GARIMA
means "dignity"
"A Comprehensive program model on Adolescent Reproductive and Sexual Health Education"

Part I. Overview of Program Model

Title:	**GARIMA, *A Comprehensive program model on "Adolescent Reproductive and Sexual Health "***
Life Stage(s) of focus:	Life stage 2 and Life stage 3
Impact group:	**Impact group**: The impact group of GARIMA model are adolescents in the age group of 10-19 years with focus to adolescent girls. • Unmarried adolescents • Married adolescents girls • Out of school adolescents girls • Adolescents from urban slums • Anaemic Adolescents • Teenage especially first-time parents especially girls
Brief description of model (1 to 3 sentences):	GARIMA, which means "dignity" is designed by ChildFund India, with an objective to improve the sexual and reproductive health behaviors and practices among adolescents. *This model supports adolescents to practice healthy behaviors, access essential SRH services, and live free from sexual exploitation and abuse*.
Pathways that the model addresses in the Life Stage(s)	**GARIMA model addresses pathways of Life Stage 2 and Life stage 3** ***The pathways addressed in Life stage 2 are:*** **Pathway 1 Responsive Parents and Caregivers:** Adolescents are positively cared for by caregivers by appropriate communication on ARSH. **Pathway 3 Positive Relationships with Peers and Adults** -GARIMA ensures adolescents have positive relationships with peers and adults through SRG **Pathways 6: Life skills for wellbeing** -Adolescents demonstrate and understand life skills. **Pathway 8 Access to Health Services**-Adolescents have access to health services through frontline workers and from primary health-centre. ***In life stage 3, all the pathways of domain2 are addressed through this program model.*** **Pathway 4: Access to Youth-Friendly Sexual and Reproductive Health Services –** Addresses Youth-friendly services based on a comprehensive understanding of what adolescents in any given community want and need. ***Pathway 5: Community Support for Adolescent and Youth Sexual and Reproductive Health and Rights (SRHR)*** -Engaging community members in dialogue and encouraging them to analyse and act on ASRH issues.

	Pathway 6: Community-Based Protection Mechanisms Against Sexual Exploitation and Abuse - Addresses Negative sexual behaviours and lack of access to services, sexual abuses, and gender-based violence during adolescence and youth
Developed in X Country Office/IO:	India
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Part II. Description of Proposed Program Model Design

1) STATEMENT OF NEED FOR GARIMA MODEL

In India, every fourth person is an adolescent (10-19 years) [1]. The adolescent population (10-19 years) in India is 253.2 million, constituting 20.9 per cent of the total population[2].The idea of sexual and reproductive health rights is inherent to the definition of reproductive health, and these rights are integral to globally recognized human rights. Global human rights are expanded or adjusted to health programs. Sexual Reproductive health rights are part of all health programs to meet reproductive and sexual health needs of adolescents , to respect their rights to privacy and confidentiality, and to ensure that the attitudes of healthcare providers do not restrict access to information and services. This program offers addresses one of the most neglected issue that is Adolescent Reproductive and Sexual Health which largely impacts the lives of adolescent girls and boys. Eventually due to inadequate knowledge and vulnerability status, they are at highest risk of exposure to unprotected sex, harmful sexual practice, STIs and HIV/AIDS.

In 2016, more than one-quarter (28%) of adolescent girls reported having unsafe sex making them vulnerable to various sexually transmitted infection and unwanted pregnancies. In India, only 14.1% (14.7% urban versus 13.9% rural) of unmarried sexually active adolescent used condoms to get protection from unsafe sex. In India condom awareness among unmarried adolescents is as high as 83.8% but condom usage is reported to be very less[3]. This proportion was higher in rural areas than in urban areas (48% vs. 24%) and in the poorest households than in the wealthiest (64% vs. 14%). Adolescents and young people are not able to access information, supplies and services that could facilitate preventing unplanned pregnancies and safe abortions. As per baseline findings of CSP conducted by Childfund India in 2020 only 38% adolescents have comprehensive ,correct and appropriate knowledge on SRH and only 19% adolescents have adopted safe and healthy practices pertaining to sexuality and reproduction**.**

In India only 19% girls and 35% boys had comprehensive knowledge about HIV/AIDS (NACO 2018). Only 15% young men and women (15-24 y) reported that they received family life or sex education. Eventually due to inadequate knowledge and vulnerability status, they are at highest risk of exposure to unprotected sex, harmful sexual practice and STIs and HIV/AIDS

In India 28 per cent of adolescents were anaemic [8]. Adolescent girls in the rural areas are at greater risk of nutritional stress because of early marriage and early conception before completion of their physical growth[9].Adolescent girls are particularly prone to iron deficiency anaemia because of increased demand of iron for haemoglobin, and to make up the loss of iron due to menstruation and poor dietary habits.

***1**.https://india.unfpa.org/sites/default/files/pub-pdf/aprofileofadolescentsandyouthinindia_0.pdf*

2.National population census 2011, a profile of adolescent and youth in India

GARIMA and Sustainable Development Goals : Garima aligns with the following 3 SDGs, ChildFund India is committed to support the country in meeting the Sustainable Development Goals, especially those goals that work to eradicate violence against children and adolescents[11]

3.7: Ensure universal access to sexual and reproductive healthcare services, including for family planning, information and education, and the integration of reproductive health into national strategies and programme

5.3: Eliminate all harmful practices such as child, early and forced marriage and female genital mutilation

5.6: Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences

National Goals: Aligns with the goals, objective, and targets of National Adolescent health Strategy (Rastriya *Kishor Swasthya Karyakram)* was launched on 7th January, 2014[11]. The key principle of this programme is adolescent participation and leadership, equity and inclusion, which is similar for Garima model.

