC Counsellor

4. Highlight Qualification of the AFHC Counsellor

5. Years of experience as AFHC Counsellor

6. Did you receive any training/course on Adolescents Counseling? (Y/N)

7. Did you feel the need for more training on Adolescents Counseling? (Y/N)

8. Did you organize any awareness or sensitization program on Adolescents Health in community level? (Y/N)

9. Did you arrange any meeting with the parents or family members of adolescent to discuss about Adolescents Health? (Y/N)

10. How you feel about the awareness of AFHC (Anwesha Clinic) among adolescents, parents and community level?

11. What are the changes you found in the Adolescents(who visited the clinic frequently)after giving Counselling services like if any changes in behaviour, belief, attitude, knowledge, education, health, menstrual hygiene and others (Descriptive type)

12. What are the challenges if any you found in providing counseling services to the Adolescents?

13. Suggestions if any for improving the system of AFHC

14. Success Stories (One if available)

15. Research's observations/comments

Appendix-2

Effectiveness of role of Adolescent Friendly Health Counsellor (Anwesha Counsellor) in contributing well-being of Adolescent: A study in Birbhum District, West Bengal.

INTERVIEW SCHEDULE

Respondent (Adolescents)

Basic Profile

Name of the BPHC/RH:

1) Name of the Respondent:

2) Age group: **10-14 yr. / 15-19 yr.**

3) Sex: **M/F**

4) Educational Status: **Primary/Upper Primary/Secondary/Higher Secondary/UG/PG**

5) Religion: **Hindu/Muslim/Christian/Sikh/Buddhist/Jain/Others(Specify)**

6) Social Status: **Gen/OBC-A/OBC-B/SC/ST**

7) Marital Status: **Unmarried / Married (***if married then mention the age of marriage)*

8) Economic Status: **APL/BPL**

9) Place of Residence: **Rural / Urban**

10) Are you a beneficiary of Kanyashree Scheme**? Y/N**

11) Availability of Toilet in own house**: Y/N**

12) Total No. of Family Members:

13) Father's Educational Status**: Primary/Upper Primary/Secondary/Higher Secondary/UG/PG**

14) Father's Occupation:

15) Mother's Educational Status**: Primary/Upper Primary/Secondary/Higher Secondary/UG/PG**

16) Mother's Occupation:

17) Whenever you faced any problem what do you do?

a. Share with Peer b. Share with Parents c. Share with ASHA d. Share with Others e. Visit AFHC

Knowledge about AFHC/Anwesha Clinic

1. Name of the AFHC (BPHC/RH):
2. Did you know about Rastriya Kishor Swastha Karyakram (RKSK) Programme? **Y/N**
3. Did you know about AFHC/Anwesha Clinic? **Y/N**
4. From where do you know about AFHC? **ASHA/ANM/AWW/Peer/School Teacher/Others(Specify)**
5. For any health issue did you directly visit AFHC or OPD?
6. Were you referred/brought by someone in AFHC or visited alone **(Y/N)? If yes, specify.**
7. With whom you visit the AFHC: **Peer/Mother/Father/Family Members/ANM/ASHA/AWW/School Teacher/Other (Specify)**
8. How many times you have visited the AFHC**? 1-2 times/3-4 times/ 5-6 times/more than 7 times**
9. Distance of AFHC from your home: **within 1km/1-2km/3-4km/4-5km/more than 5 km**
10. What are services available in the AFHC? **Counselling/Clinical/Outreach/Referral/Others(Specify)**
11. For what reason/purpose you visited the AFHC? **Physical Problem/Sexual Problem/Mental Problem/Others(Specify)**
12. Were you treated by AH Specialist Doctor (MO) for any health issues if any? **Y/N**
13. Did you know about Adolescent Health Day (AHD)? **Y/N**
14. Whether you participated in the Adolescent Health Day program? **Y/N**
15. Are you a member of any Peer Group or Teen Club or Adolescents Friendly Club? **Y/N**
16. Did you participate in any activity (Training/Camp/other) conducted by AFHC Counsellor: **Y/N (Specify)**
17. Are you aware of the services that are been provided by the Anwesha Clinic at your nearest location? **A. Clinical B. Counselling C. Referral D. Outreach V. Peer Education**
18. Type of Counselling services received by the respondent.
19. Type of Clinical services received by the respondent.
20. Type of Referral services received by the respondent.
21. Type of Outreach services received by the respondent.
22. Did you know that all the services delivered by AFHC are free of cost? **Y/N**

