HRLN
Human Rights Law Network

RKSK'S DISHA CLINICS FOR ADOLESCENTS IN DELHI

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ACRONYMS

AFHC	Adolescent Friendly Health Clinics
ANC	Antenatal Care
ANMs	Auxiliary Nurse Midwives
ARSH	Adolescent Reproductive and Sexual Health
CRC	Convention on the Rights of the Child
DISHA	Delhi Initiative for Safeguarding Health of Adolescents
DGD	Delhi Government Dispensary
IFA	IFA Acid Tablets
NAHS	National Adolescence Health Strategy
NFHS	National Family Health Survey
PMSMA	Pradhan Mantri Surakshit Matritva Abhiyan
RKSK	Rashtriya Kishor Swasthya Karyakram
SABLA	Rajiv Gandhi Scheme for Empowerment of Adolescent Girls
WHO	World Health Organisation

1. INTRODUCTION

A team consisting of eleven interns, Adil, Anamika Tyagi, Ananya Kuthiala, Anoop Kumar, Anu Anmol, Arshi, Isha Goel, Kashni Bhamra, Mahima Duggal, Nishi Sangtani and Shebani Rose and advocate, Deepak Kumar Singh (Human Rights Law Network), went on a fact-finding mission across various districts of Delhi. The purpose of the fact-finding mission was to understand the functioning and efficacy of clinics of the Delhi Initiative for Safeguarding Health of Adolescents (DISHA). Further, it was undertaken to gauge the understanding, awareness and accessibility of such adolescent friendly health clinics (AFHCs) to adolescents between the age of 10-24 years.

To conduct the fact-finding mission, the team visited four DISHA clinics, one slum cluster and conducted one interactive session with adolescents through Asmita Social Welfare Organization. In total the team interviewed 31 adolescents (five male and 26 female), DISHA Staff (three ANMs) and other stakeholders (one ASHA worker).

Type	Places Visited
1. DISHA Clinics	a. DGD Raghubir Nagar b. Guru Gobind Singh Hospital c. Delhi Government Allopathic Dispensary, Double Storey, Seelampur d. Jag Pravesh Chandra Hospital, Shastri Park
2. Slum Cluster	JJ Cluster, Raghubir Nagar
3. Interactive Session (through Asmita Social Welfare Organization)	Balmiki Mandir, Photo Chowk, Seelampur

All adolescents were interviewed separately from their parents.This was deliberately done to ensure they felt comfortable, guaranteethe privacy and confidentiality of their responsesavoid any direct influence from their parents' presence.

Objectives of the fact-finding mission:

- To understand the applicability and implementation of the services provided in the AFHCs in the form of DISHA clinics in Delhi.
- To determine ifadolescents are aware and able to access the clinics and various services available under the AFHC scheme.
- To find out if the service providers of the scheme, such as ANMs and ASHAs are aware about the scheme and able to deliver it efficiently.
- To analyze the challenges of DISHA clinics through a stakeholder analysis, by examining existing loopholes/areas for further improvements to these clinics under RKSK.
- To highlight the health rights violations that adolescents are facing and to address them by pushing for legislation that will guarantee the fulfilment of the needs of adolescents.

2. BACKGROUND

Adolescent Health:

The adolescent population in Asia accounts for more than half of the world's adolescent population.[1]Generally, investment in the past 50 years has been into the improvement of the welfare of younger children, not adolescents, and as a result, the health of adolescents has improved at a much slower rate.[2] Addressing the health problems faced by adolescents is crucial as it is during this period in which they "begin using tobacco, alcohol and drugs; having unprotected sex…[which] account for one third of the total disease burden in adults".[3]