INSPIRE: GARIMA model has taken four out of seven strategies for ending violence against children mentioned under INSPIRE[12].1) Norms and Values; GARIMA will strengthen norms and values that support non-violent, respectful, nurturing, positive and gender equitable relationships 2) Safe environments; Model will create and sustain safe spaces for adolescent friendly health centres and other environments where feel safe to discuss on ARSH 3) Parent and caregiver support; Model will create positive parent-child relationships by helping parents and caregivers understand the importance of SRH for 4) Response and support services; Model will work with government system to improve access to good quality sexual and reproductive health services.

As per CBCPM 2018-19[13] Child protection approach in model : Millions of girls are coerced into unwanted sex or marriage, putting them at risk of unwanted pregnancies, unsafe abortions, sexually transmitted infections (STIs) including HIV, and dangerous childbirth in the location of ChildFund India. CBCPM findings reveals that adolescent boys are at risk as well. Yet too many adolescents people face barriers to reproductive health information and care. Even those able to find accurate information about their health and rights may be unable to access the services needed to protect their health. GARIMA will focus on formation of adolescent groups in the community and school level, to provide a safe platform for them to develop their understanding on SRH . Garima will work with parents on building skills for communicating SRH with their children and mitigating harmful sexual practices.

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4. Adolescent friendly health services in India: a need of the hour, population council,

5,6,7. NATIONAL FAMILY HEALTH SURVEY 2015-16

8.Comprehensive National Nutrition Study , ministry of Health and UNICEF 2016-17

9.National Nutrition Monitoring Bureau 2018-19,GOI

10. https://in.one.un.org/page/sustainable-development-goals/. SDGs in India , UNDP

11.National Adolescent health strategy , https://nhm.gov.in/ 2015 ,it is Government program on adolescent health in India. The Garima model is aligned to this national strategy on adolescent health.

12. https://www.who.int/publications-detail/inspire-seven-strategies-for-ending-violence-against-children.INSPIRE: Seven strategies for Ending Violence Against Children-2016

13. Community Based Child Protection Mechanism was conducted by ChildFund India in few states with local partners in 2018-19

2) SUPPORTING EVIDENCE

Evidences suggest that investment in adolescent health not only improves SRH status but also enables youth to fulfil to their potential and have an immediate direct and positive impact on India's adolescents health , it enhances economic productivity, effective social functioning and overall population development[14]. ***ChildFund India has implemented Adolescent Sexual and Reproductive Health projects since 2017 and has integrated the learnings of this pilot while designing the GARIMA model. The interventions of GARIMA are built upon on the best practices of National Adolescent Health Program implemented by GOI since 2009. In addition, some of the best practices of development countries like mentor mothers also contextualized as lead mother in some locations and further integrated into GARIMA model.***

Peers play an important role in adolescent development and have been found to effectively provide peer education increasing SRH knowledge and condom use, delay sexual initiation and enhances gender norms[15]. Child Fund India projects has more than 500 peer educators, trained and mentored to provide information on common SR health concerns. End line studies (2018) in 9 locations reveals 60 % adolescents have gained comprehensive, correct, and appropriate knowledge on Sexual and Reproductive Health as compared to only 32 % in the baseline[16].

Adolescent girls and boys groups act as pressure groups in the community and are effective in mitigating harmful traditional practices like early marriage, teenage pregnancy, and other practices such as isolation during menstruation. Reduction and eventual eradication of such practices requires integrated interventions across the adolescent, parent, community, and service provider level. This integrated approach in ARSH projects resulted in more than 62 % adolescent girls reported menstrual hygiene or using sanitary napkins during menses[17].

The Family Matters! Program is an evidence-based, parent-focused intervention designed to promote positive parenting and effective parent-child communication about sexuality and sexual risk reduction, including risk for child sexual abuse and gender-based violence, for parents or caregivers of 9-12-year olds in Africa[18]. Child Fund has trained more than 320 parents on SRH through "Family Matters !Program ". The Safe Space Model suggested in RKSK, National Adolescent health program, aims to improve a variety of outcomes by ensuring girls' safety, building their assets, and connecting them with social networks. ChildFund India's projects have successfully engaged community level functionaries like families' teachers, Anganwadi workers and advocated with government to re-establish 48 adolescent friendly health clinics at first referral units which is sustainable and replicable to other locations of ChildFund India.

14.https://www.who.int/pmnch/media/news/2018/Adolescent-Health-Missing-Population-in-UHC.pdf?ua=1 Adolescent Health The Missing Population in Universal Health Coverage
15. Peer-led-Services-Promising-Practices , PATA 2016 Youth Summit
16.Endline pilot studies in 5 location of ChildFund by external agencies 2018 (Ekjut , UNICEF consultants)
17.Rapid survey ,KAP studies in 4 location of ChildFund India
18. https://www.cdc.gov/globalaids/publications/fmp-2-pager-final-jan-2014.pdf

Schools health programs in India have good results and strong evidence supporting SRH intervention in schools. In FY19, 83% children were aware of personal hygiene and were practicing proper hand washing and menstrual hygiene practices resulting in reduction of 5% drop out of girls from school as compared to FY 18[19]

National Ministry of Health and Family Welfare has launched a nationwide nutrition and anemia reduction program for adolescents in January 2013. The program builds on 13 years of evidence-generation through pilots and phased scale-ups by UNICEF on nutrition counselling and supplementation to address anemia in adolescent girls in different Indian states[20]. Services delivered under the scheme include supplementation; bi-annual deworming; and nutrition counselling about how to improve diet and prevent anemia.

