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FEDERATION OF OBSTETRIC AND GYNAECOLOGICAL SOCIETIES OF INDIA
FOGSI
TM

GUIDELINES AND STANDARDS
FOR ADOLESCENT AND YOUTH FRIENDLY HEALTH SERVICES
(AYFHS)

JUNE 2021

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Dr S Shantha Kumari

Preface

Dear Seniors and Colleagues

It gives us immense pleasure to share these Guidelines & Standards for Adolescent & Youth Friendly Health Services (AYFHS), which were developed through a series of iterations and consultations with key stakeholders and experts in adolescent sexual & reproductive health. These guidelines have been developed under the aegis of the SHOPS Plus- FOGSI initiative, with funding from USAID. It also gives us great pleasure in sharing that this initiative has been branded as the "Pankh" initiative; (Pankh meaning feather in English representing the aspiration of th e initiative to rise to meet the challenges of adolescent health).

The key purpose of these guidelines is to support the provision of quality SRH services by establishing Adolescent & Youth Friendly Health Services in an existing practice. These guidelines are in accordance with the WHO Global Standards for provision of quality healthcare services to adolescents and young people. The primary intention of the standards is to improve the quality of care for adolescents and young people in private healthcare services; however, they are equally applicable to facilities run by NGOs and those in the public sector. The ultimate purpose of implementing the standards is to increase utilization of services, especially SRH services by adolescents and youth, and, thus, to contribute to better health outcomes. Eight global standards define the required level of quality in the delivery of services. Each standard reflects an important facet of quality services, and to meet the needs of adolescents and young people, all standards need to be met.

The Government of India in 2014 emphasized its commitment to adolescent health through introduction of a national strategy, Rashtriya Kishor Swasthya Karyakram (RKSK). Targeting adolescents in ages 10–14 and 15–19, the programme aims to ensure universal coverage of health information and services for all adolescents—those in and out of school, married or unmarried, and vulnerable groups. Envisaged as a paradigm shift to address adolescent health beyond sexual and reproductive health, RKSK spans six domains: nutrition, sexual and reproductive health, mental health, injuries and violence including gender-based violence, substance misuse, and non-communicable diseases (NCDs).

Dr Alpesh Gandhi

Dr Madhuri Patel

However, the AYFHS guidelines developed for FOGSI expand from the national RKSK guidelines on two accounts

1. The FOGSI AYFHS guidelines target both adolescents (10-19yrs) and youth (15-24yrs), as they are aimed to support provision of services to this group of people
2. The FOGSI AYFHS guidelines have a specific focus on SRH, especially contraception and are designed to elaborate provision of these services to the target population.

These guidelines are designed to support our endeavor to provide good quality adolescent and youth friendly health services by members across the country. The establishment of these AYFHS "Pankh" centres is a part of FOGSI's position statement on Adolescent Health Education and a need for dedicated Adolescent clinics. At the same time, in order to cater to larger sections of young people, the guideline also suggest a way to mainstream care in the regular practice of our members. On any occasion a young person turns up at our clinics, there is an opportunity to provide confidential, non-judgemental and non-discriminatory care and thus position the clinics as providing adolescent and youth friendly services.

There are 232 million young people (aged 15–24) in India and although youth in India today are healthier and better educated than ever before, evidence suggests that, many young people are not making a healthy transition to adulthood. They face a variety of different experiences given the diverse political, economic, social and cultural realities within their communities. Since adolescents currently are reaching puberty earlier and marrying later, they face a longer period of sexual maturity before marriage and thus are more susceptible to a wider variety of sexual & reproductive health issues. Sexual activity during adolescence (within or outside marriage) puts adolescents at risk of sexual and reproductive health problems. These include early pregnancy (intended or otherwise), unsafe abortion, sexually transmitted infections including HIV, and sexual coercion and violence. For many of these sexually active adolescents, reproductive health services, such as provision of contraception and treatment for sexually transmitted infections, either are not available or are provided in a way that makes adolescents feel unwelcome and embarrassed. As a result, adolescents are more likely to rely on resources outside the formal health-service provision system, such as home remedies, traditional

Dr Jaydeep Tank

methods of contraception, clandestine abortion or medicines from local shops, pharmacies or traditional health practitioners.

Within the context of such a rapidly evolving social scenario, the need of the hour is to not only create safe spaces and access to correct and consistent information of SRH through innovative platforms (digital and social media) amongst the young generation but also to ensure that they have the information and choice to seek desired health services in a non-judgmental and friendly environment whenever required.

We would like to thank Dr. Zoya Ali Rizvi (Deputy Commissioner, Adolescent Health), MOHFW for her important message for adolescents in the country and for being part of the initial deliberations. We would like to place on record our sincere appreciation to all the FOGSI Office bearers, the Presidents and Secretaries of the Delhi, Gurgaon, Noida and Raipur Societies and their managing committee members and all those who participated in the deliberations for their constant encouragement & support.

We would also like to place on record the innovative process that was undertaken in development of these guidelines, vis a vis interaction with youth organizations and young people themselves. We held a series of ongoing discussions with three different youth organizations: The YP Foundation, TARSHI & Pravah to elicit feedback and recommendations on the content, structure and framework for developing the guidelines. We would like to thank Manak Matiyani, Executive Director The YP Foundation; Prabha Nagaraja, Executive Director, TARSHI & Meenu Venkateswaran (co-founder of Pravah & ComMutiny, the Youth Collective) for their valuable insights and inputs into the guidelines. It is worth noting despite the Pandemic we have produced the Guidelines in 6 months.

We would like to specially thank Moni Sagar, Sharmila Neogi & Vijay Paulraj from USAID for their constant handholding and valuable contribution in bringing these guidelines to fruition.

Finally, we would like to thank the entire team of Shops Plus project: Komal Khanna (COP), Abhilash Philip (DCOP), Dr Nisha Gupta, Ashok Raisinghani and Kulbhushan for efficient and coordinated efforts during the COVID pandemic to ensure that the guidelines were conceptualized and written on time. A special thanks to Dr Nisha Gupta who wrote the initial drafts and went on to accommodate feedback and suggestions that came from the FOGSI members. We further thank Abhilash Philip, who worked tirelessly behind the scenes, coordinating with FOGSI & USAID simultaneously to ensure smooth transition of all activities leading up to finalization of these important AYFHS guidelines.

We are happy that FOGSI has taken an initiative to update the guidelines, given the changing scenario of youth in the country. FOGSI places on record appreciation for Dr Jaydeep Tank for his dedication and persistence and we are confident that this endeavor will help us take a big stride towards achieving what we desire. We care for our youth and we endeavor to do whatever is in our capacity. We are sure that this concerted effort will go a long way in fulfilling the vision and mission of providing quality sexual and reproductive health services to young people of this country.

We encourage all FOGSI members to note this guideline and the Pankh initiative. We look forward to suggestions on what more could be done in the coming days to increase the health impact.

For and on behalf of Team FOGSI

Dr S Shantha Kumari President	**Dr Alpesh Gandhi** Immediate Past President	**Dr Madhuri Patel** Secretary General	**Dr Jaydeep Tank** Project Lead (FOGSI-USAID Projects)

Special Message from GOI

Adolescence is a critical phase of rapid growth and transition to adulthood. Health choices made during this phase can have long-term impact not only on the overall health of this population, but also on the socio- economic fabric of the country. Development can be accelerated only when the majority of youth in any country are able to make significant contributions to ensure greater stability and promotes healthier societies. However, this sizeable youth population in India remains both an opportunity and a challenge.

The adolescents are faced with a number of preventable and treatable health problems during their growth; it is hence critical to empower them to make informed choices about their health and overall wellbeing. Rashtriya Kishor Swasthya Karyakram (RKSK), launched in 2014 under the National Health Mission to strengthen India's commitment to adolescent health needs looks to empower adolescents within their ecosystem and provide equitable access to quality healthcare through facility, community and school based interventions and multi sectoral convergence. It goes beyond the traditional understanding of adolescent health, confined to sexual and reproductive health, to include important dimensions like mental health, nutrition, substance misuse, gender based violence and non-communicable diseases. Linkages are being developed with the School Health & Wellness Programme under Ayushman Bharat to make RKSK more comprehensive and complete.

I would like to congratulate FOGSI on developing the guideline on Adolescent and Youth Friendly Health Services focused on SRH, which is one of the critical components of RKSK. I believe this updated guideline is a step towards ensuring Adolescent and Youth Friendly Health Services in the private sector. I would also like to congratulate the USAID for making significant efforts in developing these under the "Pankh" initiative through a consultative process with FOGSI. I would specially like to congratulate the FOGSI team for the innovative strategy of involving and engaging youth organizations as well as young people in developing these guidelines. FOGSI members will also help in generating awareness about SRH issues amongst adolescents and the community at large; thereby creating a positive and supportive socio-cultural environment.

I look forward to collaborating with FOGSI in this tremendous effort at enhancing the quality of sexual and reproductive health services for adolescents and youth through the private sector across the country.

Dr. Zoya Ali Rizvi
Deputy Commissioner, Adolescent Health, Ministry of Health & Family Welfare

Message from USAID

USAID recognizes that youth participation in socio-economic, humanitarian, and development efforts can contribute to more sustainable efforts to end cycles of poverty; build resilient, democratic societies; improve health and nutrition outcomes; and strengthen economies. Healthy, employed, and engaged young people are better able to advance their own health, livelihoods, and the development of their countries. Gender equality and young people's reproductive health and rights remain an unfinished agenda and must be key priorities, if India is to effectively leverage its demographic dividend.

USAID/India has supported numerous initiatives to advance the interests of adolescents and young people and has found an ally in FOGSI to respond to the unmet need for reproductive health and family planning in young people through the Pankh initiative. USAID and FOGSI's partnership under this initiative has focused on improving the quality of reproductive health counselling for youth, using a balanced counselling approach, increasing demand for counselling through in-clinic support, and enhancing access to youth-friendly reproductive health services. The partnership also focusses on use of social media and digital approaches, including a multilingual helpline and an online chat platform that disseminates information on contraception.

I would like to congratulate FOGSI for taking this partnership forward by developing Adolescent and Youth Friendly Health Services (AYFHS) guidelines under the Pankh initiative through a consultative process. We are excited that these guidelines can be used to improve the quality of services for adolescents across the country.

I wish the FOGSI leadership the best in taking the Pankh initiative forward and improving sexual and reproductive health outcomes for India's adolescents and youth.

Dr. Amit Shah

Deputy Director, USAID/ India Health Office

Message from SHOPS Plus

Dear Members of the FOGSI Fraternity,

SHOPS Plus , USAID's flagship project for private sector health, is extremely proud and honored to be associated with the FOGSI "Pankh" initiative that focuses on improving the reproductive well-being of the nation's adolescents and youth. The partnership with FOGSI for the development of the AYFHS guidelines aligns with SHOPS Plus' objective to support the youth in India to make informed and responsible decisions for their sexual and reproductive health and overall well-being.

Addressing adolescent and youth health is an important public health concern. The notion that adolescence and youth is the healthiest period of life is rapidly being eroded. Sexual and reproductive health services that are most needed by adolescents and youth - such as accurate information, access to contraception and treatment for sexually transmitted infections - are often not available or are provided in a way that makes adolescents feel unwelcome and embarrassed.

The update of the AYFHS guidelines is an attempt to plug the current gaps and to make health services adolescent and youth friendly. The SHOPS Plus program in India has developed mass, social and digital media customised communication campaigns, digital tools such as the hellojubi chatbot and Qulke app, and on-ground models to reach 15-29 years with relevant, accurate and confidential messages on family planning. These activities are aimed at dispelling myths and misconceptions around short acting methods of contraception, such as condom and oral and emergency contraception pills, to promote safe sexual behaviour and appropriate contraceptive use.

SHOPS Plus has supported FOGSI members to increase their clients' access to quality family planning information, through training tools, aides and additional counselling through the SHOPS Plus helpline. The project has linked 537 FOGSI members in Noida, Gurgaon, Delhi and Raipur with the SHOPS Plus Family Planning helpline. The SHOPS Plus family planning helpline, which is endorsed by FOGSI, provides adolescents and youth a confidential and safe space to access information on contraception and reproductive health.

In order to further strengthen FOGSI members' engagement with adolescents and young patients, SHOPS Plus will support piloting of the updated FOGSI guidelines in clinics and has conducted orientation workshops to sensitize FOGSI members on this initiative. I hope that the lessons learnt from this pilot will inform an eventual scale-up of this model by FOGSI.

I sincerely hope and wish that application of the AYFHS guidelines will be made a reality by the dedicated efforts of all FOGSI members, and that adolescents and youth are able to access sexual and reproductive health services in an empowered way.

The development of this document could not have been possible without the support extended by Moni Sagar, Division Chief, Family Health Division, USAID India; S Vijay Paul, Reproductive Health and Family Planning Advisor, USAID India and Dr. Sharmila Neogi, Adolescent Health and Gender Advisor, USAID India.

I would like to thank Dr Jaydeep Tank, Dr Alpesh and Dr Shantha Kumari and the senior leadership in FOGSI at the national and city levels, for the undaunted and visionary leadership that they demonstrated during the development of this guideline. I am grateful to all the youth organizations for providing inputs to SHOPS Plus and FOGSI to draft the AYFHS guidelines. I am grateful to my SHOPS Plus team members: Abhilash Phillip - Senior Deputy Chief of Party, Ashok Raisinghani - Director Operations, Kulbhushan Singh - Regional Manager, Viplav Vinod - Program Associate - Communication, R Jayashree Nair and Dr. Nisha Gupta - Consultant For SHOPS Plus who have worked hard and enthusiastically to support this mission in the four pilot cities.

Komal Khanna
Chief of Party- SHOPS Plus Program, Abt Associates

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Executive Summary

Introduction

Over the past few decades the landscape of adolescent and youth sexual and reproductive health has altered dramatically. There **are 232 million young people (aged 15–24) in India** and although youth in India today are healthier and better educated than ever before, evidence suggests that many young people are not making a healthy transition to adulthood. They face a variety of different experiences given the diverse political, economic, social and cultural realities within their communities. Although, for many, adolescence is a period of learning and building confidence in a nurturing environment, for others it is a period of heightened risk and complex challenges. Because more adolescents currently are reaching puberty earlier and marrying later, they face a longer period of sexual maturity before marriage and thus are more susceptible to a wider variety of sexual & reproductive health problems. Sexual activity during adolescence (within or outside marriage) puts adolescents at risk of sexual and reproductive health problems. These include early pregnancy (intended or otherwise), unsafe abortion, sexually transmitted infections including HIV, and sexual coercion and violence. For many of these sexually active adolescents, reproductive health services, such as provision of contraception and treatment for sexually transmitted infections, either are not available or are provided in a way that makes adolescents feel unwelcome and embarrassed. As a result, adolescents are more likely to rely on resources outside the formal health-service provision system, such as home remedies, traditional methods of contraception, clandestine abortion or medicines from local shops, pharmacies or traditional health practitioners.