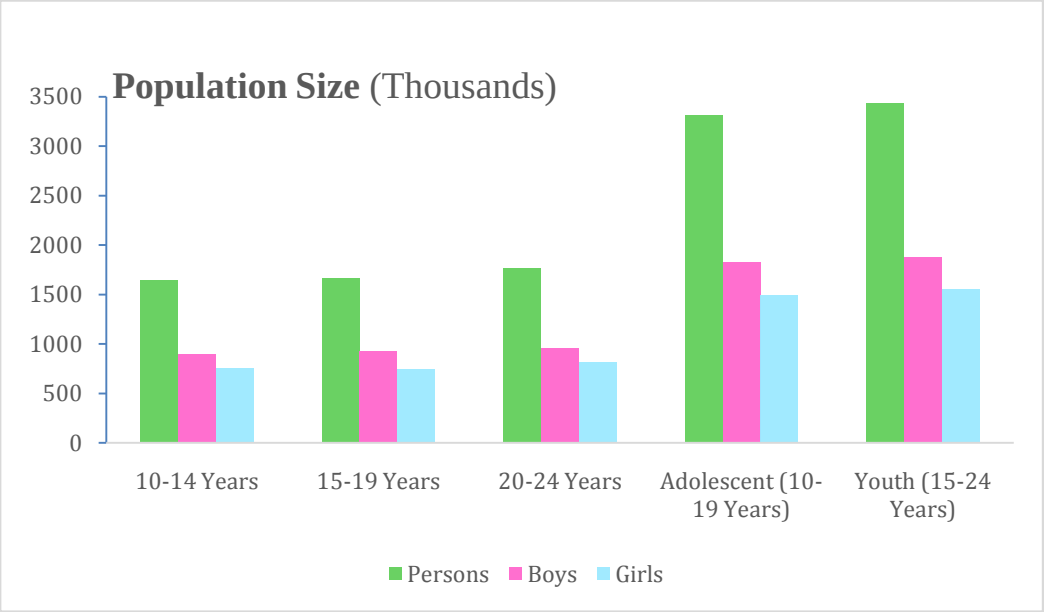
A 2012 Lancet report found that in southern Asia there was a 75% unmet need for mental health services.[4] Further in terms of nutrition, nearly 50% of adolescent girls aged, 15-19, in India were classified as underweight with a body mass index of less than 18.5.[5] This is particularly pertinent in the case of young adolescent mothers, who may suffer slow fetal

[1] UNICEF, *Progress for Children: A Report Card on Adolescents,* April 2012, http://www.unicef.in/Uploads/Publications/Resources/pub_doc68.pdf.
[2] ibid, p.18.
[3] ibid.
[4] Lancet, 'Health of the world's adolescents: a synthesis of internationally comparable data, p. 1669.
[5]UNICEF, *Progress for Children: A Report Card on Adolescents,* p. 20.

growth and low birthweight, continuing on a cycle of poor health to their children. If they are also anemic other potential consequences may include haemorrhaging and sepsis. In total, 56% of adolescent girls are anemic, which may lead to other severe long-term consequences, including cognitive and physical deficits as well as reduced productivity. UNICEF also notes that testing for diseases at clinics and at doctors is crucial for adolescents as a delayed diagnosis will only occur after the individual has expressed severe symptoms of an advanced disease. Knowledge about HIV/AIDS is disturbingly low, with only 19% of adolescent girls having a comprehensive knowledge of the disease, its transmission and the risk of unprotected sex.[6] These a just a few of the statistics that illustrate the dire situation many of the world's adolescents find themselves in without comprehensive health services. Below a specific focus on Delhi will investigate the specific areas the area is facing in relation to the issues faced by local adolescents and their families.

Delhiat a Glance: Population of Adolescent as per the Census of India, 2011

DEMOGRAPHICS

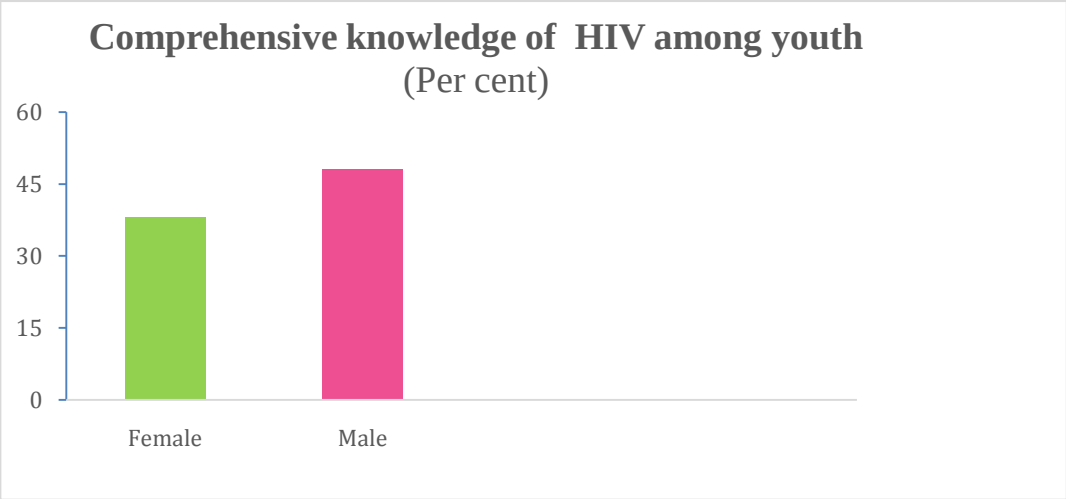


Source: Census of India 2011; Special tables on youth and adolescents, Census 2011

As per the Census of India, 2011, the total population of adolescents between the age of 10-24 years in Delhi stands at 16, 787,,941. Further, the population size of adolescents between the age of10-19 years is 3, 315, 522 and of the youth between 15-24 years is 3, 431,435.

[6]ibid, p. 29.