In summary, these programmatic findings provide empirical support for a comprehensive intervention approach that addresses Sexual and Reproductive health of Adolescents. The impact groups for this intervention package is adolescent girls and boys in vulnerable situations

3) GOALS AND OBJECTIVES RELATED TO TARGETED OUTCOMES:

GOAL : Adolescents (10-19 years) are empowered to adopt (or improve) safe and healthy sexual and reproductive and practices/behaviours enabling them to grow to their full potential
OBJECTIVES : All adolescents of age group 10-19 years have improved reproductive and sexual health.
The sub objectives of the model are:

1. All adolescents have comprehensive, correct, and appropriate knowledge on sexual and reproductive health.
2. All adolescents are adopting safe and healthy practices pertaining to SRH and other health & nutrition issues.
3. All adolescents have increased access to adolescent friendly counseling and services.

4) TIMEFRAME : The Time frame to implement this program model would be 18-24 months , which can be extended to 36 months in location with poor SRH among girls as per evidence

5)GEOGRAPHIC PRIORITY:

- ✓ States with high Total Fertility rates (TFR): Uttar Pradesh, Rajasthan, Bihar, Jharkhand, Madhya Pradesh
- ✓ High HIV prevalent states (Andhra Pradesh and Karnataka)
- ✓ Urban cities with population of more than 1 lac (Mumbai, Delhi, Chennai)

This is 3-5-year program, active in 19 districts and 9 states Odisha, AP, Maharashtra, Karnataka, Telangana, UP, Rajasthan, Chhattisgarh and Tamilnadu. The beneficiaries are 21,000 adolescents (11-18) and youth (19-24) both school going and out of school young people

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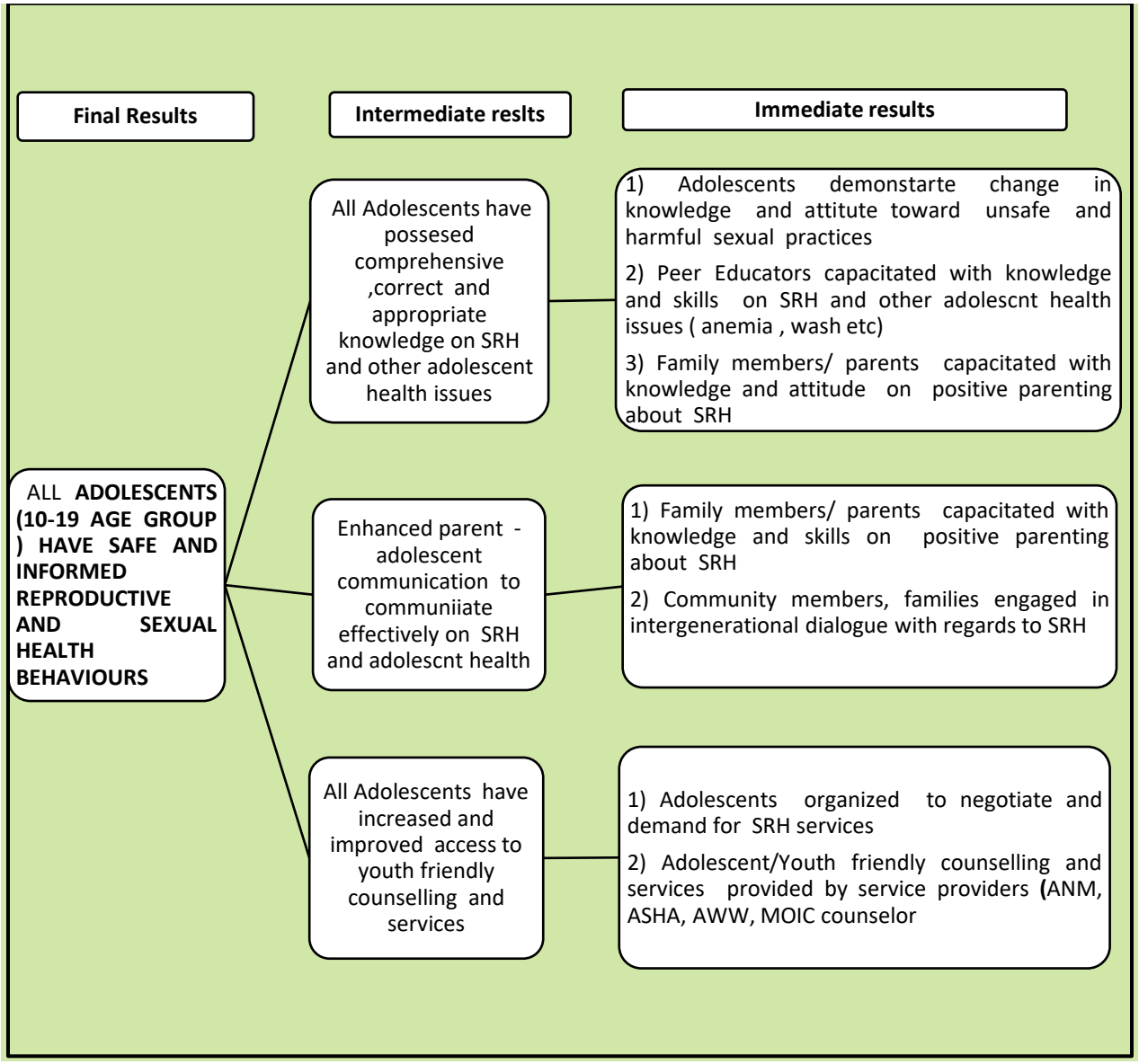
19.School WASH assessment reports 2018 , ChildFund India.
20. Adolescent nutrition, UNICEF 2013 , https://www.unicef.org/india/what-we-do/adolescent-nutrition