Adolescent and Youth-friendly services

Adolescent and Youth-friendly services are those that are based on a comprehensive understanding of, and respect for, young people's rights and realities of their diverse sexual and reproductive lives. These are services that young people trust and feel are there for them. To be considered adolescent-friendly, health services should be:

- Accessible: Adolescents and young people are able to obtain the health services that are available.
- Acceptable: Adolescents and young people feel health services are suitable for them and are willing to obtain services that are available.
- Equitable: All adolescents and young people, not just selected groups, are able to obtain the health services that are available. Serving a selected group could mean that some barriers including stigma, or services not being available in some areas, are preventing the others from accessing the services. It is because of discrimination, which is intentional, or by failing to do something about the barriers.
- Appropriate: The right health services (i.e., the ones they need) are provided to them.
- Effective: The right health services are provided in the right way, and make a positive contribution to their health.

While the term **"youth-friendly"** is very broad in nature, it is widely understood that youth-friendly services generally share the following traits.

- Health care providers and other staff are sensitized and trained to work with young people. This includes effective communication skills and a better understanding of their "own value systems" regarding sexually active youth and providing SRH services to them.
- All members of the clinic/centre communicate with youth in a respectful, unbiased and nonjudgmental manner, regardless of age, gender, sexuality, sexual orientation, marital or health status.
- The service delivery point (SDP) has specific policies and protocols for young people. This includes private counseling spaces, safe storage of files and non-disclosure of health information to parents or others without clients' permission.
- The SDP is accessible to young people in terms of location and timings. It is open during convenient hours and accessible to both young men and women.
- The SDP employs innovative marketing strategies to attract young people in areas and through mechanisms that young people access (e.g., mass and social media, youth clubs and schools, etc.).
- The entrance of the SDP and waiting area are youth friendly. This means that youth appropriate communications materials and information is displayed and easily available to read.
- Young people have the ability to pay for services. Further, they see "value for money" in the services provided to them.
- Young people participate in developing, designing, implementing and assessing services, policies and the overall environment (e.g., as members of an advisory board, peer educators, during program planning, as staff/ volunteers, etc.).
- Community members and influential leaders (e.g., faith leaders, teachers, local politicians, elders, parents, etc.) are sensitive and aware of the SRH needs of youth and support their provision.
- A minimum package of services, as defined by the World Health Organization (WHO), is provided at the SDP or through referrals to other youth-friendly services.

Rationale for developing AYFHS guidelines for FOGSI

FOGSI Adolescent Health Committee has been a close partner with the Ministry of Health and Family Welfare, Government of India since the launch of National Adolescent Reproductive and Sexual Health strategy under the RCH-II programme in 2006. With the support of MoHFW and WHO, national TOT workshops for adolescent health training were organized. At that time, there were about 100 FOGSI members in the country who were trained with the government adolescent health-training package. FOGSI, in joint collaboration with Indian Academy of Pediatrics and Indian Public Health Association had developed recommendations for strengthening education of adolescent health in MBBS and postgraduate curricula. In 2011, the Adolescent Health Committee FOGSI focused on establishment of Adolescent Friendly Health Centres by the FOGSI members in government and private sector to promote adolescent sexual and reproductive health. This committee developed standard guidelines to enable the members to initiate adolescent health services with in their existing practices. ***However, these guidelines are dated and the social, cultural and economic scenario regarding adolescents and youth has changed considerably since then.***

Three key events or scenarios that have changed in the last ten years could be considered important and worth addressing.

- First, the numbers or population of young people has increased; therefore a more nuanced and concerted effort is required to address their needs, especially sexual & reproductive health needs.
- Second, youth has embraced digital and social media to such a huge extent that any information or awareness building activities will have to take this platform into consideration.
- Third, COVID has had a severe impact on the sexual and reproductive health of young people in terms of access to services, commodities, supplies and information.

Keeping this changing and evolving scenario in mind, SHOPS Plus has designed and executed mass media, digital, and on-ground campaigns reaching this target group with relevant, accurate, and confidential messages that dispel myths and promote safe sexual behaviour and consisent contraceptive use with appropriate counselling. SHOPS Plus has collaborated with FOGSI in two key areas: updating and revising the 2011 FOGSI guidelines for providing adolescent & youth friendly health services (AYFHS) at FOGSI centers health centers, and creating demand for adolescent friendly centers.

Process of development of the AYFHS guidelines

SHOPS Plus has worked closely with FOGSI to review and update the 2011 guidelines to reflect the current needs, culture, and resources available for youth in 2020. The guidelines were developed in four stages –

- First an initial desktop research with secondary review of national and global data and resources was carried out to create a first draft;
- Second, as part of the FOGSI-USAID-SHOPS Plus initiative, a virtual consultation was organized on the 7th Of December with FOGSI members and key external stakeholders with an emphasis on Sexual and Reproductive Health issues. The consultation sought to identify what is still valid in the 2011 FOGSI Guidelines, what needs to be updated and what content is missing to inform the new guideline development. Current needs, culture, best practices and resources available for youth in 2020 were also discussed. There was also discussion around the ideal use-case for the guidelines to consider how improvements could be made to the dissemination of the guidelines to increase adoption by FOGSI members. Since FOGSI members currently face many challenges in providing FP services to adolescents under the age of 18 yrs, given the POCSO Act; the consultation also attempted to elicit strategies that might work to navigate the conflation of POCSO & MTP Acts.

  The external stakeholders who attended this meeting were Dr Zoya Ali Rizvi (Deputy Commissioner, Ministry of Health & Family Welfare, Government of India), Moni Sagar (USAID), K G Santhya (Population Council), Anand Sinha (David & Lucile Packard Foundation), Meenu Venkateswaran (Pravah and Community - The Youth Collective), Manak (Feminist Queer Activist The YP Foundation), Rajesh Mehta (Regional Advisor WHO SEARO), Vandana Nair (Center for Catalysing Change), Vidya Reddy (Tulir), Kalpana Apte (FPAI) and many others.
- Third, a rather innovative strategy was used, wherein a unique meeting was held on 22nd December 2020 with Youth leaders from three of India's leading youth focused organizations, namely YP Foundation, TARSHI and Pravah. The purpose of this meeting was to understand

the needs of young people and engage with them on issues of sexual and reproductive health and get a user-perspective. These young people were between 18-24 years of age. Some had worked on issues of sexuality and had experience of conducting sessions with teachers, college students, teachers, parents etc. Others had worked with youth in the communities and conducted trainings with them on sexual and reproductive health

The discussion focused on the following issues:

1. What do young people understand by " Adolescent and Youth Friendly services"?
2. What are their thoughts on the content of the FOGSI guidelines shared with them?
3. Do young people feel that sexual and reproductive health issues are adequately and openly discussed in India? If so, what are the platforms where these are discussed: social media platforms, cinema, print media etc.
4. Do young people feel that SRH services are provided at clinics without bias and discrimination? If not, what is the nature of bias and how can it be addressed?
5. What do young people understand by an "appropriate package of services with regards to SRH"? What do they expect when they go to avail these services?
6. Do young people feel it is important to spend money on SRH services? If so, what services should they spend on? What would they consider "satisfactory services" for x amount of money spent?
7. Do young people feel that there are adequate spaces for their representation and voice in health programs, especially SRH programs? If not, what would they like to see in this space?

After these two consultations, the information was collated and analyzed and a first full draft of the Adolescent and Youth Friendly Health Services (AYFHS) Guidelines was shared with the FOGSI review team as well as with USAID.

- Fourth, an internal discussion was held within FOGSI review committee before piloting the guidelines with 30 providers and then presenting them to a larger group within FOGSI for finalising them. This process began with an interactive consultation organized with Committee members and additional key stakeholders as identified by the project and by FOGSI to review the current guidelines

  The consultation include a discussion around the ideal use-case for the guidelines to consider how improvements and updates could be made to the dissemination of the guidelines as well as their content.

Key features of the guidelines

The guidelines have been broadly divided into four sections:

- **Section 1:** Introduction to the current scenario vis a vis adolescent and youth sexual and reproductive health, supported by different sources of data from national and global research bodies. This section also highlights efforts made by GOI to advance SRH of young people, as well as efforts made by donor groups and international organizations.

- **Section 2:** This section details out and defines adolescent and youth friendly health services. It also highlights the 8 Global Standards used by WHO for adolescent and youth friendly health services and their adaptation by FOGSI.
- **Section 3:** This section defines AYFHS for FOGSI and provides guidance to FOGSI members on how to set up these services within their existing practice. This section also delves into detail on the POCSO-MTP acts and provides guidance to FOGSI members on how to navigate these acts.
- **Section 4:** This section contains all Annexures as supporting documents and guidance as well as reference notes for FOGSI members. This section also contains hyperlinks to all the relevant sexual and reproductive health resources for adolescents and youth.

Next Steps and Way Forward

SHOPS Plus has undertaken a pilot sensitisation of 30 FOGSI members in Delhi, Gurgaon, Noida and Raipur. This included an orientation workshop on the AYFHS guidelines. Based on the feedback from local chapters, the guidelines were revised, and a scale up strategy is being developed to be rolled out to the entire membership. Simultaneously, Communication materials and counselling aids to create and sustain provider motivation, including digital assistants; using videos of participating providers, have also been developed and will be shared with providers through a campaign mode the initiative which has been branded as “Pankh” would create pride and enhance motivation for providers of the FOGSI AYFHS initiative.

Introduction

The term Adolescence is derived from the Latin term “adolescere” which means “to grow up”. It is a transitional stage of physical and mental human development that occurs between childhood and adulthood. This transition involves biological (i.e. pubertal), social, and psychological changes.

Puberty has been heavily associated with teenagers and the onset of adolescent development. In recent years, however, the start of puberty has had somewhat of an increase in preadolescence (particularly females, as seen with early and precocious puberty); adolescence has had an occasional extension beyond the teenage years (typically males). These changes have made it more difficult to rigidly define the time frame in which adolescence occurs. With this in mind, encouraged by the Regional FIGO ASRH workshop in April 2010, the Adolescent Health Committee FOGSI in consultation with team of experts from WHO developed Adolescent Friendly Clinics in different localities in India in 2011. AFHC guidelines were developed to aid the process of implementation of activities in the clinics.

Age Group

WHO defines “adolescents” as individuals in the 10-19 years age group and “youth” as the 15-24 year age group. These two overlapping age groups are combined in the group “young people” covering the age range 10-24 years. These age definitions are useful for a common understanding but do not convey strict age compartments. It should be realized that adolescence is a phase of life that has biological and socio-cultural hallmarks that vary from case to case and society to society.

Why Focus On Adolescents?

The number of adolescents (age 10-19) 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. Some of the public health challenges for adolescents are related to early pregnancy, with associated higher risk of maternal and infant mortality, sexually transmitted infections (including HIV) and reproductive tract infections, under-nutrition and anemia, substance abuse, injuries etc. This is crucial, as the health of adolescents is central to determining India’s health, mortality and morbidity and the population growth scenario.

Why Focus On Youth

There are 232 million young people (aged 15–24) in India and although youth in India today are healthier and better educated than ever before, evidence suggests that, many young people are not making a healthy transition to adulthood. Furthermore, while progress has been made in improving sexual and reproductive health (SRH) including family planning (FP) this progress is uneven, with some states lagging behind. Ensuring that youth (aged 15-24) have access to quality contraceptive counseling and

services as well as a full range of modern contraceptive methods that meet their needs is a crucial step on the path to universal access to SRH services. To achieve this, it is imperative to understand the barriers that inhibit uptake and use of contraception by different segments of youth and to design programs that effectively address these barriers to improve contraceptive use outcomes among younger cohorts. For married youth, barriers include demand-side challenges such as prevalent social norms around marriage and fertility, lack of SRH and FP knowledge, services and commodities and gender and power dynamics that undermine young women's agency. Supply side challenges include lack of mobility and provider and frontline worker bias that may restrict access to contraception in general or to certain contraceptive methods, and lack of targeted messaging or quality service provision directed at this cohort.

Cross-Cutting Issues Facing Youth Segments

Demand	**Knowledge** • Lack of sexual/reproductive health knowledge • Misconceptions about side effects of modern contraceptive methods lead to greater acceptance of traditional methods **Autonomy** • Limited decision-making power, mobility and freedom to access clinics • Lack of employment opportunity
Supply	**Accessibility** • Lack of youth-centered and integrated services **Quality of care** • Provider bias to not provide unmarried adolescents with FP because they do not approve of premarital sexual activity • Less likely to be reached by an FP worker, counseled on FP and side effects
Enabling	**Policy Environment** • Lack of enforcement of marriage and education laws; lack of policy framework for FP use by unmarried adolescents **Social norms** • Stigma surrounding premarital contraceptive use • Favorable attitudes toward child marriage • Gender norms that limit young women and girls' value, education opportunities, and power • Pressure to marry and prove fertility • Sexual and gender-based violence
Data	• **Lack of, or poor quality, data on 10-14 year olds and unmarried populations**
Technology	• **Lack of methods that are affordable, discreet, easily compliant and available outside the health system**

Priority Youth Issues
Lack of access to quality SRH information
Lack of access to quality FP services
Soico-cultural and legal norms & practices that limit education, access and supply
Data Gaps
Contraceptive Tech

Evidence shows that interventions that combine demand and supply-side approaches have been effective at increasing contraceptive use among youth.[1,2,3] In Bihar, the **PRACHAR** program implemented a combination of interventions in a gender synchronized manner that led to increased and sustained contraceptive use among young married couples and first-time parents. Some of these interventions included household visits and group sessions to promote healthy timing and spacing of pregnancies, interspousal communication and joint decision-making; linkages and referrals for FP services; and community and gatekeeper engagement to shift social norms around young married couples' contraceptive use.[4] Given the high unmet need for modern contraception amongst the younger, low parity cohorts in India (including newly married nulliparous women), there is an urgent need to scale up programs that incorporate learning and evidence from programs that have worked, such as PRACHAR, as well as to incorporate new and innovative approaches that are more relevant at scale.

Understanding the lives of adolescents and young adults (UDAYA) in Bihar and Uttar Pradesh was designed to establish the levels, patterns and trends in the situation of younger (10–14) and older (15–19) adolescents and to assess the factors that influence the quality of transitions they make. Five categories of adolescents were included in the sample: unmarried adolescent girls and boys aged 10-14 and 15-19 and married girls aged 15-19. Data disaggregated by these categories are representative at the state level. The survey was conducted in Uttar Pradesh (September 2015 to January 2016) and Bihar (January 2016 to July 2016). Key findings from the survey are as below: (see Annexure 6 for hyperlink to full report)

- Just 56 percent of younger boys in ages 13–14 and 44 percent of younger girls in ages 13–14, for example, knew that a woman cannot become pregnant after kissing or hugging; even fewer (9–10%) were aware that a woman can get pregnant at first sex. Among older boys and unmarried older girls, only 27–28 percent were aware that a woman canget pregnant at first sex, and hardly any (4–5%) knew that a woman is most likely to become pregnant if she engages in sexual relations mid-cycle (Figure 10). Even among married older girls, just 53 and 12 percent, respectively, were aware of these facts.
- Leading sources of information on sexual and reproductive matters for boys aged 13 and above included friends (17% among 13–14-year-old boys and 59% among older boys), influential adults in the community (11% among 13–14-year-old boys and 15%, among older boys), and the mass media (3% among 13–14-year-old boys and 18% among older boys). Among girls, family members (20% among 13–14-year-old girls and 36–58% among unmarried and married older girls) and friends (4% among 13–14-year-old girls and 17–18% among unmarried and married older girls) were the leading sources of information.
- Contraceptive use at any time within marriage was limited—just 11 percent of girls reported ever use of contraceptives, seven percent of girls reported its practice at the time of the interview, and eight percent reported its practice to delay the first birth.