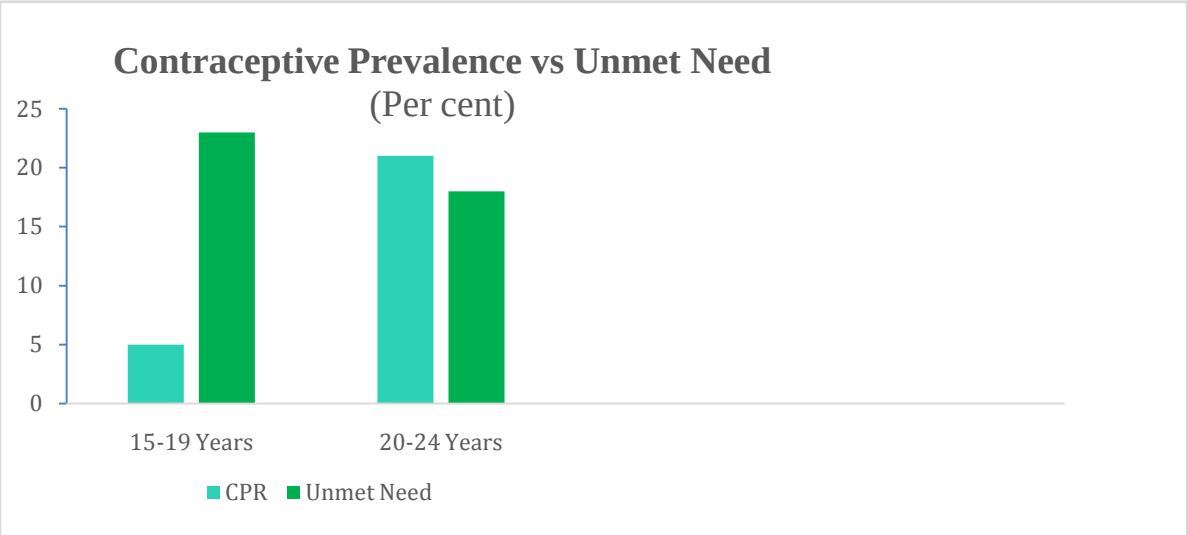
KNOWLEDGE OF HIV AMONGST YOUTH IN INDIA



Source: Behavioral Surveillance Survey (BSS), 2005-2006

As per BSS 2005-2006, only 38% females and 48% males had knowledge of HIV.

CONTRACEPTION



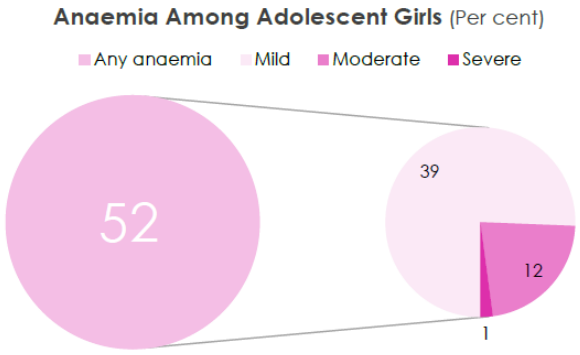
Source: National Family Health Survey (NFHS) 2005-2006

According to the third National Family Health Survey of 2005-2006 (NFHS III) the contraceptive prevalence in the 15-19year age group is 5% and among 20-24 year olds is 21%. There is a 23% unmet need for contraception among 15-19 year olds and 18% among 20-24 year olds.

According to background characteristics and sexual risk behavior, HIV prevalence among young people age 15-24 is relatively high. Overall, 0.10%of young women and men aged 15-24 are HIV positive. HIV prevalence is higher among young men than young women (0.12% versus 0.08%).

Among young women, HIV prevalence increases with age, from 0.04% among women aged 15-17 to 0.12% among women aged 20-22 before falling to 0.06% among women aged 23-24. Among young men, HIV prevalence increases from 0.04% among men aged 15-19 to 0.24% among men aged 23-24 (Table 14.12). HIV prevalence among women aged 15-24 does not vary by residence, but HIV prevalence is much higher among urban men aged 15-24 (0.20%) than among rural men age 15-24 (0.08%). Young women who are widowed, divorced, separated, or deserted have a higher HIV prevalence than their currently married and never married counterparts (0.70% versus 0.17% and 0.02%, respectively). Among men in this age group, those who are currently married have the highest prevalence of HIV (0.28%). Among young women who have had sex at least once, those who have had 10 or more lifetime sexual partners have ahigher HIV prevalence than women with 1-2 lifetime sexual partners. However, among young men who have had sex at least once, HIV prevalence does not vary consistently according to the number oflifetime sexual partners.

ANAEMIA AMONG ADOLESCENT GIRLS



Source: National Family Health Survey, 2005-2006

As can be seen in the above figure in 2005-2006, 52% of adolescent girls suffered from anaemia, 39% suffered from mild anaemia, and 12% suffered from moderate anaemia and 1% had severe anaemia.