6) STANDARD PROGRAM MODEL ELEMENTS:

1) A Clear Results Framework: A results framework which includes the Model's goal and corresponding higher-level objectives, as well as the expected immediate results we want to achieve from implementing the program model with the identified participant and impact groups.

Logical Framework: A results framework includes the goal of the model and the corresponding higher-level objectives, as well as the immediate results we want to achieve with the implementation of an ARSH Model as well as with the participating children and identified impact groups



7. INTERVENTION STRATEGIES:

This subsection first provides a short description of the components of the program model and of the main interventions within each component. The ARSH model addresses the core issues through the following intervention strategies to achieve better sexual and reproductive health of adolescents.

a) **Peer-Focused and Mentor-Supported Programs :** Peers play an important role in adolescent development and have been found to effectively provide peer education that in some cases increases SRH knowledge and condom use, delays sexual initiation and enhances gender norms. Peer educators in ASRH have a double benefit. Those who become peer educators learn valuable leadership, teamwork, communication, and negotiation skills that will provide on-going benefit for them as individuals. Those receiving—scientifically-accurate, culturally-appropriate, and gender-sensitive—information from their peers are more likely to listen, absorb, internalize, and act upon the information they receive, rather than receiving it from parents, teachers, community leaders or health providers

This model will implement this peer Educators approach for SRH for improving SRH status .A set of trained SRH educators (At the beginning to avoid resistance from the parents we may call them as Health Animators or Change Agents) and slowly equipped them with SRH knowledge and understanding.

Qualities of a Peer Educator

- ***Ability to keep abreast of new information and knowledge***
- ***Ability to listen and communicate effectively***
- ***Ability to deal with emotions and difficult situations***
- ***Ability to express emotions***
- ***Adaptive and flexible nature***
- ***Ability to encourage and provide support***
- ***Ability to lead by example***
- ***Ability to look at things from various perspectives***
- ***Sensitivity to gender issues***

b) **Skilled delivery of comprehensive sexuality education and counselling : C**omprehensive Sexuality Education (CSE) and counselling would be provided through outreach clinics, Government Primary Health centres or community-based health workers or peer educators, in either one-on-one or group formats. Service providers should be respectful, non-judgmental and a trusted source for information. Facilitators' confidence and comfort must be addressed as well as under-standing of the curricula and the varying developmental needs of . Training of ASHA[21], AWWs [22] on counselling skill and SRH for 2 days can be conducted on quarterly basis. Model will work with health department for skilled delivery of SRH services by proving training , tools and regular follow ups and networking with respective department accountable for skilled delivery of SRH services. With mobile phones and the Internet penetrating deep into rural areas, and being the prime users of these emerging technologies, it is imperative to leverage emerging opportunities such as telephone helplines and e-counselling, social media, V-SAT, SMS and other ICTs. These technologies provide easy, wider and 24 x 7 reach for two-way information dissemination

c) **Family matters! Program for parents on communicating SRH with adolescents:** Through this model, parent-focused intervention designed to promote positive parenting and effective parent-child communication about sexuality and sexual risk reduction, including gender-based violence, for parents or caregivers of adolescent. This promotes positive parenting practices and effective parent-child communication about sex-related issues and sexual risk reduction. This intervention with parents and caregivers will support to effectively define and convey their values and expectations about sexual behaviour. Model engaged with parents and families with 12 days' sessions to increase knowledge and understanding around the social norms that increase risk for unsafe sex and its negative health impacts for their children .

d) **Nutrition counselling and supplementation** : This will focus on improving adolescent nutrition include food-based strategies like dietary diversification and food fortification, for ensuring adequate

nutrition at household level; addressing behaviour modification to bring about dietary change in adolescents. This will be achieved through school-based nutrition interventions, using a behaviour change through communication and mobilizing families and communities; control of micronutrient deficiencies; regular nutrition assessment and counselling of adolescents; care of adolescents during pregnancy and postnatal period; intersectoral linkages at community level and building linkages with adolescent friendly health services.

e) **Reproductive & Sexual Health through Schools:** Garima will work with government schools engaging school management committees , schools' teachers and make SRH as a part of school's curriculum from 6th to 12th classes. Teachers would be trained on communicating SRH to students, class wise peer educators would be selected and trained on health , hygiene and SRH. The project provisions for WASH facilities, gender separated facilities in schools, strengthening School management committees to advocate for WASH, initiate hand washing campaign, and nutrition interventions for adolescent girls and boys. Schools management would be empowered for adolescent friendly health services once in a quarter in the school , linkages with government school health programs like SABLA and MHM schemes for girls including IFA supplementation and deworming of adolescent through IFA supplementation and nutrition counselling.