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[1]Gottschalk LB, Ortayli N. Interventions to Improve Adolescents' Contraceptive Behaviours in Low- and Middle-income Countries: A Review of the Evidence base. ***Contraception***, (2014): 90(3):211-225.

[2]Hindin MJ, Kalamar AM, Thompson TA, Upadhyay UD. Interventions to Prevent Unintended and Repeat Pregnancy Among Young People in Low- and Middle-Income Countries: A Systematic Review of the Published and Gray Literature. ***Journal of Adolescent Health,*** (2016): 59(suppl. 3):S8-S15.

[3]Population Reference Bureau. ***Youth Contraceptive Use: Effective Interventions,*** (Washington, DC: PRB, 2017).

[4]Shireen J. Jejeebhoy et al. Meeting Contraceptive Needs: Long-Term Associations of the PRACHAR Project with Married Women's Awareness and Behavior in ***Bihar. International Perspectives on Sexual and Reproductive Health 41,*** No. 3 (2015): 115-25;

- A substantial proportion of married girls had an unmet need for contraception: 45 percent of married girls had an unmet need for spacing; and six percent had an unmet need for limiting childbearing. On the whole, 51 percent of married girls had an unmet need for contraception. While 58 percent of married girls had a demand for contraception—51 percent for spacing and eight percent for limiting childbearing—just 12 percent of the total demand for contraception was satisfied.

Government of India's efforts

The Ministry of Health and Family Welfare, Government of India included Adolescent Reproductive and Sexual Health (ARSH) as a key technical strategy under the National RCH II programme. This strategy focused on reorganizing and strengthening the existing public health system in order to meet the reproductive and sexual health needs of adolescents. The primary focus was on meeting the national targets of reduction of Total Fertility Rate (TFR), Maternal and Infant Mortality Rates (MMR and IMR), and the incidence of STI and HIV. Addressing adolescent population would yield dividends 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. A core package of services that includes preventive, promotive, curative and counseling services was delivered during routine clinics at sub-centre, PHCs and CHCs, and dedicated adolescent clinics on fixed days and time as well as through outreach activities. FOGSI Adolescent Health Committee , has been a close partner with the Ministry of Health and Family Welfare, Government of India since the launch of National Adolescent Reproductive and Sexual Health strategy under the RCH-II programme in 2006. With the support of MoHFW and WHO, national TOT workshops for adolescent health training were organized. At that time, there were about 100 FOGSI members in the country who were trained with the government adolescent health-training package. FOGSI, in joint collaboration with Indian Academy of Pediatrics and Indian Public Health Association had developed recommendations for strengthening education of adolescent health in MBBS and postgraduate curricula. In 2011 the Adolescent Health Committee FOGSI focused on establishment of Adolescent Friendly Health Centres by the FOGSI members in government and private sector to promote adolescent sexual and reproductive health. This committee developed standard guidelines to enable the members to initiate adolescent health services with in their existing practices. ***However, these guidelines are dated and the social, cultural and economic scenario regarding adolescents and youth has changed considerably since then.***

In July 2012, the UK Government and the Bill & Melinda Gates Foundation, in partnership with UNFPA, national governments, donors, civil society, the private sector, the research and development community, and others came together at the London Summit on Family Planning to support the right of women and girls to decide freely and for themselves, whether, when and how many children to have.They launched a groundbreaking effort to make available affordable, lifesaving contraceptive information, services, and supplies to an additional **120 million women and girls by 2020.** As a result of this effort, a global partnership called Family Planning 2020 (FP2020) was born. **India was one of the countries that made a commitment to include family planning as a central element of its efforts to achieve Universal Health Coverage. The cornerstone of the new, evolved FP strategy emphasized addressing equity, ensuring quality, including adolescents and integration into the**

continuum of care through the National Health Mission. The 2016 Lancet Commission report on adolescents and wellbeing reiterates the triple dividend of investing in adolescents: ***for adolescents now, for their future adult lives, and for their children***[5]. It also emphasizes that investment in their health will enable adolescents to become healthy adults who are equipped to contribute positively to society.

There is a growing recognition of the widespread unmet contraceptive needs of sexually active adolescents (both married and unmarried), and the enormous health, social, and economic consequences of low levels of use. Millions of adolescents who wish to postpone or space childbearing are currently not using an effective method of contraception. The Guttmacher Institute estimates that 38 of the 252 million adolescent women aged 15 to 19 living in developing regions are sexually active, and do not wish to have a child in the next two years[6]. Among these adolescents, 23 million have an unmet need for modern contraception. This has enormous individual and social repercussions.

Research from India indicates that family planning programs often attempt to reach women only after they reach their desired family size, despite indications that demand for contraception to delay and space pregnancy is high. Young, married couples between the ages of 15-24 have high unmet need for modern contraception and mCPR for this cohort is much lower compared to mCPR for all married women of reproductive age (Married Women of Reproductive Age (MWRASurvey, 2016). ***While as many as 76% of newly married adolescents expressed the desire to delay their first birth by two years, only 11% had used contraception (MWRA Survey, 2016).*** Reasons for non-use included ***demand-side challenges*** such as prevalent social norms that require young women to prove fertility immediately after marriage, preference for a male child, male-dominated decision-making due to existing gender norms, and negative stereotypes and social stigma around contraceptive use and sex. Other frequently cited reasons for non-use were opposition from a spouse or partner, incorrect information and prevalent myths around contraception and different contraceptive methods, infrequent sex because of migrant work, inability to perceive the risk of child-bearing, and incorrect beliefs around risk of conception. ***Supply side challenges*** emphasized issues of inconvenience or high opportunity costs in accessing methods; bias and judgmental behavior of providers, pharmacists/drug shopkeepers, and frontline health workers; inadequate counseling and poor quality services that do not respond to the needs of youth.

The data modeled by Darroch et al. clearly underlines the potential demographic and public health gains of ensuring access and uptake of modern contraception by adolescents.“ Meeting the unmet need for modern contraception of women aged 15-19 would reduce unintended pregnancies among this group by 6 million annually. That would mean averting 2.1 million unplanned births, 3.2 million abortions and 5,600 maternal deaths. The dramatic reduction in unintended pregnancies would spare women and their families the adverse consequences of early childbearing, reap savings in maternal and child health care, and boost women’ s education and economic prospects” (6)

The ***Rashtriya Kishor Swasthya Karyakram,*** **launched by the Government in 2014,** provides the strategic framework for services for young people’s health in general, and their sexual and reproductive health, mental health, and prevention and care of non-communicable diseases, in particular (Ministry

[5]Patton GC, Sawyer SM, Santelli JS, Ross DA, Afifi R, Allen NB, et al. Our future: a Lancet commission on adolescent health and wellbeing. Lancet (London, England). 2016;387:2423–78.

[6]Darroch JE, Woog V, Bankole A, Ashford L. Adding it up: Costs and benefits of meeting the contraceptive needs of adolescents. New York New York Guttmacher Institute 2016. Available from: http://www.popline.org/node/649435

of Health and Family Welfare, 2006; 2014). RKSK is a comprehensive program that focuses on a multi pronged approach of not only providing facility based services through adolescent friendly health clinics (AFHCs) to adolescents but also empowering them to make informed decisions about their health. **RKSK expanded and broadened the scope of adolescent health programming in India from being limited to sexual and reproductive health to include nutrition, injuries and violence (including gender based violence), non-communicable diseases, mental health and substance abuse.** Broadening the scope of programming was accompanied by a shift in the strategic approach as well. There was a paradigm shift from the existing clinic-based services to promotion and prevention and reaching adolescents in their own environment, such as in schools, families and communities. Key elements of the program included community based interventions, outreach services by counselors as well as facility based counselling, with a focus on inter-personal counselling (IPC) ; social and behavior change communication approaches; and strengthening of Adolescent Friendly Health Clinics (AFHCs) across all levels of care.

In keeping with these developments, FOGSI took a decision to update their 2011 guidelines, with a focus on sexual and reproductive health. These guidelines were developed through a participatory process involving extensive interactive consultations with young people themselves, researchers, as well as youth programmers and other key stakeholders in the development sector.

Impact of COVID on the sexual and reproductive lives of young people

In just a single year, a 10 percent decrease in sexual and reproductive health services in low- and middle-income countries could lead to another 49 million women with unmet need for contraception, according to Guttmacher Institute estimates from April 2020. Other possible effects include another 15 million unintended pregnancies, another 28,000 maternal deaths and 168,000 newborn deaths due to untreated complications, and another 3 million unsafe abortions and 1,000 maternal deaths due to unsafe abortions. The implications are staggering in terms of unmet needs, unintended pregnancies, unsafe abortions, and maternal and newborn deaths in 132 countries that are home to more than 1.6 billion women of reproductive age (15–49 years).

During the COVID-19 pandemic, millions of people lost access to essential sexual and reproductive health services due to bad policies and structural barriers. Even before the epidemic, many governments around the world failed to adequately support or fund sexual and reproductive health services. The global economic downturn is limiting the financial resources available to governments for such services. Structural issues during the pandemic included lack of supplies and equipment, staff diverted to other types of care, supply chain disruptions, people avoiding preventive care or choosing to deliver outside of facilities, and clinic closures.

At the start of the pandemic, UNFPA, Avenir Health, Johns Hopkins University and Victoria University modelled the potential impact of the pandemic on family planning services. They found that six months of severe health system disruptions in 114 low- and middle-income countries could lead to 47 million women unable to use contraceptives, leading to 7 million unplanned pregnancies. Unplanned pregnancies, of course, have serious consequences for women and girls' educations and livelihoods. But they also come with the risk of pregnancy-related complications and even mortality at a time when many countries' health systems are overburdened. Women in countries around the world are reporting barriers to receiving antenatal care and safe delivery services. Horrifically, incidences of sexual and gender-based violence are also on the rise, which can increase the risk of unintended pregnancy for women and girls. The full toll of pandemic-related unplanned pregnancies is unknowable, but it will include lost lives, lost health and lost dreams for the future.

Adolescents and Youth-Friendly Health Services

When adolescents and youth fall ill with commonly occurring conditions such as fevers, coughs and colds, they have no hesitation in seeking care. On the other hand, they may be less willing to do so for more "sensitive issues". For example, a young girl may prefer to turn to her mother for advice and help, rather than to a nurse or a doctor when she suffers from painful menstrual periods, or she may turn to her friends and peers for sexual health related advice. Unfortunately, these "sensitive issues" may be more dangerous to the health of young people. Not surprisingly, a key factor that influences adolescents' health care-seeking behaviour is whether or not the act of seeking health care could get them into trouble with their parents or guardians. In many cultures, social norms strongly forbid premarital sex, therefore unmarried adolescents are likely to shy away from or delay seeking care even if they have a painful genital ulcer, an STI or a possible unwanted pregnancy. They are likely to try to deal with the problem themselves, or with the help of friends or siblings whom they can trust to keep their secrets. For fear of social stigma, they tend to turn to service delivery points such as pharmacies and clinics at a safe distance from their homes, as well as to service providers who are as keen as they are to maintain secrecy (such as those who carry out abortions illegally) and who may exploit them financially. This can have an adverse impact not only on the physical health of young people, but also on their mental health. Some barriers to seeking care may also be related to the health facility like crowding, absence of dedicated space or services for adolescents, policies that make privacy and confidentiality difficult to ensure. Healthcare provider's unsupportive and judgmental attitude is an important barrier that prevents adolescents from accessing services.

Adolescents and youth-friendly services are those that are based on a comprehensive understanding of, and respect for, young people's rights and realities of their diverse sexual and reproductive lives. These are services that young people trust and feel are there for them. To be considered adolescent-friendly, health services should be:

- Accessible: Adolescents and young people are able to obtain the health services that are available.
- Acceptable: Adolescents and young people feel health services are suitable for them and are willing to obtain services that are available.
- Equitable: All adolescents and young people, not just selected groups, are able to obtain the health services that are available. Serving a selected group could mean that some barriers including stigma, or services not being available in some areas, are preventing the others from accessing the services. It is because of discrimination, which is intentional, or by failing to do something about the barriers.
- Appropriate: The right health services (i.e., the ones they need) are provided to them.
- Effective: The right health services are provided in the right way, and make a positive contribution to their health.

While the term **"youth-friendly"** is very broad in nature, it is widely understood that youth-friendly services generally share the following traits.

- Health care providers and other staff are sensitized and trained to work with young people. This includes effective communication skills and a better understanding of their "own value systems" regarding sexually active youth and providing SRH services to them.

- All members of the clinic/centre communicate with youth in a respectful, unbiased and nonjudgmental manner, regardless of age, gender, sexuality, sexual orientation, marital or health status.
- The service delivery point (SDP) has specific policies and protocols for young people. This includes private counseling spaces, safe storage of files and non-disclosure of health information to parents or others without clients' permission.
- The SDP is accessible to young people in terms of location and timings. It is open during convenient hours and accessible to both young men and women.
- The SDP employs innovative marketing strategies to attract young people in areas and through mechanisms that young people access (e.g., mass and social media, youth clubs and schools, etc.).
- The entrance of the SDP and waiting area are youth friendly. This means that youth appropriate communications materials and information is displayed and easily available to read.
- Young people have the ability to pay for services. Further, they see "value for money" in the services provided to them.
- Young people participate in developing, designing, implementing and assessing services, policies and the overall environment (e.g., as members of an advisory board, peer educators, during program planning, as staff/ volunteers, etc.).
- Community members and influential leaders (e.g., faith leaders, teachers, local politicians, elders, parents, etc.) are sensitive and aware of the SRH needs of youth and support their provision.
- A minimum package of services, as defined by the World Health Organization (WHO), is provided at the SDP or through referrals to other youth-friendly services.

Developing a strategic framework to address SRH needs of adolescents and youth

The broad vision of adolescent and youth SRH programs focuses on "accelerating progress towards universal access to SRH by eliminating unintended pregnancies among adolescents and youth and supporting their ability to survive and thrive".