Area of concern: Adolescent Friendly Health Clinics

The need to meet the needs of the adolescent age group was first recognized in the 12th five years' program and subsequently received substantial recognition in the 17th five years' program. The age of adolescence from 10 to 19 is believed to be a transitional stage of life facing various social and cultural barriers. The most vulnerable groups inthis age group are females and working children. We are not oblivious to the sanctions and the stigmas against a menstruating woman that prevail in our country. In the present scenario a lack of proper education for a child regarding bodily changes, such as the beginning of menstrual cycles and use of contraceptives, hinders the process of family planning.More importantly it impairs thedevelopment of individual life.

The potential for major behavioral changes increases with thephysical changes experienced during adolescence. They become vulnerable to sexually transmitted diseases, unwanted pregnancy, substance misuse, and various mental disorders. The significant contributory factor to such growing trends is the lack of a proper framework to change the conservative mindsets of individuals and communities.

Before 1986, the government did not provide basic education for all children. Girls under the age of 18 were often victims of child marriage. Essential welfare needs and products, like sanitary napkins, condoms and others,did not reachpeople in need in the country. Further academic studies with respect to adolescent health remain neglected, and the only accessible data is from the NFHS III and the National Sample Survey organization.

After intensive reports on bonded child labor, child marriages and crimes against woman, the government drafter a plan to adopt a curative and preventive approach to issues faced by adolescents in India. The National Adolescence Health Strategy (NAHS) known as Rashtriya Kishor Swasthya Karyakram (RKSK), seeks to address the facilitation of basic nutrition, provision of contraceptives and sanitary napkins and others, and the availability of proper counseling for adolescents. Further, the guidelines for the implementation of the RKSK provides for the establishment of AFHCs along with trained counselors.

The NAHS 2014 envisages the development of the overall health of children between the age group of 10 to 19. It provides for guidelines thatlay down abasic framework and createan

accessible infrastructure, enablingthe operation of equal participation. The NAHS aims tocreate a general awareness in society regarding adolescent health.

The health strategy aims to achieve the following objectives:

- Improve nutrition
- Improve sexual and reproductive health
- Enhance mental health
- Prevent injuries and violence
- Prevent substance misuse

The acknowledgement of such issues reflects the government's past failed delivery of adequate health services in these areas. NFHS III suggests that the failure of government policies coupled with social sanctions has led to the neglect of children between the age of 10 to 19. This isespecially evident forfemale children, who have suffered because society has often forgiven crimes against them on the basis of religious grounds.

The governmenthas clearly already acknowledged the need to provide for AFHCs. These clinics work with a curative and preventive approach. The guidelines for implementation of RKSK suggests that the clinics should provide for counseling in important health areas such as nutrition, contraceptives, RTI and STI diseases, child bearing and delaying child marriages. The counseling service must be operate with qualified and trained counselors. Additionally, other facilities such as weekly 'Iron & Folic Acid Supplementation & Albendazole', sanitary napkins, contraceptives and medicines shouldbe provided.

These clinics work on a fixed date and time schedule with regular intervals. This implies that potential patients must already be aware of the exact date and time of the clinic's hours. This is particularly unlikely in rural areas. This trend extends to urban areas where people largely remain ignorant about their health status.

Under RKSK, the Delhi government established DISHA clinics to strengthen and promote services that cater specifically to adolescent health. This program serves to provide curative, preventive, referral and counseling services. This initiative envisages the following approach to achieve its aims.

1. Weekly Iron & Folic Acid Supplementation Program: Distribute iron and folic acid tablets (IFAs) to cure anemia.
2. Peer Education Program: Create awareness and educate teenagers regarding contraceptives, child bearing and delayed marriages. It is believed that a peer may provide a better way to educate and communicate with children.
3. Adolescent Health Day: This program is conducted quarterly; aiming to create social awareness regarding gender violence, nutrition and various other health needs.
4. Menstrual Hygiene Scheme: It focuses upon teaching menstruating women to use high quality sanitary napkins and ensure their eco friendly disposal.

Suggestions

Under RKSK children between the ages of 10 to 19 are recognized as adolescents and subsequently there is emphasis on delaying marriage. Also, modernization is fuelling urbanization and thus creating the possibility to delay marriage. Hence, there is a need to expand the age of recognized adolescence from 10 to 24 to cover a greater population target group. Research in Maharashtra revealed that counselling onmasturbation was not properly conducted and there was a great needto recruit absolutely qualified and trained counsellors. Sex education should become part of school curriculums. Operational guidelines should provide for mandatory counselling for parents. There is a need to actively support NGOs and other actors to undertake intensive studies to analysepoorer sections of India. The government should collaborate with non-government actors to widen the scope of RKSK and to realize its full potential. Further, initiatives in the form of advertisements, workshops in schools and colleges should be undertaken to increase awareness of such initiatives. Further, the guidelines that direct adolescent health clinics are too vague and give extensive discretionary power to counsellors and individuals managing clinics. An attempt should be made to increase the specificity of guidelines to prevent arbitrary practices by counsellors.