8. DIVERSITY & PROMOTING SOCIAL INCLUSION: Garima model asserted that all are 'marginalized' or 'vulnerable' or 'at risk' due to their age and to adolescence being a period of transition. However, this assertion neglects the variability in adolescent and youth experiences. Identifying groups of adolescents, who are particularly marginalised and vulnerable, and identifying specific communication strategies to reach them is very important. The communication needs of out-of-school adolescents, those living in remote areas or facing other kinds of marginalisation would be factored in. Model will include following while implementing this program model include:

- ✓ **Gender and associated norms**: for example, who are child brides, unmarried sexually active females, survivors of gender-based violence, females in conservative or patriarchal religious communities, or adolescents men under pressure to conform to gender norms
- ✓ **Socio-cultural status**: for example, who are from ethnic minority, indigenous or 'closed' religious/cultural communities, unmarried mothers, out-of-school , orphans, or who use drugs
- ✓ **Socio-economic status:** for example, who live in poverty, who have low literacy/have dropped out of school, have been trafficked, are migrants, are child labourers, are head of households, who live or work on the streets, or who are in informal labour
- ✓ **Geographic location**: for example, who live in rural areas, in urban slums, in nomadic communities or who are displaced

9.CHILD PROTECTION APPROACH IN MODEL: ChildFund India focuses on children's right to protection throughout their life stages, tailoring our efforts to the distinct needs of each age group. For infants and toddlers, the primary risk is violence in the home. Adolescents often face violence e.g. bullying, inter-personal violence, corporal punishment etc.in their schools or are forced to work in the worst forms of child labour. Before they reach young adulthood, girls face the likelihood of child marriage and dropping out of school, and boys are at increased risk for being used by anti-social gangs, indulging in substance abuse/addiction, conflict with law, violence, suicide etc.

- ✓ **Engaging with adolescents and youth:** Formation of adolescent groups/clubs at community and school level, plays a role in providing a safe platform for adolescents to develop their understanding on child rights, equipping them knowledge on various child laws and mandated protective mechanisms at community, district, state and national level, building their resilience and empowering them to take part in their own protection through the following strategic interventions:

- ✓ Through awareness and education to parents and caregivers to help adolescents in the community to understand their rights, protective systems and laws protecting rights of children. This process empowers children to become agents of change by advocating for redressed of their concerns/issues.
- ✓ By including adults and leaders from the communities in the decision-making process, the families and caregivers are being educated on the safety and protection issues of the children.

10.GBV and GARIMA :

ChildFund India, through its GARIMA program models strategically address child protection issues such as female feticide and infanticide, female illiteracy, child marriage, child labour, child sexual abuse, child trafficking including gender biased violence against children/adolescents, eve teasing, bullying, corporal punishment. ChildFund India designs programs in partnership with local NGOs to end violence against children in the community.

Model will consider following and implement following activities to address GVB through Issues related to GVB i.e. raising awareness about the laws and penalties related to gender-based violence Screening, identification, support, and referral for cases of injuries and sexual abuse as per the protocol. Issues related to gender stereotypes, discrimination and injuries/violence taken up in adolescent through teen clubs and others, as relevant. Awareness and skills to challenge gender stereotypes, discrimination and injuries/ violence incorporated in life skills-focused Adolescent Education Program in schools and in the community.

11.TECHNICAL AND CONTENT STANDARDS :

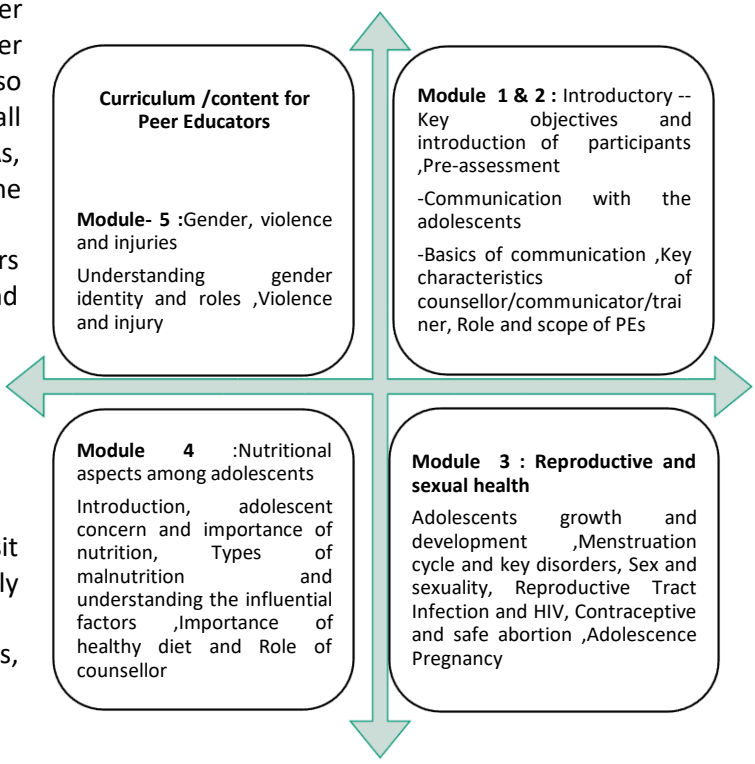
This includes technical and content standards for each intervention strategy.

a) **Adolescents demonstrate change in knowledge and attitude toward unsafe and harmful sexual and reproductive health practice -** Adolescents will be trained on life skill, this will prepare them to manage peer pressure and make good decisions related to family life, SRH and protection issues. Adolescents people will be encouraged to practice and adopt quality methods of contraception available. Risky social behaviour will be decreased. Safe and hygienic menstrual practices among girls will be promoted. The technical component would be :