This vision can be achieved by addressing sustainability of its efforts by working on strengthening the system itself, as an inbuilt part of adolescent and Youth programing. A concerted effort is required to embed monitoring within the program; to build skills and systems for designing, implementing, and disseminating relevant program research; to strengthen quality and coverage of an appropriate package of SRH services and to ensure a rights based and gender responsive perspective in youth programming. It is also important to establish sustainable and quality community based mechanisms to reduce demand side barriers, **resulting in increased agency, empowered decision making and realization of SRH goals by adolescents and youth.**

Key enablers to achieve this vision focus on creating a critical pathway of change to increase contraceptive use by addressing the SRH needs of adolescents and youth through a "life cycle" approach- addressing issues, concerns and needs related to menstrual hygiene, sexual debut,

marriage, childbearing and spacing. It is also critical to address social and structure determinants that restrict access to services, through a set of innovative supply and demand approaches, as well as by influencing, mobilizing, and leveraging existing resources to achieve maximum impact at scale.

"Youth" are heterogeneous, with several segments that require individual consideration in structuring an approach:

- **Ages 10-14** are particularly underserved and not well understood;
- **Unmarried ages 15-19 and Married Nulliparous, ages 15-19** pose an opportunity to delay age at first birth and reduce risky sexual practices;
- **Married with children, ages 15-19 and Married with children, ages 20-24** represent an opportunity to increase birth spacing to improve maternal and infant health outcomes;
- Other factors such as geography, schooling, and employment are all factors that affect demand and access to services.

Key strategies to address this cohort include:

- Ensuring the inclusion of young people from extremely poor and socially and economically marginalized communities;
- Promoting gender equality by engaging boys and responsible behaviour
- Providing equitable access to women and girls in the SRHR space;
- Enabling women and girls to exercise decision autonomy;
- Building awareness among women and girls to make decisions for the prevention of gender-based violence;
- Promoting nonjudgmental responses with a commitment to social inclusion;
- Enabling and supporting women, girls, and young people to make informed decisions regarding sexuality and reproductive health;
- Promoting behavior change to enable men and women to prevent unintended pregnancies and men to be responsible and equal partners in FP;
- Reducing prevalent gender-related stigma and discrimination as well as provider bias in health care settings;
- Ensuring continued investment in adolescents – starting early, including boys, and addressing the proximate factors that may affect their ability to make a successful transition to adulthood;
- Providing quality, confidential, non-judgmental services and contraceptive supplies to all adolescents irrespective of marital status, and including newlyweds;
- Orienting the gatekeepers, especially parents, teachers and health care providers about what is adolescent friendly.
- Increasing focus on value of girl child and not promoting social evils such as sex-selective abortions

WHO Global Standards of 2015, to assess the quality of adolescent healthcare services.

Realizing the importance and need to address cross cutting issues facing adolescents, ***WHO developed 8 Global standards*** to ensure provision of quality health care services. These standards were developed after an intensive, collaborative process, beginning with a needs assessment, which was informed by a literature review and online surveys, in conjunction with the analysis of 26 national standards from 25 countries.

The analysis of national standards identified the most common standards and their criteria, which were then reviewed against the findings of the literature review and global surveys. **The aim of Global standards for quality health-care services for adolescents is to assist policy-makers and health service planners in improving the quality of health-care services. These standards also serve as a guidance for identifying and defining action plans as well as specific activities to be undertaken in either government health care set ups or private sector clinics across the globe. The ultimate purpose of implementing the standards is to enhance adolescents' use of services and, thus, to contribute to better health outcomes.** The eight global standards define the required level of quality in the delivery of services as shown in the table below. Each standard reflects an important facet of quality services, and in order to meet the needs of adolescents all standards need to be met.

FOGSI SRH STANDARDS FOR ADOLESCENT AND YOUTH FRIENDLY HEALTH SERVICES 2020-21

Standard 1: Adolescents' Health Literacy:	The health facility implements systems to ensure that adolescents are knowledgeable about their own health, and they know where and when to obtain health services.
Standard 2: Community support	The health facility implements systems to ensure that parents, guardians and other community members and community organizations recognize the value of providing health services to adolescents and support such provision and the utilization of services by adolescents.
Standard 3: Appropriate package of services	The health facility provides a package of information, counseling, diagnostic, treatment and care services that fulfill the needs of all adolescents. Services are provided in the facility and through referral linkages and outreach.
Standard 4: Providers' competencies.	Healthcare providers demonstrate the technical competence required to provide effective health services to adolescents. Both healthcare providers and support staff respect, protect and fulfill adolescents' rights to information, privacy, confidentiality, non-discrimination, non-judgmental attitude and respect.

Standard 5: Facility characteristics	The health facility has convenient operating hours, a welcoming and clean environment and maintains privacy and confidentiality. It has the equipment, medicines, supplies and technology needed to ensure effective service provision to adolescents.
Standard 6: Equity and non-discrimination.	The health facility provides quality services to all adolescents irrespective of their age, sex, marital status, education level, ethnic origin, sexual orientation or other characteristics and ability to pay for services.
Standard 7: Data and quality improvement.	The health facility collects, analyses and uses data on service utilization and quality of care, disaggregated by age and sex, to support quality improvement. Health facility staff is supported to participate in continuous quality improvement.
Standard 8: Adolescents' Participation	Adolescents are involved in the planning, monitoring and evaluation of health services and in decisions regarding their own care, as well as in certain appropriate aspects of service provision.

The purpose of detailing out these standards in the FOGSI guidelines is to provide guidance to FOGSI members to implement them in their settings with ease and effectiveness. We will be adapting these standards to enhance use of SRH services by adolescents and youth and will call them FOGSI SRH Standards for "Adolescent and Youth Friendly Health Services" 2020-2021

Standard 1:
Adolescent Health Literacy

Health literacy is critical to empowerment and includes, among other things, the timely recognition of the need for health or other services; the ability to seek advice and care, including successfully making appointments; and the ability to navigate through the sometimes-complicated system of services available. Yet, adolescents often are not aware of what health or other services are being provided (e.g. educational and vocational support, drug and alcohol counseling, legal and social support), where they are provided and how to obtain them (WHO, 2011a; WHO, 2014a). ***Health literacy is commonly defined as the degree to which individuals have the capacity to obtain, process and comprehend health information and services, to make appropriate decisions regarding their own health.*** Adolescents have comparatively less interaction with the health care system and lower health care costs than adults, therefore are vulnerable to what the health systems offers them. They rely on mass media and other digital and social media platforms to access health information, therefore it is imperative that responsible and correct information is provided to them. Although this WHO standard specifies only adolescents, FOGSI clinics will be expanding this cohort to provide services to both adolescents and youth (we will refer to them as young people). To ensure that young people have access to correct and responsible information about their health, especially their sexual and reproductive health, below is a checklist that can be used to ensure this at the FOGSI clinics.

The following job-aids and communication tools have been developed under the "Pankh" initiative and are available on fogsi.org/pankh

1. Counseling aids containing

- Introduction to Pankh Booklet
- Case History Checklist
- Counseling flipbook
- Contraceptive methods leaflet
- Process Flow Chart
- Soft Skill Booklet
- Wallchart containing information on all methods
- Pankh Badge
- Pankh Poster
- Pankh Tent Card

2. 11 Method brochures of:

- Centchroman
- Combined Oral Contraceptive Pills
- Contraceptive Injectables
- Emergency Contraceptive Pills
- Hormonal Implants
- Intrauterine Devices
- Lactational Amenorrhea Method
- Male Condoms
- Progestin Only Pills
- Tubal Ligation
- Vasectomy

Checklist to Implement Standard 1:

Criteria	Yes	No	Remarks
The health facility has a signboard that mentions operating hours and directions to the AYFHS center. A telephone helpline number of SRH services can also be displayed.			
The health facility has a waiting area with adequate seating space. The waiting area and consultation room should have up-to-date information, education and communication materials specifically developed for young people. **It should be inviting, with a good color scheme and should have activities to hold the interest of young people: puzzles, board games etc.**			
Health-care providers have competencies to provide health education to young people and to communicate about health and available services. They are trained in creating a safe space for young people and providing comprehensive and scientifically correct information. ***{for details on provider competencies, refer to Standard 4 later}***			
The health facility has outreach workers that are trained to conduct health education, specifically SRH education, including menstrual hygiene. Outreach workers should have knowledge of AYFHS centers and trained in referring young people to the nearest center. These workers should also stock SRH commodities such as FP methods, sanitary pads, urine pregnancy tests etc.			
The health facility has a plan for outreach activities and/or involvement of outreach workers in activities to promote health and increase young people use of services.			
Health-care providers provide age and developmentally appropriate health education and counseling to young people and inform them about the availability of appropriate referral services for specific SRH issues.			
Young people are aware of what health services are being provided, where and when they are provided and how to obtain them.			
Outreach activities to promote health and increase young peoples' use of services are carried out according to the health facility's plan.			
Young people are knowledgeable about their sexual and reproductive health. Healthcare providers take feedback at the end of the session to ensure young people have received correct information and knowledge about their SRH. Healthcare providers can encourage young people to bring their friends to the center.			

Educational materials are easily available on the following issues: (this is an indicative list, more can be added, based on local context)			
• Contraception • Sexuality and sexual orientation • Safe sex and condom use (for dual protection) • Sexually transmitted infections & HIV/AIDS • Early pregnancy and its consequences • Gender equity and value of girl child • How to prevent gender based violence and how to seek support • Healthy and unhealthy relationships, consent in relationships • Menstrual health and hygiene			

Linking Sexuality to Youth-friendly Services

- SRH services and providers often forget what sex and sexuality mean for youth, and many disapprove of young people having sex.
- Providers often behave as if they are a young person's parent, rather than a provider. Like everyone else, youth have sex for many reasons such as love, intimacy, curiosity, (peer) pressure or economic need. Providers need to provide health services, not act as parents.

Therefore, make sure to consider:

- Whether SRH services are limited to prevention of unwanted consequences or whether they really address issues of sexuality, desire and sexual enjoyment.
- Safe sex includes more than protected sex; it includes feeling safe and at ease with your partner, because there is trust, communication and enjoyment.
- Assumptions providers have about young people's sexual behavior may not be correct (e.g., young people are irresponsible, driven by hormones, have sex all of the time or never have sex).
- Young people requesting SRH services may be heterosexual, bisexual or homosexual, or can be questioning their sexual orientation. They may be sexually inexperienced or have different experiences than staff members. Providers should ask if the client is sexually active or not, instead of focusing on marital status. They should ask the gender of the partner instead of assuming it is a heterosexual relationship.
- Talking about sexuality is difficult but it's important for promoting safer sex, helping young people express their concerns and negotiate safer sex and accepting their own sexuality and communicating with their partners.
- SRH services can become more youth-friendly if staff can discuss these topics openly and without judgment with youth.

Standard 2:
Community Support

Parents, guardians, family, elders and gatekeepers in the community and religious leaders play an important role in supporting young people to access and use services, in this case SRH services. Evidence suggests that without gatekeepers' support, adolescent health programmes are not successful (WHO, 2014a; Denno DM et al.2015). In many countries unmarried adolescents have little support to access and use sexual and reproductive health services (Chandra-Mouli et al.2014). This standard, thus, sets expectations for the level of support for young peoples' use of services from parents, guardians and other community members. The health facility informs, orients and sensitizes community members about the value of providing health services to young people, either during visits to the facility or through outreach. However, just informing and sensitizing community members about the importance of young peoples' use of SRH services is not enough. To ensure that parents, guardians and other community members support all young people – married and unmarried, younger and older – to use the health services they need, it is essential that the facility engage in sustainable and effective partnerships with community members and organizations to develop health education and communication strategies and materials, to get their buy-in and to plan service provision. Involving young people in this work is also essential. An "all inclusive" strategy is crucial to ensuring provision of sustainable, quality SRH services to young people at FOGSI facilities.

Checklist to Implement Standard 2:

Criteria	Yes	No	Remarks
Health-care providers have competencies and support materials to communicate with parents, guardians and other community members and organizations about the value of providing SRH services to young people.: Refer to Annexure 3: tool			
The health facility has an updated list of agencies and organizations with which it partners to increase community support for young peoples' use of services.			
The health facility has a plan for outreach activities and/ or involvement of outreach workers in activities to increase gatekeepers' support for young peoples' use of services.			
The health facility engages in partnerships with young people, gatekeepers and community organizations to develop appropriate IEC materials on sexual and reproductive health and behaviour-oriented communication strategies and materials and plan service provision.			
Health-care providers inform, orients and sensitizes parents/ guardians visiting the health facility about the value of providing health services to adolescents.			
Health-care providers and/or outreach workers inform youth and other community organizations about the value of providing health services to young people.			
Outreach activities to promote health and increase young peoples' use of services are carried out according to the health facility's plan.			

Suggested outreach activities to promote health and increase young peoples' access to services beyond the AYFHS center:

- Identify community organizations in the catchment area to promote adolescent and youth friendly health services and organize community camps for creating enabling social environment for promoting sexual and reproductive health.
- Identify schools in the neighborhood to interact with teachers and students periodically to promote young peoples' health and inform about services available. Develop such an initiative with prior consultation and concurrence of the Principal, teachers and parents.
- Offer annual SRH check up for students.
- Disseminate messages and communication materials on priority adolescent and youth health issues in schools, youth clubs, youth centers, youth associations and different community organizations to support awareness generation. Also inform about where and when they can access adolescent and youth friendly health services.

Standard 3:
Appropriate package of services

Sexual and reproductive health, including HIV in young people, remains a critical health concern in many regions; however, it is important that other contributors to the burden of disease are adequately addressed. Several assessments have found that the low rate of service utilization among youth – including their low contraceptive use - is attributable to a number of factors, including:

- Lack of access to youth-friendly services;
- Lack of information on availability of services;
- Poor skills among service providers on how to deal with youth;
- Stigma associated with seeking sexual and reproductive health services by youth;
- Limited understanding on the need for youth-friendly SRH services by parents, teachers, policy makers and faith leaders.

Since these guidelines are being developed for FOGSI settings, our focus remains on sexual and reproductive health. A combination of SRH services is required to respond effectively to the needs of adolescent and youth, in all their diversity. Below is a checklist that can be used by FOGSI providers and staff to provide SRH clinical services to young people.

Minimum package of youth-friendly SRH services includes:

- Information and counseling on sexuality, safe sex, pre-marital counseling and reproductive health;
- Contraception and protective method provision (with an emphasis on dual protection);
- STI diagnosis and management;
- HIV counseling (and referral for testing and care);
- Pregnancy testing and antenatal and postnatal care;
- Counseling on sexual violence and abuse (and referral for needed services);
- Post-abortion care (PAC) counseling and contraception (with referral when necessary);
- Menstrual health and hygiene.
- Sexual health information and counseling for LGBT persons. (The Transgender Persons (Protection of Rights) Act, 2019, was passed last year in Parliament amid criticism from transgender rights activists and protests by the LGBTQ community. The community has maintained that the rules will do little to allay fears of continued discrimination with their initial protests ignored by the government.)