3. FACT FINDING

A. CASE STUDIES OF ADOLESCENTS

A1. GIRLS:

1. Naina (name changed), 11 years old, 7th standard

a. Unaware of DISHA clinics and their services, but aware of the local government dispensaryand had attended with her father. She felt uncomfortable attending clinics alone due to a lack of female counsellor or doctor.
b. Receives IFA tablets for anemia at school and aware of their purpose.
c. Menstruation has not started. Aware of the usage of sanitary napkins and cloth due to information from friends. Unaware which option is best.
d. Comfortable discussing menstrual or genital problems with her mother and friends.
e. No sexual experience or attraction to boys, and unaware of contraceptives.

2. Iqra, 12 years old, 7th standard

- She is active playing cricket, badminton and kho-kho. She aspires to be a teacher.

a. She is not yet attracted to boys. Her friends discuss them with her, however she prefers to discuss travel plans in India. Iqra identified a girl in her class who has a boyfriend and described her as 'badtameez' as she finds it disgusting having a boyfriend.
b. Menstrual cycle began last year. Unaware of menstruation-related issues as parents and teachers have not provided information and very scared at the prospect. Advised by her mother not to bathe regularly, avoid sour foods and avoid going out. She uses sanitary pads, changing them two to three times a day.
c. Aware of the dangers of substance abuse and has attempted to persuade her father from smoking.
d. Believes that the right age to marry is 24-25 as then people are knowledgeable enough to make informed decisions.
e. No knowledge regarding government health services, HIV/AIDS, STIs and sex generally.

3. Nandini; 12 years old, 5th standard

a. Unaware of DISHA clinics and their services (as well as her parents) and unaware of local government dispensary.
b. Menstruation has not started. No knowledge about menstruation and family and teachers have not explained anything.
c. No counselling.
d. Confirmed non-operation of SABLA program.

4. Ishpreet, 13 years old, Resident of Seelampur, 9th standard

a. Unaware of DISHA clinics and their services.
b. Menstrual cycle has not begun.

c. Comfortable discussing menstrual or genital problems with her friends.
d. Shows signs of mental distress and is therefore eligible for counsellor under the RKSK, but is unaware of the service or of peer educators.

5. Pooja, 13 years old, 5th standard

a. Unaware of DISHA clinics and their services and never attended or was aware of the local government dispensary. Never experienced counselling.
b. Menstrual cycle has not begun. Unaware of menstruation-related issues as parents and teachers have not provided information.
c. The Anganwadis in her community do not hold any meetings for them as part of the Rajiv Gandhi Scheme for Empowerment of Adolescent Girls (SABLA) as it has only been newly implemented in the centre. The Angawadi worker has only recently been told of the scheme and the need to determine the total number of adolescent girls in the community.

6. Khushi, 13 years old, 5th standard

a. Unaware of DISHA clinics and their services or attended the local government dispensary. Never exposed to counselling. She faces menstrual cramps and vomiting but has never sought medical attention.
b. Unaware about personal hygiene management.
c. Confirmed non-operation of the SABLA program.
d. Identified as anemic and the trainee and ANM advised her to visit DISHA Clinic on Saturday to get a checkup by the doctor and have a counseling session on nutrition.

7. Muskan, 13 years old, 8th standard

a. Unaware of DISHA clinics and their services and never attended the local government dispensary. She reported that though she faces menstrual cramps and complained of vomiting during her periods, she has never been to a doctor, or even a clinic.
b. Confirmed non-operation of SABLA program.
c. On being asked about the personal hygiene routine, she was very lost. She has been identified as anemic by the ANM, and she was then advised to visit the DISHA clinic to receive a checkup and counseling session on nutrition.

8. Nisha, 13 years old

a. Studied until the 5th standard at Rajkiya Vikas Vidyalaya before dropping out.
b. Unaware of DISHA clinics or the government dispensary. She has never been exposed to any counselling. Face menstrual cramps but has never sought medical attention.
c. Confirmed non-operation of SABLA program.
d. As she had already been identified as anemic, the trainee and ANM advised her to visit the DISHA Clinic on Saturday to get a checkup by the doctor and have a counselling on nutrition.

9. Lakshmi, 13 years old, Resident of Seelampur, 8th standard

a. Unaware of DISHA clinics and their services, but aware of the local dispensary. She had never visited an Anganwadi centre. She has constant pain in her stomach but has only visited a private doctor.
b. Receives IFA tablets for anemia at school.
c. Menstrual cycle began recently. She wears sanitary napkins and receives one or two from school and the rest from the store, which is often expensive.
d. Comfortable discussing menstrual or genital problems with her mother.
e. She has never heard of contraceptives.