Views about Service Delivery of AFHC

1. Are you feel comfortable while visiting AFHC? **Y/N**
2. Are you easily share your problem with the AFHC Counsellor**? Y/N**
3. Did you counsel by gender based counsellor? **Y/N/Both Counsellor**
4. Were you treated in the Clinic with warmth, respect and friendly attitude? **Y/N**
5. Did you feel that confidentiality & privacy are maintained in AFHC? **Y/N**
6. Did you think that non-judgmental attitude is maintained in AFHC? **Y/N**
7. Did you feel that AFHC Counsellor deal with your problem with care**? Y/N**
8. Are you satisfied with the services that you received from AFHC? **Y/N**
9. Did you get any commodities from AFHC? **a. IFA b.Contraceptive c. Sanitary Napkin d. Others (specify)**
10. As per your opinion what additional services or facilities should be available in AFHC clinic?
11. Would you like to refer your peers to this clinic for any Adolescent Health issues and why? **Y/N**

Impact/Changes after getting services from AFHC

1. Are you satisfied that the Anwesha Counsellor gives proper care towards the Client? **Y/N (Specify the reason).**
2. Did you feel any positive change in your physical health after receiving counselling services from Anwesha Clinic? **Y/N (Specify the reason).**
3. Did you feel any positive change in your mental health after receiving counselling services from Anwesha Clinic? **Y/N (Specify the reason).**
4. Did you feel any positive change in your social health after receiving counselling services from Anwesha Clinic? **Y/N (Specify the reason).**
5. Did you feel any impact in your study/education after receiving counselling services from Anwesha Clinic? **Y/N (Specify the reason).**

6. What are the attitudes/beliefs changes after getting counselling from the AFHC?

7. What are the changes you find in your life after receiving counselling from the AFHC if any?

8. Does your parent or family members understand the need of the services provided by Anwesha Clinic?

   Y/N (Specify the reason).

9. Your opinion regarding the behavior of AFHC Counsellor towards the Client.

10. Your opinion regarding the attitude of AFHC Counsellor towards the Client.

11. Your opinion regarding the competency of AFHC Counsellor in solving problem of the client.

12. What are the challenges you faced to access the health services of Anwesha Clinic?

13. View/Opinion of Adolescents about the overall services of AFHC.

14. Suggestions for improving the service delivery process/system in AFHC if any.

Researcher's Observation / Comment

Date: **Signature of the respondent / LTI**

School of Professional Studies
Netaji Subhas Open University
(Established by WB Act (XIX) of 1997, Recognized by UGC)
Accredited by NAAC with grade "A"

One Day Focus Group Discussion
On
Evidenced Based Practice in AFHC

(Under NSOU Sponsored Research Project)

Date: 09/04/2023 (Sunday)

Venue: Annapurna Society for Urban and Rural Community Development, Trisulaputty, Bolpur, Birbhum (V-76) an approved Study Centre of School of Vocational Studies (SVS), NSOU.

Time: 11:00 AM to 2:00 PM

Mode: Face to Face (Discussion, Interaction, Group Activity)

Participants: AFHC Counsellor, Professional working on Adolescent Health (Invited)

Agenda

(Discussion on Evidenced Based Practices in AFHC)

1. Present Health Scenario of Adolescent in Birbhum, West Bengal.
2. Problems that Adolescent comes with in AFHC. *(Male / Female Separately or Jointly).*
3. Counselling Techniques applied by the Counsellor *(Male / Female Separately or jointly as applicable).*
4. Attitude, Knowledge and Belief of the Parents / Community toward the AFHC.
5. Nature and Type of Outreach Activities conducted by AFHC.
6. Process of Formation of Peer Educators and Role of Peer Educators.
7. Model and Innovative Practices of AFHC if any.
8. Success Story (One / Two by Each Group).
9. Review of RKSK / ARSH programme.

Group Presentation, Session Summary, Suggestions and Recommendations

Organizer and Convener

Sd/-
Monojit Garai
Assistant Professor of Social Work
And PI