- ✓ Adolescents and youth would be trained on life skill module (demo and practice)
- ✓ Adolescent health day celebration at AWCs
- ✓ Conducting monthly sessions with in community with PEs
- ✓ SRH sessions in schools through teachers
- ✓ IEC and BCC for including games, learning and other materials Android-based communication material for boys and girls (leveraging from government

b) **Peer Educators capacitated with knowledge and skills on SRH and other adolescent health issues (Anemia, WASH etc.)-** Selected adolescents will be trained as Peer Education. One separate PE will be for 10-14 and 15-19 age. These trained Peer Educators conduct sessions with other adolescent and youth groups. PEs would also be selected in schools one for one class and all the Pes would be depot holders for IFAs, sanitary napkins and contraceptives etc. The main activities would be :

- ✓ Identification of boy and girl Peer Educators from each village (1 for 10 boys /girls) and schools (1 for each class from 6th standard onwards
- ✓ Adolescent Peer Educators training in community and in schools
- ✓ Monthly meetings of adolescents and adolescent by Peer Educators.
- ✓ Prepare calendar, monthly register, home visit register, facilitation guide for monthly meetings
- ✓ Making PEs depot holders for contraceptives, IFAs and other health materials



c) **Family members/ parents capacitated with knowledge and attitude on positive parenting about SRH**-This program offer will build capacities/skills of parents and family members on positive parenting & communicating SRH to adolescents, those who are more connected to parents and their families will be less likely to become vulnerable to unsafe sexual practices, abuses etc This project will provide the opportunity to parents and children communicate more on SRH and results in improved awareness on SRH. This program offer will build capacities/skills of parents and family members on positive parenting & communicating SRH to adolescents. The main activities would be :

- ✓ Training of TOT on Family matters program
- ✓ Training of the identified parents on FMP
- ✓ 6-12 days Family matters sessions with parents
- ✓ Developing IEC, BCC for responding parenting on SRH
- ✓ Capacity building/training of peer educator to facilitate the parents on positive parenting.

d) **Community members, families engaged in intergenerational dialogue**- Grass root level workers sensitive towards SRH needs and supporting in breaking barriers prevalent in the community This will improve quality of counselling and other services and also these frontline workers will be able to provide counselling to adolescents

- ✓ Formation of mothers group and parents group
- ✓ Selection of ARSH mother – lead for taking sessions
- ✓ Demonstration session on health and hygiene especially on anaemia
- ✓ Home visits and counselling –Parent – child communications
- ✓ Facilitating intergeneration dialogue with parents and children on SRH

There would be 3-4-hour session with parents of adolescents.
Session 1: Introduction to parent child communication and Steps to Understanding adolescents
Session 2: Good Parenting Skills
Session 3: Parents' Role in Educating Their Children about Sexuality, reproduction, and overall health
Session 4: Information to Increase Comfort and Skills in Discussing SRH related issues
Session 5: Discussing Sexuality and Pressures Children Face

e) **Adolescents groups/clubs/ collective organized to negotiate and demand for SRH** :Adolescents between 10-19 years of age form one third of the Indian population. The ' situation varies by age as they are adolescents from 10-19 years, when sexual identities are formed and between 20-24 years when they retrieve their sexuality and begin reproductive life. This project will provide opportunities for adolescents people to understand SRH, rights associated with it and taboos, myths and its social dynamics and the critical role they can play in creating a better society where the SRH rights and services are assured

- ✓ Training of Adolescent and youth groups on SRHR (Sexual Reproductive health and rights)
- ✓ Formation of boys and girl's adolescent groups in the community (there would be separate groups for 10-14 and 15-19 and for girls and boys)
- ✓ Strengthening of youth clubs /adolescent groups etc.
- ✓ Provision of WASH especially MHM in school through *school health programs*

f) **Youth/Adolescent friendly counseling and ARSH services provided by service providers (ANM, ASHA, AWW, MOIC, counselor) :** This is part of system strengthening upward linkages will be strengthened. ARSH Strategy in National RCH II PIP-A strategy for ARSH has been approved as part of the National RCH II Programme Implementation Plan (PIP). This strategy focuses on reorganizing the existing public health system to meet the service needs of . Steps are to be taken to ensure improved service delivery for during routine check-ups at sub centre clinics and to ensure service availability on fixed days and timings at the PHC and CHC levels. This is to be in tune with the outreach activities

- ✓ Regularize adolescent friendly clinic day at PHC or CHCs
- ✓ Community (Jigyasa Centres) Adolescent health centres at the community
- ✓ ANMs, ASHA providing counselling and referral services to through home visits
- ✓ Provision of IFAs and sanitary napkins through ANMs and ASHA
- ✓ State, district, and block level convergence meeting with health department for service provision.
- ✓ State and district level workshops on adolescent health (biannually)
- ✓ MOU with health department to implement ARSH and support

21.AWW and AWC- Aganwadi centre , an ECD centre in India ,run by Government for children's overall development covering 1000-1500 population. It is a Government scheme.
22. ASHA- Accredited Social Health activities- A volunteer under Health department ,working in villages to improve health of people.
ANM- Auxiliary Nurse mid wives , A nurse under health department responsible for providing health facilities to few villages