10. Riya, 13 years old, 7th standard

a. Unaware of DISHA clinics or the government dispensary and their services. She has never been exposed to any counselling on menstrual hygiene, nutrition, sex education or any health related issue. She has experienced cramps but has never sought medical treatment.
b. Confirmed the non-operation of the SABLA scheme.
c. On being asked about her personal hygiene routine, she was very lost. As she was already identified as anemic by the ANM, the trainee and ANM advised her to visit the DISHA Clinic on Saturday to get a checkup by the doctor and be counseled on nutrition. But it was clearly evident that though the DISHA clinics have been running in the community, the people of the community have absolutely no idea about their operation

11. Shakuntala (name changed), 14 years old, 7th standard

a. Unaware of DISHA clinics and their services, but aware of the local government dispensary and had attended on behalf of a friend.Uncomfortable attending clinics due to a lack of female counsellor or doctor.
b. Receives IFA tablets for anemia at school and is aware of their purpose.
c. Menstrual cycle began in 2017. She wears sanitary napkins purchased from the store for Rs. 15 per packet and some from her school for free. Unaware of DISHA's Rs. 6 offer for napkins.
d. Comfortable discussing menstrual or genital problems with friends.
e. No sexual experience, but aware of contraceptives and their use.

12. Tooba (name changed), 14 years old, 9th standard

a. Unaware of DISHA clinics and their services, but aware of the local government dispensary near Shri Ram Mandir. She attends when she has an infection or illness, and recently attended for a rash on her arm.
b. Receives IFA tablets for anemia at school, however she does not consume them after pressure from friends however post-interview she has indicted a desire to take them.
c. Menstrual cycle began when she was 12. She wears freely available napkins from school. She also buys sanitary napkins from the store for Rs. 46 per packet.
d. Uncomfortable discussing menstrual or genital problems with parents or friends.

13. Juhi (name changed), 14 years old, 9th standard

a. Unaware of DISHA clinics and their services, but aware of the local government dispensary and attends to receive menstrual pain medication. Does not seek counselling there as there is no female doctor or counsellor.
b. Received IFA tablets for anemia at school, however she does not consume them as she was unaware of their health benefits. Her father has recently encouraged her to take them with him.
c. Menstrual cycle began when she was 12. She wears freely available napkins from school. She also buys sanitary napkins from the store for Rs. 40 per packet.
d. Comfortable discussing menstrual or genital problems with her friends.
e. Not sexually active or aware about contraceptives.

14. Pammi, 14 years old, Resident of Seelampur, 9th standard

a. Unaware of DISHA clinics and their services, but she is aware of the local dispensary as she visited an Anganwadi centre when she was young.
b. Receives IFA tablets for anemia at school but is unaware of their purpose. When explained to her she does not believe she is anemic.
c. Menstrual cycle has begun. School provides one sanitary pad and she purchases others from the store for Rs. 30-35 for a single pad.
d. Comfortable discussing menstrual or genital problems with her mother, but not with health practitioners. She has never interacted with a peer education or counsellor.
e. Unaware of contraceptives.

15. Kanchan,14 years old

a. Studied until the 5th standard before dropping out.
b. Unaware of DISHA clinics and their services and never attended local government dispensary. Never exposed to counselling. Experiences menstrual cramps but has not sought medical attention.
c. Unaware of personal hygiene management.
d. She was also identified as anemic and the trainee and ANM advised her to visit DISHA Clinic on Saturday to get a checkup by the doctor and have a counseling session on nutrition.
e. Confirmed non-operation of SABLA program.

16. Zaiba, 16 years old, Resident of Zafrabad

a. Studied until the 8th standard before dropping out to assist her family with chores and has no wish to return as her marriage has been fixed (her future husband is 22 years old). Attracted to boys, however inexperienced interacting with them.
b. Menstrual cycle began at age 12. Sister explained the menstrual cycle to her. She uses sanitary pads and changes them two to three times per day.

c. She sought a doctor's assistance after gaining weight in her abdominal area, was given medicinal syrup but did not improve. She felt uncomfortable discussing female medical ailments with male doctors.
d. Comfortable discussing menstrual or genital problems with her sister.
e. No knowledge of HIV/AIDS, STIs, the concept of sex or contraceptives.

17. Antara, 17 years old, Resident of Seelampur, 11th standard

a. Unaware of DISHA clinics and their services, but aware of the local government dispensary and Anganvadi centre.
b. Menstrual cycle began a few years ago. Receives one sanitary pad from school, so purchases them from the store for Rs. 30-35 per packet.
c. Receives IFA tablets for anemia at school every week.
d. Comfortable discussing menstrual or genital problems with her friends. Has not interacted with a peer educator or is she aware of the RKSK's counselling service.
e. Unaware of female contraceptives.