SRH clinical services for adolescents and youth	Components
Assessment questions on client history	Take a standard medical history
	Take a detailed sexual health assessment. This could include: • Sexual partners, current and recent • Sexual function and satisfaction, including level of interest in sex, change in libido, regularity, any difficulties during sexual intercourse, and level of satisfaction. • Current and future pregnancy prevention/family planning as appropriate • Current use of SRH and HIV medicines and commodities • STI/HIV protection • Past STI/HIV history • Ask if the client has any questions about sex. Note that it is particularly important to ask young people, especially unmarried, about sex, given stigma in such areas.
	Assess for fertility intentions (Determine fertility intentions and whether there are any known difficulties with fertility. If the intention is not to have children at present – ensure there is knowledge about contraceptive options available)
	Assess for experience of sexual and gender-based violence, including intimate partner violence (initial assessment questions): Conduct initial assessment for history of incidences of all forms of violence and abuse, physical, emotional/mental, including sexual violence and domestic violence. It is important to remember that young people may be apprehensive about discussing violence, such as rape and partner abuse. This should include assessing experience and perpetration of violence, as well as a history of exposure to childhood family violence (given links between childhood experience of violence and future perpetration in men). If there is an indicator of any of the above conduct a fuller assessment and provide counseling and referrals, as appropriate. Screening can either be done in response to situations where signs of abuse are present or routine screening for all clients of a particular service. Provide counseling and referrals, as is appropriate, for survivors and perpetrators of sexual abuse and domestic violence.
	Assess for alcohol, tobacco and other substance use: Assess for alcohol use, other substance use and smoking habits/use of other tobacco products, and whether use is having deleterious consequences for the client or others. Counseling should then be provided based on assessment, with referral to behavioural interventions to reduce alcohol/other substance use and smoking cessation, as appropriate, acceptable and available.

	Assessment of mental health status and further plan for appropriate counseling or referrals
	A Assess for nutrition, food availability, diet and exercise
Physical exam of client	Measure height and weight, and calculate Body-Mass Index (BMI)
	Measure blood pressure
	Conduct other physical exam relevant from history using clinical judgment
	Conduct external genital examination, if needed
Contraception	Counsel client (if not undertaking couple counseling) and provide information on all available contraceptive options, her/his role in this, and how to be supportive and communicate with her/his partner in choosing the contraceptive option that works for them both: Offer couple counseling to male and female partners during family planning visits and provide only if female partner consents to this. Provide information (individually or with couples) on the various types of contraceptive methods, and their effectiveness, merits, and side effects, and help the couple/individual client choose a method and explain its use. As most methods are female-controlled, encouraging couple communication around family planning, and that men provide support to their partners in this area, is essential (including the lactational amenorrhea method (LAM) and fertility awareness methods) and the man's role in supporting his partner in effectively following these methods. Highlight the importance of triple protection from HIV, other STIs, and unintended pregnancy, and that family planning can help women and men plan and space births and prevent unintended pregnancy. Couple counselling should ideally be linked to the provision of skills development on equitable and safe negotiation around sex.
	Counsel a couple (if partner agrees) and provide information on all available methods of contraception, including promotion of dual protection through use of condoms. ***(See Annexure: your contraceptive choices)***
Sexually transmitted infections (STIs)	Counsel client and provide information on STIs, including couple counseling (if partner agrees)
	Conduct external genital and perianal exam (as part of syndromic management)
	Provide etiological diagnosis of STIs (diagnostic testing), i.e. laboratory and microscopy
	Treat STIs following syndromic management or etiological diagnosis
	Counsel client and provide support for partner notification for STIs and facilitated treatment (where applicable)
	Provide condoms and condom-compatible lubricant

HIV and AIDS	Provide HIV testing services (including information and counseling)
	Provide antiretroviral treatment for HIV (or referral) including initiation, monitoring and adherence support
	Provide pre-exposure prophylaxis (PrEP) for HIV
	Provide post-exposure prophylaxis (PEP) for HIV
	Counsel client on how to support partner in preventing mother to-child transmission of HIV (if partner wants)
	Diagnose, manage and prevent HIV-related co-infections and co morbidities
	Provide care and support for young people living with HIV
Pregnancy testing, antenatal and post natal care	Counsel client on preconception, support during antenatal and post-natal period and care-giving. Provide information on the role and responsibilities of parents, particularly the father, during antenatal period, childbirth, newborn care, child development, and childcare. Provide information on the positive role men can play in supporting safe motherhood, including: • Reducing the delay in women getting treatment by learning to recognize complications of pregnancy and delivery and the ways to respond to them • Being supportive of her decision to seek medical attention, despite possible resistance from others including family members • Ensuring that transportation is available, in case of an emergency and allocating family and community resources for transportation and delivery
Sexual and gender-based violence (SGBV) support	Screen for experience of SGBV, including intimate partner violence: The clinic as well as its outreach activities can play a crucial role in responding to sexual and gender-based violence, through breaking the silence around such violence and preventing violence from happening (through detection and referral services) and offering care. Also, for many survivors of violence, visiting a health care facility may be one of the only opportunities (and potentially a lost opportunity) for detecting and stopping abuse, and providing them with the necessary medical and counseling services. Globally, women and girls have been found to report lifetime experiences of physical and sexual violence at between 10-70% (with most estimates falling between 30-60%).[7] Emerging data is also finding that adolescent boys and men, particularly in high violence settings, may experience concerning levels of physical and sexual violence, including during childhood.[8] Given that

[7]Garcia-Moreno, C., Jansen, H., Ellsberg, G., Heise, L., Watts, C. (2005) WHO Multi-Country Study on Women's Health and Domestic Violence Against Women

[8]Barker, G., Contreras, J.M., Heilman, B., Singh, A.K., Verma, R.K., and Nascimento, M. (2011) Evolving Men: Initial Results from the International Men and Gender Equality Survey (IMAGES).

	violence violates human rights and the evidence that adolescent boys who experience SGBV are more likely to go on to perpetrate violence in later life, it is important to intervene, where possible, to stop this cycle of violence. There is also stigma associated with men and adolescent boys acknowledging that they have been the victims of SGBV. Also be congnizant of psychological and emotional forms of violence
	Counsel and support clients affected by violence and refer for clinical, psychosocial and protection services
	Refer clients who have a history of perpetrating violence against women to a relevant programme/support group; if it exists.
Post abortion care counseling	Counsel clients in post abortion care and encourage them to join support groups: Enable and encourage men and adolescent boys to participate in pre-and post-abortion care counseling sessions, if a woman so desires. Some women want their partner, husband or other support person present for such counseling. And likewise, many male partners express the desire for more information about their partner's condition during post-abortion care and about family planning
	Provide them with contraceptive choices
Information and counseling	Provide information and counsel client on sex, sexuality and sexual health
	Provide information and counsel client on self-confidence and self-esteem
	Provide information and counsel client on relationships and non-violent communication and negotiation
	Provide information on comprehensive sexuality education (CSE), values and gender equality, with specific focus on role of men, to reach in-school and out-of-school youth
	Provide information on genital and menstrual health and hygiene
	Counsel client and provide information on stigma reduction, particularly in the context of HIV and other STIs

Standard 4:
Providers' competencies

Health-care providers' attitudes, knowledge and skills are at the core of quality service provision (Ambresin A-E et al., 2012; WHO, 2015a). Guideline-driven care is central to young people's positive experience of care (Ambresin A-E et al., 2012). Yet, many healthcare professionals report insufficient knowledge of and technical competence in adolescent and youth-specific aspects of health promotion, disease prevention and management. In addition, health-care providers' own attitudes and beliefs may lead them to discourage the use of certain services or to withhold certain services from young people – for example, refusing to provide contraception to unmarried sexually active adolescents (Chandra-Mouli et al., 2014). Insufficient respect in clinical practice for young peoples' rights to information, privacy, confidentiality, non-discrimination and nonjudgmental attitudes is a major barrier to adolescents' use of services (WHO, 2014a). Therefore, hand in hand with developing technical competencies in adolescent health care, there is a need to assess and, where needed, change providers' attitudes towards adolescents and their right to quality health care (WHO, 2015a).

Standard 4 sets expectations for the **technical and attitudinal competencies** required by providers for effective, unbiased quality care, including competencies related to a human rights-based approach to adolescent and youth SRH services.

Provider Competencies in adolescent and youth health care can be categorized in three domains.[9] Although these domains are relevant for provision of comprehensive health care services for young people, our focus will remain on SRH services and we will analyze them in this context.

First, providers of young peoples' health care require specialized skills in consultation, interpersonal communication and interdisciplinary care appropriate to the developmental phase and context of the individual. Providers who care for young people need competencies in confidentiality, integrated health risk assessment, motivational and cognitive approaches to counseling and care in the transition from paediatric to adult care. Moreover, the fact that young peoples' capacities evolve with age and experience means that health-care providers also need competence in assessing their capacity for autonomous decision-making in order to maintain the balance between protection and autonomy. These competencies are grouped into **Domain 1: Basic concepts in adolescent and youth health and development, and effective communication.**

[9]Core competencies in adolescent health and development for primary care providers (WHO, 2015a).

Second, within clinical practice laws and policies that promote, protect and fulfill young peoples' right to health must be applied. Delivering services in line with professional and quality standards and consistent with human rights principles of equity, non-discrimination, participation and inclusion, and accountability is paramount. This set of knowledge, skills and attitudes is essential for ensuring that quality care is provided legally. These competencies are grouped into ***Domain 2: Laws, policies and quality standards.***

Third, caring for young people with specific conditions requires tailoring management approaches. For example, it is one thing in terms of competencies to discuss HIV prevention with a sexually experienced adult, but quite another to discuss the same issue with a young person who is not yet sexually active or feels ashamed because social norms condemn certain behaviours or circumstances (e.g. sexual activity before marriage, not being in school, same-sex sexual orientation). The competencies linked to the effective management of young people in specific clinical situations are grouped in ***Domain 3: Clinical care of young people with specific conditions.***

Domains and competencies for young peoples' health and development.

Domain 1. Basic concepts in young peoples' health and development, and effective communication	Competency 1.1. Demonstrate an understanding of normal adolescent and youth development, its impact on health and its implications
	Competency 1.2 Effectively interact with a young client
Domain 2. Laws, policies and quality standards	Competency 2.1. Apply in clinical practice the laws and policies that affect adolescent and youth health-care provision
	Competency 2.2. Deliver services for young people in line with quality standards
Domain 3. Clinical care of Young people with specific conditions	Competency 3.1. Assess normal growth and pubertal development and manage disorders of growth and puberty
	Competency 3.2. Manage common health conditions of adolescents and youth
	Competency 3.3. Provide age appropriate sexual and reproductive health care to young people
	Competency 3.4 Provide HIV prevention, detection, management and care services
	Competency 3.5 Promote physical activity
	Competency 3.6 Detect sexual and gender based violence and provide first-line support to the victim

All services for young people and associated competencies should be driven by respect for human rights, principles of equity, meaningful participation and inclusion. Therefore, a number of overarching attitudes are a fundamental component of all the competencies as shown in the table below.

Attitudes, knowledge, skills and practices required to demonstrate core competencies

- Treat each young person with full respect for her/his human rights.
- Show respect for young clients' choices as well as their right to consent or refuse physical examination, testing and interventions.
- Approach all young people, including those from marginalized and vulnerable populations, in a nonjudgmental and non-discriminatory manner, respecting individual dignity.
- Demonstrate understanding of young people as agents of change and as a source of innovation.
- Demonstrate understanding of the value of engaging in partnerships with adolescents, gatekeepers and community organizations to ensure quality health-care services for adolescents.
- Approach young peoples' health care, especially SRH as a process, not a one-off event, and appreciate that young people need time to take decisions and that ongoing support and advice might be needed.
- Approach every young person as an individual, with differing needs and concerns, and differing levels of maturity, health literacy and understanding of their rights, as well as differing social circumstances (schooling, work, marriage, migration).
- Show respect for the knowledge and learning styles of individuals.
- Demonstrate empathy, reassurance, non-authoritarian communication and active listening.
- Offer services that are confidential and provided in privacy.
- Demonstrate awareness of one's own attitudes, values and prejudices that may interfere with the ability to provide confidential, non-discriminatory, non-judgmental and respectful care to young people.

Checklist to Implement Standard 4:

Criteria	Yes	No	Remarks
Health-care providers and support staff of the required profile are in place. (The required competencies of staff should be clear in job descriptions.)			
Health-care providers have the technical competencies necessary to provide the required package of services.			
Health-care providers have been trained/sensitized on the importance of respecting the rights of young people to information, privacy, confidentiality, and of the health care that is provided in a respectful, non-judgmental and nondiscriminatory manner.			
Providers' obligations and young peoples' rights are clearly displayed in the health facility.			
Up-to-date decision support tools (guidelines, protocols, algorithms) that cover topics of clinical care in line with the package of services are in place.			
A system of supportive supervision is in place to improve health-care providers' performance.			
Health-care providers and support staff relate to young people in a friendly manner, and respect their rights to information, privacy, confidentiality, non-discrimination, non-judgmental attitude, and respectful care.			

Standard 5:
Facility Characteristics

Evidence suggests that the process of care can be confusing and even overwhelming for a young person.

Convenient operating hours (e.g. outside of school hours) and flexible appointment procedures (e.g. the possibility of a consultation without an appointment) are important for young peoples' access to services (Ambresin A-E et al., 2012;WHO, 2017). **Standard 5 emphasizes,** therefore, the importance of the organizational and design features of the facility that are important to provide accessible, efficient, and safe clinical care in a secure and supportive environment. The standard has three elements:

- Organization of operating hours and an appointment system to meet the needs of young people;
- Importance of design features and local policies to maintain privacy and confidentiality;
- Importance of systems to ensure adequate equipment, drugs and supplies.

To make the care process seamless for young people, the facility takes actions to support an adolescent and ***youth-focused process*** such as:

- Operating hours are convenient for young people in the community (ies)
- Care may be provided on an appointment basis or a walk-in basis
- The appointment and registration processes are respectful of young peoples' time and are designed to minimize waiting times.
- The facility plans and implements actions to manage the physical environment to ensure that it is clean, safe and accessible to all young people.
- Maintaining privacy and confidentiality is a matter of staff attitudes (see Standard 4), but it is also a matter of how the facility is designed.

Facility design features that enable privacy, confidentiality and safety include the following:

- Offices/examining rooms are designed to ensure privacy for young clients during clinical examinations and treatments.
- Adequate hand hygiene facilities are located in or adjacent to the office/exam room.
- Adequate seating is provided in the waiting room for normal patient flow, in a manner that ensures privacy of communication with reception staff.
- The premises, fittings, and furniture are kept clean and in good repair, meeting standards for lighting, heating, ventilation, and infection control.
- The facility provides for safe storage and disposal of clinical waste and potentially infectious waste that require special disposal, such as sharps/needles and other disposable equipment that may have come in contact with body fluids.

In addition to design features, policies and procedures that maintain young peoples' confidentiality at all times (except where staff are obliged by legal requirements to report incidents such as sexual assaults, POCSO act, road traffic accidents or gunshot wounds, to the relevant authorities) are in place.