6. PROGRAM MODEL LOGIC :

PROJECT OBJECTIVES	DESCRIPTION	INTERVENTIONS / ACTIVITIES	SUCCESS INDICATORS FOR OBJECTIVE, OUTCOMES AND OUTPUTS
Project Goal: Adolescents (10-19 years) are empowered to adopt (or improve) safe and healthy sexual and reproductive and practices/behaviours enabling them to grow to their full potential **Project Objective : Improved reproductive and sexual health status of adolescent (10-19) yrs.**	Through this program offer adolescents in selected marginalized project locations will have improved sexual and reproductive health status including positive sexual behaviors and accessibility to the SRH related information, counselling, and services. There would reduce unsafe sex practices and adolescents would be protected from RTI/STI/HIV AIDS and other sexual & reproductive related morbidities. The families, peers, and community will become more protective and sensitive to their issues. In India "Youth making choices of living a healthy reproductive life emphasizes on information, attitudes, and skills based on adolescents' relevance for promoting healthy behaviors and for preventing risk behaviors. Health promoting behaviors include acquiring accurate information, clarifying personal values, developing peer support for safer behaviors. Child fund India will address values, attitudes, and behaviors in individuals and project locations and provide basic facts about preventing pregnancy and STIs, including HIV through Garima .		50 % (40,000) adolescent in 17 project locations in 9 states adopt safe and healthy practices pertaining to sexuality and reproduction
Outcome 1: **All adolescents have comprehensive & correct and appropriate knowledge on SRH and other health issues**	This program offer will equip adolescents with knowledge, skills, and attitude to make responsible choices about their sexual and social relationships. This program offer will improve knowledge and practices that can help adolescents people make healthy, informed choices about their reproductive live. Understanding levels of knowledge among can help identify gaps in pre-paring adolescents people for this important part of life.		✓ 60 % (**55,000**) of adolescent in 17 locations in 9 states have comprehensive, correct, and appropriate knowledge on Sexual and Reproductive Health ✓ % of girls using sanitary napkins, clean and sun-dried cloth ✓ % reduction in anaemia among adolescents

			Child protections indicators would be any of the below, partner to focus on any 2. ***-% decrease in teenage pregnancies*** ***-%*** who know about sexual abuse & how to access services. % who show improved understanding on the impact of gender biases
Outputs 1.1: **Adolescents demonstrate change in knowledge and attitude toward unsafe and harmful sexual and reproductive health practices**	Adolescents will be trained on life skill, this will prepare them to manage peer pressure and make good decisions related to family life, SRH and protection issues. Adolescents people will be encouraged to practice and adopt quality methods of contraception available. Risky social behaviour will be decreased. Safe and hygienic menstrual practices among girls will be promoted.	1. Adolescents trained on life skill module (demo and practice 2. Identification and Training of trainers on life skill module about SRH 3. Adolescent health day celebration at AWCs 4. Conducting monthly sessions with in community 5. SRH sessions in schools through teachers 6. IEC and BCC for including games, learning and other materials 7. Android based communication material for boys and girls (leveraging from government)	✓ # of batches of TOT /list ✓ # of trained on life skills and SRH ✓ #of monthly session ✓ # of IEC/BCC material used by PEs ✓ # counselled for medical and other health issues ✓ Tools on monthly progress and PEs registers in place

Output 1.2: Peer Educators capacitated with knowledge and skills on SRH and other adolescent health issues (Anemia, WASH etc.)	Selected adolescents will be trained as Peer Education. One separate PE will be for 10-14 and 15-19 age. These trained Peer Educators conduct sessions with other adolescent and youth groups. PEs would also be selected in schools one for one class and all the Pes would be depot holders for IFAs, sanitary napkins and contraceptives etc.	1. Identification of boy and girl Peer Educators from each village (1 for 10 boys /girls) and schools (1 for each class from 6th standard onwards 2. Conduct adolescent Peer Educators training in community and in schools 3. Organize need based refresher trainings 4. Quarterly Meeting with Peer Educators for Review & Planning 5. Organise monthly meetings of adolescents and adolescent by Peer Educators. 6. Prepare calendar, monthly register, home visit register, facilitation guide for monthly meetings 7. Making PEs depot holders for contraceptives, IFAs	✓ Number of Peer Educators successfully trained in SRH **(partner *will identify prominent health issues and will provide training accordingly like anaemia)*** ✓ Number of Peer Educators conducting sessions on SRH with . ✓ # of PEs using IEC and BCC to conduct monthly session ✓ # of PEs as Depot holders

		and other health materials	
Outcome- 2: Enhanced parent -child communication to communicate effectively on SRH with their adolescents	Parents play very important role in promoting adolescent sexual and reproductive health. Parents are role models for the children and if parents communicate the appropriate messages regarding SR, research has found to reduce sexual risk behaviours. Assisting and capacitated parents to assume their role is feasible and leads to results in creating a safe space for within the family and in the community at large		60 % of parent's /family members with improved parent –child communication on positive parenting and SRH issues Or 60 % of parents of adolescent have communicated about SRH with their adolescent in last 2 weeks ***Child protection indicator would be.*** ***# Parents aware of sexual abuse, exploitation among .*** ***# Parents seeking health support for SRH regarding their children*** ***Partner can add or delete the indicators as per their location.***
Output 2.1 2.1: Family members/ parents capacitated with knowledge and attitude on positive parenting about SRH	This program offer will build capacities/skills of parents and family members on positive parenting & communicating SRH to adolescents. who are more connected to parents and their families will be less likely to become vulnerable to unsafe sexual practices, abuses etc.? This project will provide the opportunity to parents and children communicate more on SRH and results in improved awareness on SRH	1. Training of TOT on Family matters program 2. Training of the identified parents on FMP 3. 6-12 days Family matters sessions with parents 4. Developing IEC, BCC for responding parenting on SRH 5. Capacity building/training of peer educator to facilitate the parents on positive parenting.	# of parent's /family members who report receiving education on positive parenting and SRH issues # of IEC /BCC developed and distributed #Session of PEs with parents # batches of TOT for family matters programs # of parents visiting Jigyasa centres with