18. Asma, 17 years old, Resident of Jaffarabad, 12th standard

a. Daughter of an ASHA worker, unmarried
b. Unaware of DISHA clinics but aware of ASHA workers and Anganwadi centres, despite never attending them. She visited a doctor who reported a lack of calcium in her body however she has not received any medication.
c. Menstrual cycle began at age 14. Unaware how many times a day a sanitary napkin should be changed. She is only aware that she needs to bathe only once during her period.
d. Uncomfortable discussing menstrual or genital problems with her friends. Has not interacted with a peer educator or is she aware of the RKSK's counselling service
e. Not sexually active or knowledgeable about sex, pregnancy or contraceptives. Very shy when interacting with boys and has often experienced bullying from them, while no action has been taken. Nevertheless she is attracted to boys, but believes the right age to engage in sexual activity is twenty-two or any time after marriage.

19. Savita, 17 years old

a. Studied until the 5th standard before dropping out
b. Unaware of DISHA clinics and their services or nearby dispensaries. Never received health counselling. Experiences menstrual cramps but never sought medical attention.
c. Not sexually active but her marriage has been fixed. No information concerning family planning (abstinence method, contraceptives, HIV/AIDS, STIs etc.). Has not been explained to her by her mother.
d. As she was identified as needing counselling for sexual health issues, the trainee and ANM advised her to visit the DISHA Clinic on Saturday to get a checkup by the doctor and have in depth counselling.
e. Confirmed non-operation of the SABLA program.

20. Irma Khan, 17 years old

a. Studied until the 8th standard before dropping out
b. Menstrual cycle began at age 14. She was scared as she had no knowledge of menstruation and believed she was bleeding from her abdomen. Consulted a doctor concerning heavy blood flow.
c. Previously considered a male, but after menstruation began to identify as a woman.
d. Developed attraction to males and females. Not sexually active, however she has kissed her boyfriend at age 16. Incomplete knowledge about sex, HIV/AIDS and STIs. She is likely to marry soon but is unaware of family planning options.
e. Uncomfortable discussing menstrual or genital problems with her mother or doctors.

21. Pooja, 19 years old, 12th standard

a. Unaware of DISHA clinics and their services (as well as her parents), but she did know of the nearby dispensaries and the Anganwadi centre.
b. Receives IFA tablets for anemia at school but is unaware of their purpose. When explained to her she does not believe she is anemic.
c. Menstrual cycle began at age 14. Purchases sanitary napkins from the store for Rs. 30-35 per packet.
d. Comfortable discussing menstrual or genital problems with her mother and potentially a health centre.
e. Aware of condoms, but unaware of female contraceptives.

22. Aleema Imtiyaz, 19 years old

a. Studying a Bachelor's degree from Delhi University. Daughter of an ASHA worker.
b. Unaware of DISHA clinics and their services, andunaware of the local government dispensary. She noted that if a minor seek a doctor to discuss reproductive health a parent is required to consent and be present.
c. Comfortable discussing most issues with her mother but uncomfortable discussing sex or romantic relationships with either her sister, mother or doctor.
d. Incomplete knowledge of sexual issues. For examples she believes that AIDS may be spread through any physical contact.

23. Saadia (name changed), 20 years old

a. Studied until the 10th standard, dropped out after several friends dropped out due to a lack of belief in the efficacy of the school system.
b. Unaware of DISHA clinics and their services, but aware of the local government dispensary, and had attended for a stomach infection. Uncomfortable attending clinics due to a lack of female counsellor or doctor.
c. Received IFA tablets for anemia at school once or twice but was unaware of their purpose.
d. Menstrual cycle began 4-5 years ago. Received poor quality sanitary napkins from school, so purchases them from the store for Rs. 42 per packet.

e. Comfortable discussing menstrual or genital problems with her mother and issues of substance abuse with her friends.
f. Sexually active but has never used or is aware about contraceptives.

24. Shatarupa (name changed), 23 years old

a. Studied until the 10th standard, before dropping out due to contraction of typhoid, she did not pass exams to reenrol in school however she desires to return to receive an education and attend college.
b. Unaware of DISHA clinics and their services, but she was aware of the local dispensary and visited an Anganwadi centre when she was young. She has never heard of peer educators or medical counsellors.
c. Did not receive IFA tablets as she is not in school, but is unaware where else to source them. She does not believe she has any signs of anemia.
d. Menstrual cycle began a few years ago. Purchases sanitary napkins from the store for Rs. 30-35 each.
e. No knowledge of female contraceptives but is aware of male condoms.