Policies and procedures:

- Registration – information on the identity of the young person and the presenting issue are gathered in confidence;
- Consultation – confidentiality is maintained throughout the visit of young people to the point of health service delivery (i.e. before, during and after a consultation);
- Record-keeping – case-records are kept in a secure place, accessible only to authorized personnel; the facility also considers unauthorized access to electronically stored information and implements processes to prevent such access;
- Disclosure of information – staff do not disclose any information given to or received from a young person to third parties such as family members, schoolteachers or employers, without their consent.

In addition to the above, it is important to ensure that the facility implements actions for inspecting, testing, and maintaining medical equipment and documenting the results. Also, the facility has a system for procurement and stock management of the medicines and supplies necessary to deliver the required package of services to young people.

Checklist to Implement Standard 5:

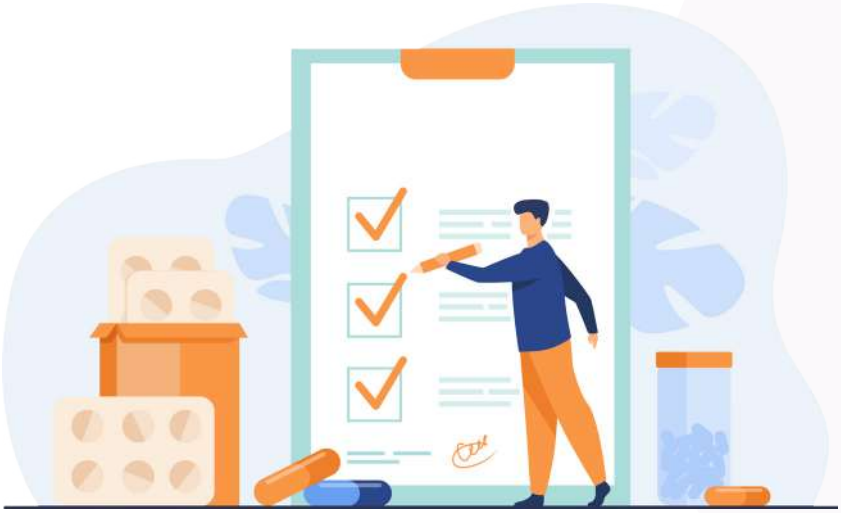
Criteria	Yes	No	Remarks
A policy is in place, including assigned responsibilities across health-care providers and support staff, to ensure a welcoming and clean environment, minimize waiting times and ensure convenient operating hours and flexible appointment procedures.			
The facility has a comfortable seating area, available drinking water, displayed educational materials in local language(s) that are attractive to young people, clean surroundings, waiting area and toilets.			
The facility has basic amenities (electricity, water, sanitation and waste disposal).			
Policies and procedures to protect the privacy and confidentiality of young people are in place. Both health-care providers and support staff know them as well as their own roles and responsibilities.			
Medicines and supplies are in adequate quantities without shortages (stock-outs), and are equitably used.			
Health-care providers offer consultations during hours that are convenient to young people in local communities, with or without an appointment.			
Health-care providers provide services to all young people without discrimination, in line with policies and procedures.			
The equipment necessary to provide the required package of services to young people is available, functioning and equitably used.			

Standard 6:
Equity and non-discrimination

This standard emphasizes the importance of providing equitable and non-discriminatory care so that all young people, not just certain groups, are able to obtain the health services they need. It stresses that equity concerns all dimensions of quality of care outlined in these standards. That is, equity is observed not just in the levels of service use by various groups of young people, but also in, for example, the level of respect, application of technical competence, use of medicines and technologies, involvement in the care process and its planning and monitoring. The facility provides equitable care and treatment for young people with the same health problems and care needs, especially with regards to sexual and reproductive health. Providers use guidelines and protocols that ensure a high level of patient care, which is applied to all groups of young people in an equitable manner. Clinical and managerial leaders plan and coordinate policies and procedures to ensure equity, monitor that this equity is observed at all times and to take remedial actions when necessary. The facility has policies and procedures for services that are free at the point of use, or affordable, to young people.

Checklist to Implement Standard 6:

Criteria	Yes	No	Remarks
Policies and procedures are in place stating the obligation of facility staff to provide services to all young people irrespective of their ability to pay, age, sex, marital status, schooling, race/ethnicity, disability , sexual orientation or other characteristics.			
Policies and procedures are in place for services that are free at the point of use, or affordable.			
Health-care providers and support staff are aware of the above policies and procedures, and know how to implement them.			
The policy commitment of the health facility to provide health services to all young people without discrimination, and to take remedial actions when necessary, is displayed prominently in the health facility.			
Health-care providers know who are the vulnerable group(s) of young people in their community (ies).			
Health-care providers and support staff demonstrate the same friendly, nonjudgmental and respectful attitude to all young people, regardless of age, sex, gender, marital status, religious background, education, caste, sexual orientation, cultural background, ethnic origin, disability or any other reason.			
Health-care providers provide services to all young people without discrimination, in line with policies and procedures.			
The health facility involves vulnerable group(s) of young people in the planning, monitoring and evaluation of health services, as well as in certain aspects of service provision.			



Standard 7:
Data and Quality Improvement

Effective policy-making for adolescent and youth health care and programme design requires strategic information on the health-related behaviors of adolescents and young people and about available health services for them. For the latter, data that come from routine facility data collection and facility assessments of services and service quality are extremely important (WHO, 2014a). Through facility-level registers health management information systems (HMIS) collect data that includes client information about age, sex, presenting problem, diagnosis and services provided. However, HMIS tends to focus on children less than 5 years of age and women of reproductive age, 15–49 years of age. This data is not sufficiently disaggregated by age to be able to focus on the adolescent age group, 10–19 years of age, and the subgroups of 10–14 and 15–19 years of age as well as on youth 15-24 years of age and the subgroup 20-24 years of age.

This becomes increasingly relevant because programmes have addressed adolescents and youth as a homogenous group, whereas they are a heterogeneous group. Programs must respond to the differing needs of different groups of adolescents and young people, such as sexually active younger adolescents (those below 15 years of age), those who are married including newlyweds, first-time parents, unmarried adolescents etc.

In addition, data on quality of care, even if it exists, often lacks a focus on adolescent and youth-specific elements of quality.

This standard, therefore, emphasizes the importance of the facility's activities to collect, analyse and use data on service utilization and quality of care, disaggregated by age and sex to support quality improvement. For FOGSI settings, it will be crucial to collect this data on SRH services. To monitor equity, it might be necessary to disaggregate data by other important characteristics such as school enrolment or marital status (see Standard 6). Aggregate data are an important part of the facility's performance improvement activities, as it provides a profile of the facility over time and allows benchmarking and the comparison of the facility's performance with the performance of other similar facilities. For example, dissemination of good practices and lessons learnt could be organized at local, subnational and national review meetings. For FOGSI settings, it might make sense to share data from different facilities across the country, as a cross learning exercise.

The aggregation and analysis of data and information and planning of subsequent improvements frequently requires knowledge and skills that most staff do not have or do not use regularly. Thus, staff involved in these processes need to be provided with the training and tools to manage, display, and report data and information on adolescents and youth in a useful and informative manner.

Staff motivation to participate in data collection activities for quality improvement, may depend on a number of factors, including factors outside the control of facility managers or health systems. However, initiatives such as supportive supervision or reward and recognition of highly performing staff could help drive a culture that engages in health improvement initiatives and effective use of data for provision of quality SRH services.

Checklist to Implement Standard 7:

Criteria	Yes	No	Remarks
The health facility collects data on service utilization disaggregated by age and sex, and conducts regular self-assessments of quality of care			
Health-care providers are trained to collect and analyse data to inform quality improvement initiatives.			
Tools and mechanisms for self-monitoring of the quality of health services for adolescents are in place.			
Health-care providers and support staff use data on service utilization and quality of care for action planning and implementation of quality improvement initiatives.			
Health-care providers and support staff receive supportive supervision in areas identified during self-assessments			
Mechanisms are in place for reward and recognition of highly performing health-care providers and support staff.			

Standard 8:
Adolescents' Participation

Adolescents and youth have the right to participate in decisions that affect their lives. In fact, this right is being increasingly recognized globally and all strategies, policies and programmes involving young people ensure their participation in the process. This meaningful involvement is an integral component of effective adolescent health care (Ambresin A-E et al., 2012). It is essential that their involvement is encouraged and supported by facility staff, in this case FOGSI clinics. There are a number of ways that young people can be involved, all of which can influence both the quality of services provided as well as health outcomes. Young people have important contributions to make in the policy-making, planning, implementation and monitoring of services provided in the community. Furthermore, if given the opportunity and empowered and trained, they could be effective peer educators, counselors, trainers and advocates. Young people usually have the best knowledge about their own lives and their needs, and they have the capacity to identify approaches or solutions that will best adapt a health-care solution or management option to their personal lives and circumstances. Ignoring views regarding their own care can lead to disengagement (e.g. discontinuation of a treatment), and loss to follow-up. In turn, ensuring young peoples' participation in their own care supports the provision of sustainable, acceptable, socially and culturally appropriate and more effective solutions, which ensures that more young people will seek and remain engaged in care. This standard emphasizes three important areas for young peoples' participation. First, it highlights their participation in the planning, monitoring and evaluation of health services. Second, it stresses their participation in decisions regarding their own health care. Third, it emphasizes their participation in certain aspects of health care service provision. Health-care providers have an obligation to make sure that opportunities are available for young people to exercise these rights. A choice made by a young person regarding elements of his/her care is a result of adequate, appropriate and clear information in order to understand the nature, risks and alternatives of a medical procedure or treatment and their implications for health and other aspects of

their life. Unless they lack decision-making capacity, or the decision-making capacity is delegated by law to a third party, young people can make decisions about all aspects of care, including refusing care. A WHO guideline recommends, for example, the provision of sexual and reproductive health services, including contraceptive information and services, for young people without mandatory parental and guardian authorization/notification, in order to meet the educational and service needs of adolescents (WHO, 2014b). In some situations a documented consent for a procedure or treatment is required. It is important to ensure that the health facility has policies and procedures on how to handle an informed consent, and makes sure the providers know and respect them. Finally, the facility engages young people in certain aspects of service delivery such as peer education, counseling, training and advocacy. In order to participate in a meaningful way, young people should be empowered, engaged and trained to do so effectively. Privacy and confidentiality is an important principle of AYFHS that needs to be highlighted in the standards.

There are gender and age related barriers that young people face. To mitigate age related barriers, health care providers can have support staff who are younger in age. Young people will be more comfortable in sharing their problem or concerns. To mitigate gender related barriers, young client should be asked which medical doctor they prefer seeing.

Checklist to Implement Standard 8:

Criteria	Yes	No	Remarks
The governance structure of the facility includes young people.			
The facility has support staff that is young in age. This staff is trained to counsel adolescents and young people about SRH issues.			
There is a policy in place to engage young people in service planning, monitoring and evaluation.			
Health-care providers are aware of laws and regulations that govern informed consent, and the consent process is clearly defined by facility policies and procedures in line with laws and regulations.			
The health facility carries out regular activities to identify young peoples' expectations about the service and to assess their experience of care, and it involves them in the planning, monitoring and evaluation of health services.			
Health-care providers provide accurate and clear information on the medical condition and management/ treatment options, and explicitly take into account the young peoples' decision on the preferred option and follow-up actions.			
The health facility carries out activities to build adolescents' capacity in certain aspects of health-service provision. Eg. peer group approach.			

Defining Adolescent And Youth Friendly Health Services (AYFHS) For FOGSI

1. AYFHS within existing solo practice:

Most common option for practicing gynecologists and obstetricians who have their own OPD clinics would be to consider an AYFHS center at a designated time on particular days (if not daily) exclusively to provide quality services to young girls and if possible boys. Boys and young men should be welcome in the gynecologist's clinic since it has been observed that at times they want to help their female partners by seeking advice on their behalf or accompany their partners. They should also be provided with SRH services.

Understandably, an individual gynecologist would be able to limit number / types of services at the AYFHS center that she / he must decide before hand depending on her/his capacity. For additional services and clinical requirements, there should be an arrangement to refer such clients to appropriate experts / specialists who are equally respectful and friendly to young people.

2. Multi-specialty adolescent and youth friendly health services at big Nursing Homes and Hospitals:

At bigger set ups, where several specialists are attached or available, it may be possible to develop a multispecialty AYFHS center that provides single window services.

Multi-specialty team:
In such a center, a team of some or all of the specialists may be considered: Gynaecologist, Paediatrician specializing in adolescent medicine, Professional Counsellor, Endocrinologist, Trained Nurse, Health educator, Psychologist, and Social worker.

Location of the AYFHS center: Such a multi-specialty center in a big Hospital should be located in an accessible location that does not hinder the movements by young clients. If it is planned to initiate a new independent unit in a private or NGO setting it should be centrally located in the city, easily approachable to young people from every corner. In a big city several centers are required to serve a large portion of young population.

The standards and guidelines for adolescent and youth friendly health services described here must be applied and adhered to in this setting as well.

The POCSO and MTP Acts in India: How to navigate them?

POCSO stands for "Protection of Children from Sexual Offences" As the name suggests the act is a comprehensive law made to protect children from sexual offences. This act was established in 2012. **The POCSO Act 2012** defines a child as any person below eighteen years of age. The act is gender neutral and hence any boy or girl below the age of 18 years can find relief under the act. It was crucial to have a law that enforces adoption of a very sensitive and humane approach during the process of

providing justice to a child who has undergone a traumatic experience as a victim of sexual offence. The main focus of the act lies in safeguarding the interests of the child victim at every stage of the judicial process, by incorporating child-friendly mechanisms for reporting, recording of evidence, investigation and speedy trial of offences through designated Special Courts. ***The punishment is more stringent under POCSO act 2012 and the burden of proof is not on the child but the offender.***

At present the age of consent in India is 18 years with both the Protection of Children against Sexual Offences (POCSO) and the Criminal Law Amendment Act (anti-rape law). Therefore, even consensual sexual act with any individual below 18 years of age is considered as rape. ***The Indian legal system criminalizes consensual sexual activity among adolescents, which means that even if a girl or boy under 18 years are willing to have sex with their respective partners who are also under 18 years, it will be considered rape.*** The Act makes it mandatory to report cases where the sexual offence has been committed or likely to be committed. It makes it the legal duty of a person aware of the offence to report the sexual abuse. In case he fails to do so, the person can be punished with six months' imprisonment or fine.

The Medical Termination of Pregnancy (MTP) Act, 1971 provides the legal framework for making comprehensive abortion care (CAC) services available in India. Termination of pregnancy is permitted for a broad range of conditions up to 20 weeks of gestation as detailed below:

- When continuation of pregnancy is a risk to the life of a pregnant woman or could cause grave injury to her physical or mental health;
- When there is substantial risk that the child, if born, would be seriously handicapped due to physical or mental abnormalities;
- When pregnancy is caused due to rape (presumed to cause grave injury to the mental health of the woman);
- When pregnancy is caused due to failure of contraceptives used by a married woman or her husband (presumed to constitute grave injury to mental health of the woman).