		6. Social mapping /tools formed for tracking adolescent health 7. Conduct workshop & handhold support to parents & caregivers on MHM	
Output 2.2: Community members, families engaged in intergenerational dialogue	Grass root level workers sensitive towards SRH needs and supporting in breaking barriers prevalent in the community This will improve quality of counselling and other services and these frontline workers will be able to provide counselling to adolescents.	1. Formation of mothers group and parents group 2. Selection of ARSH mother – lead for taking sessions 3. Demonstration session on health and hygiene especially on anaemia 4. Nutrition garden 5. Home visits and counselling –Parent –child communications 6. Facilitating intergeneration dialogue with parents and children on SRH 7. MA – Beti (mother - daughter) sammelan	# of mother and parent's groups # session on intergenerational dialogues # of Ma- Beti sammelan # of girls and boys getting nutritious food
Outcome 3:	The awareness, knowledge and accessibility will be improved through this program offer. The adolescent, parents and community will demand		40 % **(35,000**) and youth in 17 project locations in 9 states have

Adolescents have increased and improved access to youth friendly counseling and services	Adolescent and youth friendly services and supplies. Community and family members will realize their roles and responsibilities and will be able to practice the same to ensure a youth friendly and safe SRH environment.		increased access to friendly counselling and services ***Child protection indicator would be. % increase in reporting sexual and gender-based violence at health centres***
Output 3.1: **Adolescents groups/clubs/ collective organized to negotiate and demand for SRH**	Adolescents between 10-19 years of age form one third of the Indian population. The ' situation varies by age as they are adolescents from 10-19 years, when sexual identities are formed and between 20-24 years when they retrieve their sexuality and begin reproductive life. This project will provide opportunities for adolescents people to understand SRH, rights associated with it and taboos, myths and its social dynamics and the critical role they can play in creating a better society where the SRH rights and services are assured.	1. Training of Adolescent and youth groups on SRHR (Sexual Reproductive health and rights) ***2.*** Formation of boys and girl's adolescent groups in the community ***(there would be separate groups for 10-14 and 15-19 and for girls and boys)*** ***3.*** Strengthening of youth clubs /adolescent groups etc. *4. Provision of WASH especially MHM in school through school health programs* 5. Kisor- Kisori diwas celebration at AWCs	✓ Number of Youth led advocacy plan on SRH issues. ✓ # of adolescent groups formed ✓ Number of youth collectives and adolescent group active in responding to SRH issues ✓ # of group accessing government schemes and entitlements ✓ .# of schools with wash facilities for boys and girls

Output 3.2 **Youth/Adolescent friendly counseling and ARSH services provided by service providers (ANM, ASHA, AWW, MOIC, counselor)**	This is part of system strengthening Upward linkages will be strengthened. ARSH Strategy in National RCH II PIP-A strategy for ARSH has been approved as part of the National RCH II Programme Implementation Plan (PIP). This strategy focuses on reorganizing the existing public health system to meet the service needs of . Steps are to be taken to ensure improved service delivery for during routine check-ups at sub centre clinics and to ensure service availability on fixed days and timings at the PHC and CHC levels. This is to be in tune with the outreach activities.	1. Regularize adolescent friendly clinic day at PHC or CHCs 2. Community (Jigyasa Centres) Adolescent health centres at the community 3. ANMs, ASHA providing counselling and referral services to through home visits 4. Provision of IFAs and sanitary napkins through ANMs and ASHA 5. State, district, and block level convergence meeting with health department for service provision. 6. State and district level workshops on adolescent health (biannually) 7. MOU with health department to implement ARSH and support for service provision	✓ % of youth and counselled on SRH by ASHA, ANM and MOIC. ✓ % of counselling session attended by both boys and girls ✓ # of MOU for service provision ✓ # of fixed days at Jigyasa centres ✓ # of state and district level workshops

Annexures:

Adolescent phases and curriculum :

Stage with Age	Early Adolescence (ages 11-13 years)	Middle Adolescence (ages 14-15 years)	Late Adolescence (ages 16-18 years)
Physical Growth	✍Puberty: Rapid growth period ✍Secondary sexual characteristics begin to appear	✍Secondary sexual characteristics further develop ✍95%ofadult height reached	✍Physical maturity and reproductive growth levelling off and ending
Intellectual / Cognition	✍Concrete thought dominates “here and now” ✍Cause and effect relationships are Underdeveloped ✍Stronger “ Self” than “Social awareness”	✍Reverts to concrete thought under stress ✍Cause and effect relationships are better understood ✍Highly self-absorbed	✍Abstract thought established ✍Future oriented; able to understand, plan and pursue long term goals ✍Philosophical and idealistic
Autonomy	✍Challenge the authority of family Structure ✍Lonely ✍Wide mood swings ✍Begins to reject childhood likings ✍Argumentative and Disobedient	✍Conflict with family predominates due to ambivalence about emerging independence	✍Emancipation: Vocational /technical/college and /or work -- adult lifestyle