As per the MTP Act, pregnancy can be terminated only by a registered medical practitioner (RMP) who meets the following requirements:

- Has a recognized medical qualification under the Indian Medical Council Act
- Whose name is entered in the State Medical Register
- Who has such experience or training in gynecology and obstetrics as per the MTP Rules

All government hospitals are by default permitted to provide CAC services. Facilities in the private sector however require approval of the government. As per the provisions of the MTP Act, only the consent of the woman whose pregnancy is being terminated is required. However, in case of a minor i.e. below the age of 18 years, or a mentally ill woman, consent of guardian (MTP Act defines guardian as someone who has the care of the minor. This does not imply that only parent/s are required to consent.) is required for termination.

The amendments to the MTP Act in 2002 decentralized the process of approval of a private place to offer abortion services to the district level. The District level committee is empowered to approve a private place to offer MTP services in order to increase the number of providers offering Comprehensive Abortion Care services in the legal ambit. The word 'lunatic' was substituted with the words 'mentally ill person'. This change in language was instituted to lay emphasis that "mentally ill person" means a

person who is in need for treatment by reason of any mental disorder other than mental retardation. For ensuring compliance and safety of women, strict penalties were introduced for MTPs being conducted in unapproved sites or by untrained medical providers by the Act.

Where does the problem lie?

The Indian legal system criminalizes even consensual sexual activity among adolescents. Under the POCSO Act, 2012 (9), a sexual act with any individual below 18 years of age is rape. Such acts should also be reported to the local police or the Special Juvenile Police Unit. In 1992, India ratified the United Nations Convention on the Rights of the Child (UNCRC) (10), which recognizes that the best interests of the child should be of primary concern when making decisions affecting her/him (Article 3). Article 12 of the UNCRC states: " Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child." with the age and maturity of the child."

The POCSO Act, although passed a decade later, is in violation of the Convention and is regressive in so far as it criminalizes all sexual activity among children, not acknowledging consensual sexual activity among adolescents. An unwanted pregnancy resulting from consensual sexual activity involving an adolescent also ends up being viewed as an outcome of sexual violence by the law.

The Medical Termination of Pregnancy (MTP) Act, 1971 governs induced abortion service delivery in India. It very clearly defines by who, where, and when abortion services may be provided. The Government of India enacted the Protection of Children from Sexual Offences (POCSO) Act, 2012 to prevent and address child sexual abuse. These Acts overlap where the POCSO Act requires medical providers to report sexual abuse among minors and the MTP Act allows registered providers to terminate pregnancies resulting from rape. The intersection between the MTP Act and the POCSO Act creates confusion, delays, and sometimes denial of abortion services for young girls.

How does one navigate these Acts?

Section 19(1) of the POCSO Act requires anyone who knows that a sexual offence has been committed to report the case to the appropriate authorities (the local police or special juvenile police unit or child protection committee) or to the relevant person in the organization who could report the pregnancy to the appropriate authorities (the Chief Medical Officer, for example). Under the POCSO Act, a minor girl (under the age of 18) is unable to consent to sexual intercourse. Therefore, a pregnant minor girl married/unmarried is considered a victim of sexual assault, and a medical provider is required to report the pregnancy to the appropriate authorities, even if the girl has not expressed a desire to take legal action. . Anyone who knowingly fails to make this report can be punished with up to six months in prison and a fine. The National Commission for the Protection of Child Rights (NCPCR) has stated that providing a medico-legal certificate to the authorities is sufficient to comply with the reporting for requirements of the POCSO Act.

Guidance for FOGSI members to navigate the Act: Frequently Asked questions	
Q: Does a provider have a legal duty to inform the authorities if signs of sexual activity are noticed in an adolescent?	A: Yes. Any sexual activity under the age of 18 years is considered as sexual offence in the court of law. The POCSO Act requires anyone who knows that a sexual offence has been committed to report the case to the appropriate authorities (the local police or special juvenile police unit or child protection committee) or to the relevant person in the organization who could report the pregnancy to the appropriate authorities (the Chief Medical Officer, for example). Anyone who knowingly fails to make this report can be punished with up to six months in prison and a fine.
Q: Does the service provider have to follow the same rules for married adolescents?	A: Yes. As previously mentioned, any sexual activity under the age of 18 years is considered as sexual offence in the court of law and hence marital status makes no difference to the reporting requirement under the POCSO Act
Q: Does the service provider have to wait for the legal authorities to take action before proceeding with the termination of pregnancy in adolescents?	A: No. The provider does not need to wait till the authorities take action and may proceed with the termination of pregnancy in line with the provisions of the MTP Act after maintaining complete and detailed records of the case
Q: What procedure does the service provider follow with respect to reporting requirement if the child's age is uncertain?	A: If the girl's age is uncertain, it is advised to report the pregnancy as per the legal requirement under the POCSO Act and to allow the authorities to decide what actions to take. The provider may proceed with the termination of pregnancy in line with the provisions of the MTP Act after maintaining complete and detailed records of the case
Q: Is mandatory to report the adolescent pregnancy to the authorities before performing the MTP?	A: NO. The provider can inform the authorities about the pregnant minor after performing the abortion
Q: Does the medical provider have a legal obligation to preserve the products of conception for abortion services for adolescent girls?	A: Yes. Since a minor girl who is pregnant is considered a rape victim under the law, the products of conception might be evidence of an offence that the medical provider must preserve under Section 201 of IPC, if possible. Under this section, it would be considered a violation only if a provider destroys evidence with the intent to protect the accused from legal action. Therefore, providers who dispose of the products of conception (POCs) for a good faith reason (for example inadequate preservation facilities or following standard operating procedures) should be shielded from prosecution. Section 8 of the MTP Act guarantees protection for providers who act in good faith.

Q: When there is conflation between The POCSO Act 2012 and any other act, which act to follow?	A: The POCSO Act 2012 as it overrides any other Act, which is in conflation to it. Section 42 A of the POCSO Act says that the provision of POCSO act shall be in addition to and not in derogation of the provisions of any other law for the time being in force and, in case of any inconsistency, the provisions of this Act shall have overriding effect on the provisions of any such law to the extent of the inconsistency
Q: Should the service provider provide emergency medical care to adolescents?	A: It is mandatory for service provider to offer emergency medical care to any adolescent who comes for the services alone or is accompanied by someone or is brought in by the SJPU or police.
Q: Under what conditions such care should be provided?	A: Emergency medical care shall be rendered in such a manner as to protect the privacy of the child, and in the presence of the parent or guardian or any other person in whom the child has trust and confidence.

The MTP Act guarantees protection for providers who act in good faith. This recognizes that above all else, it is imperative that girls and women receive the highest standard of medical care available. Accordingly, all providers should fulfill their reporting requirements and legal obligations under the MTP Act and the POCSO Act after ensuring essential services. A provider is not obligated to file an FIR or to conduct an investigation; the provider's duty is only to inform the authorities when providing safe abortion service under the MTP Act.

Inputs from Youth Organizations (the YP Foundation, Tarshi and Pravah)

Recognizing the importance and value of receiving inputs from youth organizations, a discussion was held with select representatives from three youth organizations- the YP Foundation (TYPF), TARSHI and Pravah. These young people were between 18-24 years of age. Some had worked on issues of sexuality and had experience of conducting sessions with teachers, college students, teachers, parents etc. Others had worked with youth in the communities and conducted trainings with them on SRHR. They also hold meetings with the community health workers in their respective locations .

The discussion focused on the following issues:

1. What do young people understand by " Adolescent and Youth Friendly services"?
2. What are their thoughts on the content of the FOGSI guidelines shared with them?
3. Do young people feel that sexual and reproductive health issues are adequately and openly discussed in India? If so, what are the platforms where these are discussed: social media platforms, cinema, print media etc.
4. Do young people feel that SRH services are provided at clinics without bias and discrimination? If not, what is the nature of bias and how can it be addressed?
5. What do young people understand by an "appropriate package of services with regards to SRH"? What do they expect when they go to avail these services?

6. Do young people feel it is important to spend money on SRH services? If so, what services should they spend on? What would they consider "satisfactory services" for x amount of money spent?

7. Do young people feel that there are adequate spaces for their representation and voice in health programs, especially SRH programs? If not, what would they like to see in this space?

There were interesting responses to each of these issues, and these have been highlighted below:

1. What do young people understand by " Adolescent and Youth Friendly services"?

   TARSHI: "Youth friendly should mean that it is pleasurable and rights-affirming for young people. The health providers cannot just talk to youth clinically for prevention of STIs because that is not a comprehensive approach. Accessibility, correct information, safe, inclusive and sexuality-affirmative spaces are important components of adolescent and youth-friendly services. Young people can go and openly talk about their bodies. People can express their concerns and ask questions without fear of judgment."

   TYPF: "Privacy and confidentiality, ensuring satisfaction, taking feedback, non-judgmental attitude and behaviour are the important components. Providers should not question them back to ask why they need the services. This is what we had observed in our audits. They ask why do you want to get this information before marriage. They are not trained so much to talk to young people non-judgmentally. Some other observations from the audits: the support staff was not trained, sign boards were missing, the main point was all the services were not free also. Young people do not have money, so that limits their access to quality services. For college and school-going young people, they do not get the time if the facility is open only in the morning. So the providers should remember about the timings also. In our audits, we also saw the dressing of people was a factor. Doctors behave better if it is a rich person."

   What do we mean by non-judgmental attitude: "Doctors sometimes propagate the same ideas of morality related to pre-marital sex and same-sex relationships that we otherwise observe in the society. This causes fear in young people to access services as doctors tend to question them instead of behaving non-judgmentally. When conducting sexual health counseling, the doctors should refrain from getting into moral policing."

2. What are their thoughts on the content of the FOGSI guidelines shared with them?

   Pravah: "When we discuss intimate gender violence, it is important to engage with young boys and men. It is also important to understand young men's sexual health. That can be included in the package of services being provided to men."

3. Do young people feel that sexual and reproductive health issues are adequately and openly discussed in India? If so, what are the platforms where these are discussed: social media platforms, cinema, print media etc.

From all youth organizations: SRH information is accessible for young people who use Android mobile phones on Instagram and Facebook. There are lots of NGOs who provide information on social media but not all young people have access to that information. So people's experiences may vary. Porn may be available more easily, which is not a bad thing in itself but to get accurate information, we need to create an ecosystem where people can access information and timely access to services.

4. Do young people feel that SRH services are provided at clinics without bias and discrimination? If not, what is the nature of bias and how can it be addressed?

From all youth organizations: SRH services need to be more accessible for people from lower income groups as well as LGBT community. Unmarried youth are sometimes overcharged, especially for abortion services. If they display the cost of services charter in the facilities, that may help in addressing the bias. Pricing of adolescent and youth friendly health services is an important factor for making the services more accessible. Attitudinal shift towards premarital sex, people who identify as transgender or who are in same-sex relationships is another important criteria.

5. What do young people understand by an "appropriate package of services with regards to SRH"? What do they expect when they go to avail these services?

    - Adolescent and youth-friendly services should have appropriate signage within the facility, they should be free, appropriate tests and assessments should be there in the package.
    - In private facilities- It should be minimum. Overcharging should be avoided.
    - Equal and respectful behaviour: It should be implemented in the facility. Not just the provider but also support staff.
    - Creating safe spaces: There are not enough safe spaces, it is important to create safe spaces. The peer educators in the programmes also have limited information. Misinformation also goes around. Because there are limited spaces, how will they be educated on the health system and ecosystem. It is a vicious cycle of getting trapped into this.
    - Routine reproductive health visit: It exists in many countries, but is not there in India. This will help in gaining their confidence. It will start the conversation and destigmatise SRHR.

6. What should sexual and reproductive health services be called in Hindi so that young people feel ease in accessing without stigma and shame?

Yaun and prajnan swasthya- young people understand that. They will definitely come if you use this terminology. There should be gender neutral terminology in the guidelines to make it more inclusive, instead of keeping it in the binary of men and women.

7. Do young people feel it is important to spend money on SRH services? If so, what services should they spend on? What would they consider "satisfactory services" for x amount of money spent?

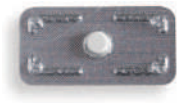
    - It is difficult to keep a universally accepted cost because services could be more expensive in Delhi than in smaller cities. But there can be a higher cap in pricing to ensure affordability and accessibility.

Suggestions from FOGSI members: SRH services in colleges can help improve young people's access to services. While this was considered a great idea, confidentiality and training of providers is still important as stigma within university spaces, fear of recognition can also impact young people's access. This was identified as an important discussion to continue for later also. Another suggestion on this was to create a module for doing digital/ virtual consultations to adapt to the covid realities.

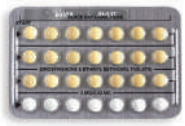
Annexures 1

Your Birth Control Choices

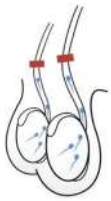
Method	How to Use	Impact on Bleeding	Things to Know	How well does it work?
External Condom 	• Use a new condom each time you have sex • Use a polyurethane condom if allergic to latex	None	• Can buy at many stores • Can put on as part of sex play/foreplay • Can help prevent early ejaculation • Can be used for oral, vaginal, and anal sex • Protects against HIV and other STIs • • Can decrease penile sensation • Can cause loss of erection • Can break or slip off • Does not need a prescription	87%
Internal Condom 	• Use a new condom each time you have sex • Use extra lubrication as needed	None	• Can put in as part of sex play/foreplay • Can be used for anal and vaginal sex • May increase vaginal/anal pleasure Good for people with latex allergy • Protects against HIV and other STIs • Can decrease penile sensation • May be noisy • May be hard to insert • May slip out of place during sex • May require a prescription from your health care provider	79%
Diaphragm Caya® and Milex® 	• Put in vagina each time you have sex • Use with spermicide every time	None	• Can last several years • Costs very little to use • May protect against some infections, but not HIV • Using spermicide may raise the risk of getting HIV • Should not be used with vaginal bleeding or infection • Raises risk of bladder infection	83%

Method	How to Use	Impact on Bleeding	Things to Know	How well does it work?
Emergency Contraception Pills Progestin EC (Plan B® One-Step and others) and ulipristal acetate (ella®) 	• Works best the sooner you take it after unprotected sex • You can take EC up to 5 days after unprotected sex • If pack contains 2 pills, take both at once	• Your next period may come early or late • May cause spotting	• Available at pharmacies, health centers, or health care providers: call ahead to see if they have it • People of any age can get progestin EC without a prescription • May cause stomach upset or nausea • Progestin EC does not interact with testosterone, but we don't know whether Ulipristal acetate EC does or not • Ulipristal acetate EC requires a prescription • May cost a lot • Ulipristal acetate EC works better than progestin EC if your body mass index (BMI) is over 26. • Ulipristal acetate EC works better than progestin EC 3-5 days after sex	58 - 94%
Fertility Awareness Natural Family Planning 	• Predict fertile days by: taking temperature daily, checking vaginal mucus for changes, and/or keeping a record of your monthly bleeding • It works best if you use more than one of these methods • Avoid sex or use condoms/spermicide on fertile days	• Does not work well if your monthly bleeding is irregular	• Costs little • Can help with avoiding or trying to become pregnant • Use a different method on fertile days • This method requires a lot of effort • Does not require a prescription	85%

Method	How to Use	Impact on Bleeding	Things to Know	How well does it work?
The Implant Nexplanon® 	• A clinician places it under the skin of the upper arm • It must be removed by a clinician	• Can cause irregular bleeding and spotting • After 1 year, you may have no period at all • Cramps often improve	• Long lasting (up to 5 years) • You can become pregnant right after it is removed • It may lower the risk of uterine lining cancer, ovarian cancer, and polycystic ovary syndrome (PCOS) • May cause mood changes	> 99%
Copper IUD ParaGard® 	• Must be placed in uterus by a clinican • Usually removed by a clinician	• May cause cramps and heavy monthly bleeding • May cause spotting between monthly bleeding (if you take testosterone, this may not be an issue)	• May be left in place for up to 12 years • You can become pregnant right after removal • It may lower the risk of uterine lining cancer, ovarian cancer, and polycystic ovary syndrome (PCOS) • Rarely, uterus is injured during placement	> 99%
Progestin IUD Liletta®, Mirena®, Skyla® and others 	• Must be placed in uterus by a clinican • Usually removed by a clinician	• May improve cramps • May cause lighter monthly bleeding, spotting, or no period at all	• May be left in place 3 to 7 years, depending on which IUD you choose • You can become pregnant right after removal • It may lower the risk of uterine lining cancer, ovarian cancer, and polycystic ovary syndrome (PCOS) • Rarely, uterus is injured during placement	> 99%

Method	How to Use	Impact on Bleeding	Things to Know	How well does it work?
The Patch Ortho Evra® 	• Apply a new patch once a week for three weeks • No patch in week 4	• Can make monthly bleeding more regular and less painful • May cause spotting the first few months	• You can become pregnant right after stopping patch • Can irritate skin under the patch • This method contains estrogen - it is unclear if estrogen interacts with testosterone	93%
The Pill 	• Take the pill daily	• Often causes spotting, which may last for many months	• Can improve PMS symptoms • Can improve acne • Helps prevent cancer of the ovaries • This method contains estrogen - it is unclear if estrogen interacts with testosterone • You can become pregnant right after stopping the pills • May cause nausea, weight gain, headaches, change in sex drive - some of these can be relieved by changing to a new brand	93%
Progestin-Only Pills 	• Take the pill daily	• Can make monthly bleeding more regular and less painful • May cause spotting the first few months	• You can become pregnant right after stopping the pills • It may lower the risk of uterine lining cancer, ovarian cancer, and polycystic ovary syndrome (PCOS) • May cause depression, hair or skin changes,change in sex drive	93%

Method	How to Use	Impact on Bleeding	Things to Know	How well does it work?
The Ring Nuvaring® 	• Insert a small ring into the vagina • Change ring each month	• Can make monthly bleeding more regular and less painful • May cause spotting the first few months • Can increase vaginal discharge	• One size fits all • Private • You can become pregnant right after • stopping the ring • This method contains estrogen - it is unclear • if estrogen interacts with testosterone	93%
The Shot Depo-Provera® 	• Get a shot every 3 months • Give yourself the shot or get it in a medical office	• Often decreases monthly bleeding • May cause spotting or no period	• Each shot works for 12 weeks • Private for user • Helps prevent cancer of the uterus • May cause weight gain, depression, hair orskin changes, change in sex drive • It may lower the risk of uterine lining cancer, ovarian cancer, and polycystic ovary syndrome (PCOS) • Side effects may last up to 6 months after you stop the shots	96%
Spermicide Cream, gel, sponge, foam, inserts, film 	• Insert spermicide each time you have sex	None	• Can buy at many stores • Can be put in as part of sex play/ foreplay • Comes in many forms: cream, gel, sponge, goam, inserts, film • May raise the risk of getting HIV • May irritate vagina, penis • Cream, gel, and foam can be messy • Does not require a prescription	79%

Method	How to Use	Impact on Bleeding	Things to Know	How well does it work?
Sterilization: Tubal Methods 	• These methods block or cut the Fallopian tubes • A clinician reaches the tubes through two small cuts in your belly or through your vagina	None	• These methods are permanent and highly effective • Reversal is difficult • The risks include infection, bleeding, pain, and reactions to anesthesia	> 98%
Sterilization: Va 	• A clinician blocks or cuts the tubes that carry sperm from your testicles	None	• This method is permanent and highly effective • It is more effective, safer, and cheaper than tubal procedures • Can be done in the clinician's office • No general anesthesia needed • Reversal is difficult • Risks include infection, pain, and bleeding • It takes up to 3 months to work	> 99%
Withdrawal Pull-out	• Pull penis out of vagina before ejaculations (that is, before coming)	None	• Costs nothing • Less pleasure for some • Does not work if penis is not pulled out in time • Must interrupt sex	80%

Annexures 2

Youth-Friendly Services Supervision Checklist

Source: Population Services International, Making Your Health Services Youth-Friendly: A guide for Program Planner and Implementers, 2014.

Adapted from Pathfinder International's Clinic Assessment of Youth Friendly Services, 2002

Name of Service Delivery Site: _____

Date of visit: _____

Supervisor Name: _____

Date of previous visit: _____

Supervisor Title: _____

Date of next visit: _____

Advance Preparations

Contact site to be visited (ensure the site has already passed the general site selection criteria) and arrange for obser¬vation of services and counseling and review of service delivery records. Read baseline facility assessment, previous program and any supervisory reports, and any action plan.

YFHS Site Visit

Meeting with staff

- Explain objectives of this visit, and write them in the space below:
- Mention highlights from any previous program/supervision report, and note these below:
- Ask staff about progress on making services more youth-friendly. Note specific accomplishments below.
- If YFHS work has not commenced, list the priorities for YFHS outlined by program staff. Ask staff about any barriers or challenges they have encountered in providing YFHS. Also ask them about what has been effective.
- Note problems and effective solutions in the space below, and briefly describe any technical assis-tance or additional funding needed to address problems.

If needed, revise the YFHS action plan to reflect any new changes. Attach new action plan.

Client Interaction and Provision of Services

For this section of the supervision checklist, it is best to directly observe client-provider sessions to verify provider practices. Ideally, observe two sessions (one male client, one female client) to find out how services are being pro¬vided to both sexes. Please fill in one checklist for each session observed. ***Before observing any client sessions, be sure to ask permission from both the client and provider and explain that you will keep all information confidential.*** The client should be told that s/he has

the right to refuse being observed or interviewed. Discussions among the supervisor and providers or team members about specific client-provider observations should always take place in private areas and should be conducted without reference to the client's name.

If it is not possible to observe client-provider sessions, you can ask the providers about different scenarios to allow you to answer the questions about what happens during sessions (e.g., If an unmarried 16 year old young woman comes in asking for contraception, how would you respond?). Please make a note in the Comments column that you were unable to directly observe any sessions.

Please note any explanations or feedback in the Comments column.

FINDINGS

When you have completed the checklist, share your findings with relevant staff.

Overall conclusions from visit:

Recommended actions to be taken:

Annexures 3

Site Observation Tool

Source: Population Services International, Making Your Health Services Youth-Friendly: A guide for Program Planner and Implementers, 2014.

Site Observation Tool

This guide can be used to assess the site's needs and capacity for youth-friendly services. Information can be collected through a combination of observations and individual interviews with service providers. The questions are designed to align with WHO's YFHS Quality of Care Standards.

Primary Questions – These questions should be answered first, before moving onto the secondary questions below.

Equitable

Are procedures in place to ensure that no young people are excluded from services?

Accessible

- Is information and referrals provided about where young people can access other youth-friendly health or social services in the community?
- Are services available during hours that are convenient to young people in the community?
- Are services located in an area that is accessible to youth and safe for them to travel to?
- Are services free of cost or affordable for young people?

Appropriate

- Does the site have posters, brochures and other IEC materials that target young people, including information about their rights?
- Are youth involved in program design, delivery and evaluation?
- Are the services advertised to young people in places where they congregate (e.g., schools, youth clubs, recreation centers, etc.)?

Acceptable

- Are young people greeted warmly upon entering?
- In the reception and waiting areas, is it possible to hear conversations between receptionist and clients?
- Are youth able to be seen without parental or spousal consent?
- Are sessions conducted in an area that provides privacy so that nobody can see or hear the conversations taking place?
- Is there a confidentiality policy and non-disclosure policy in place?

Secondary Questions – If you can ask the following questions in addition to the primary questions, please do. They will add much value to your assessment.

Accessible

- Are youth able to access all of their health services in one visit?
- Do clients have to wait long before seeing providers? If so, are there items to help pass the time (e.g., TV, IEC materials, magazines, health education, etc.)?
- Is transportation support available?
- Does the facility welcome drop-in clients?
- Are there separate clinic hours or waiting areas just for young people?

Appropriate

- Is peer support or mentoring available?
- Are educational activities youth-friendly and address topics of interest to youth? (e.g., role plays, theater, games, etc.)

Acceptable

- Is there a confidential mechanism for youth to provide feedback?

Effective

- Are youth referred to specific providers with appropriate background/training?
- Are condoms available to young people on-site? Are other methods available? (Please list)
- Has the site been certified as youth-friendly?
- Does the site have a youth-friendly strategy or action plan in place?

Annexures 4

Provider Observation Tool

Source: Population Services International, Making Your Health Services Youth-Friendly: A guide for Program Planner and Implementers, 2014.

This guide can be used to assess the client-provider consultation. Information can be collected by observing a client visit.

Primary Questions – These questions should be answered first, before moving onto the secondary questions below.

1. Does the provider give his/her full attention to the client?
2. Does the provider use non-technical language that the client can understand?
3. Does the provider demonstrate respect and a non-judgmental attitude toward the client?
4. Does the provider perform physical exams with the client's dignity, modesty and comfort in mind (e.g., using drapes to cover the body, curtains, etc.)?
5. Does the provider tell the client that s/he can change his/her mind before receiving a service?
6. Is the client counseled on physical and emotional issues related to puberty?
7. Is the client counseled on sexuality?
8. Is the client counseled on HIV/AIDS?
9. Is the client counseled on sexual and gender-based violence?
10. Is the client counseled on drug and alcohol use?
11. Is the client counseled on relationships?
12. Does the provider counsel on pregnancy, abortion and care during and after childbirth?
13. Does the provider communicate what he/she is doing (e.g., tests, results, treatment, etc.)
14. Does the provider use youth-friendly visual aids such as job aids, pamphlets and posters during the consultation?
15. Is the provider able to answer the client's questions?

Secondary Questions – If you can ask the following questions in addition to the primary questions please do. They will add much value to your assessment.

1. Are there any non-essential interruptions during the consultation?
2. Does the provider discuss all of the contraceptive options available?
3. Does the provider verify that the client understands the information provided?

Annexures 5

Youth Client Satisfaction Tool

Source: Population Services International, Making Your Health Services Youth-Friendly: A guide for Program Planner and Implementers, 2014.

1. Was it easy for you to get to this health care site today?
2. Were the services that you came for affordable?
3. Did you find the waiting time acceptable?
4. Did anyone interrupt your discussion with the health care provider?
5. Did the health provider tell you that everything you discuss would remain confidential?
6. Was anybody else in the room during your visit? If so, did the provider explain who they were?
7. Do you believe that others could hear your discussions with the health care provider when you were in the treatment/ consultation room?
8. Did the health care provider give you his/her full attention?
9. Did the health care provider seem interested in what you had to say?
10. Did the health care provider respect your opinion and decisions even if they were different from his/hers?
11. Did you find the environment at the health service site welcoming?
12. Did you feel comfortable talking to all of the people working at the health facility?
13. Did you feel that you could talk about everything that you wanted to and ask all of the questions that you wanted to with your provider?
14. Did the health care provider explain everything that he or she was doing and about any services being provided?
15. Did you understand everything that the provider told you?
16. Did the health care provider refer you to any services that are not provided here?
17. Would you recommend this health site to a friend who needed similar help?
18. Is there a staff member who you feel works especially well with you? (Describe what that person did to make you feel comfortable.)

Annexures 6

Hyperlinks to resources

1. https://knowledgecommons.popcouncil.org/do search/?q=data%20on%20unmarried%20adolescents%20 from%20UDAYA&start=0&context=13284515&facet=subject_ facet%3AAdolescents%20(Female)#
2. https://www.who.int/pmnch/covid-19/toolkits/adolescent/srhr/en/
3. https://www.guttmacher.org/article/2020/06/covid-19-could-have-devastating-effects-adolescents-sexual-and-reproductive-health#
4. https://www.fogsi.org/fogsi-international-adolescent-health-e-conference/
5. https://www.fogsi.org/welcome-to-our-latest-views/
6. https://esaro.unfpa.org/sites/default/files/pubpdf/Assessment%20 of%20Adolescents%20and%20Youth-Friendly%20Health%20Service%20 Delivery%20in%20ESA.pdf
7. https://www.health.gov.ng/doc/GuidelinesPromotingAccess.pdf
8. https://www.ippf.org/resource/introduction -keys-youth-friendly-services
9. http://teampata.org/wp-content/uploads/2017/06/Youth-Friendly-Sexual-and-Reproductive-Health-Servics-An-Assessment-of-Facilities.pdf
10. https://www.psi.org/publication/making-your-health-services-youth-friendly-a-guide-for-program-planners-and-implementers/
11. https://www.psi.org/publication/sexual-and-reproductive-healthof-adolescents-and-youth-a-review-of-the-evidence/
12. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4570008/
13. https://www.a360learninghub.org/wp-content/uploads/2019/05/Final-Ethiopia-youth-engagement-plan.pdf
14. https://www.fogsi.org/fogsi-clinical-standards-for-accreditationto-ensure-safe-delivery/
15. https://www.bandhu-bd.org/wp-content/uploads/2021/01/USAID_PSI_ Innovation-to-Scale_Youth-SRHR.pdf

16. https://apps.who.int/iris/handle/10665/183935

17. https://www.who.int/maternal_child_adolescent/documents/adolescent_friendly_services/en/

18. https://nhm.gov.in/New_Updates_2018/NHM_Components/RMNCHA/AH/guidelines/Implementation_Guidelines_Rashtriya_Kishor_Swasthya_Karyakram(RKSK)_2018.pdf

19. https://www.who.int/maternal_child_adolescent/documents/core_competencies/en/

20. https://reproductive-health-journal.biomedcentral.com/track/pdf/10.1186/s12978-017-0347-9.pdf

21. https://www.popcouncil.org/research/family-planning

22. https://www.popcouncil.org/research

23. https://toolkits.knowledgesuccess.org/toolkits/iud/balanced-counseling-strategy-toolkit-family-planning-service-providers

24. https://www.fhi360.org/sites/default/files/media/documents/Training%20Manual%20for%20the%20Providers%20of%20Youth-Friendly%20Services_0.pdf

25. http://www.wefoundation.org.in/about-too-shy-to-ask/

26. Kishori Film- https://www.youtube.com/watch?v=ZVDnprEpTVs

27. https://theypfoundation.org/resources/

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