25. Shivali, 23 years old, Resident of Seelampur

a. Studied until the 10th standard and dropped out, but she is planning to reenrol and complete the 11th and 12th standards.
b. Unaware of DISHA clinics and their services, but aware of the local government dispensary. Uncomfortable attending clinics due to a lack of female counsellor or doctor.
c. Received IFA tablets for anemia at school but was unaware of their purpose. Also received tablets weekly from the local Anganvadi centre, before the service stopped a year ago.
d. Menstrual cycle began when she was 16. Received sanitary napkins from school for free. Mother convinced her to replace them with cloth before she began to feel uncomfortable. She now purchases them from the store for Rs. 35 per packet.
e. Sexually active but has never used or is aware about contraceptives except for condoms. Believes that condom use results in infection.

26. Arshi, 16 years old, Resident of Seelampur

a. Working at FIIR, an NGO
b. Little knowledge of HIV/AIDS, STIs, the concept of sex or contraceptives. Only discussed briefly with friends and has grave misconceptions regarding the transmission of HIV.
c. She expressed her interest in assisting the team in the fact-finding team and consequently she went to Jag Pravesh Chandra Hospital, Shastri Park for two days, one of the locations for the DISHA clinics.
d. She went between 2PM-3PM when the clinic was theoretically open, however the clinic was locked. It is advertised that it is open every Monday, Wednesday and Friday between 2PM-4PM. She attended the next day and was told that the clinic did not exist, but she could go to the gynecology section which operated between 9AM-3PM. Otherwise her only option was to attend the emergency department.

A2. BOYS:

Prakash, 17 years old, Resident of Seelampur

- Law student and aspires to the UPSC
- Unaware of DISHA clinics, but aware of the local dispensary. Does not receive assistance from either the dispensary or the Anganwadi centre.
- Receives IFA tablets from school however was unaware about anemia.
- Experienced bodily changes including physical growth and hair growth and is knowledgeable on puberty and male development.
- Comfortable discussing genital problems with friends, family and health care centres.
- Attracted to females and indulges in masturbation.
- Knowledgeable about contraceptives and their uses.

Satya, 15 years old

- Aspiring actor
- Unaware of DISHA clinics. However he received polio drops from Anganwadi workers.
- Has not experienced bodily changes.
- Comfortable discussing genital problems with mother and friends and willing to attend healthcare centres.
- Receives IFA tablets from school however does not consume them and was unaware about anemia.
- Attracted to females and indulges in masturbation. Knowledgeable about contraceptives and their uses.

Manjeet, 17 years old

- Aspiring dancer
- Unaware of DISHA clinics and hesitant to approach healthcare centres due to excessive crowds and long waiting times. Does not receive assistance from school or Anganwadi centres
- Experienced bodily changes including the growth of a beard, moustache and pubic hair.
- He is unaware of anemia and its causes.
- Comfortable discussing genital problems with his friends, but not his family.
- Indulges in masturbation
- Aware of men's condoms however uninformed about their exact purpose.

Vikash, 20 years old

- Aspiring actor
- Heard the name 'DISHA' however unaware of what it is. Not receiving any assistance from any Anganwadi centre or schools.
- Experienced physical and mental changes and feels able to think critically.Has experienced genital problems in the past.

- Receives IFA tablets from school however unaware of their purpose.
- Comfortable discussing genital problems with his mother and potentially his friends and healthcare providers.
- Indulges in masturbation
- Aware of contraceptives

Pavan, 17 years old, Resident of Seelampur

- Unaware about DISHA clinics. He has eaten food from Anganwadi centres.
- Experienced physical growth in his body. He has never experienced any genital problems.
- Uninformed about anemia.
- Comfortable discussing genital problems with friends and family but not healthcare centres.
- Does not indulge in masturbation
- Aware of contraceptives used by both males and females.

A3. OBSERVATIONS

- **GIRLS:**

  All the girls lived in the vicinity. A total of twelve girls participated in the session. Most of them studied or had previously studied in the local government school. A majority of the adolescents were school drop-outs or intendedto drop out in the comingyears. They stated that they considered education futile in terms of fulfilling life's ambitions and the results it yielded.

  All of the girls were aware of the presence of the government dispensary in the vicinity but were unaware of DISHA clinics or the government initiated RKSK scheme. There was a general unawareness of why the IFAtablets were being provided in school. Due to peer pressure and a lack of understanding about the purpose and benefits of the consumption of such tablets, a few girls did not consume them.

  Most females were unaware of contraceptives and their use. The limited few that were informed, had misconceptions about them. None used contraceptives despite being sexually active. Many who adopted modern methods of sanitary and menstrual hygiene after being introduced to such methods in school, later returned to more traditional methods after being convinced by their mothers. The girls addressed issues in the individual session, which they stated they were wary of discussing with their parents or friends.

- **BOYS:**

  All of the boys were local residents. A total of five male adults participatedin the session. The reason for such low participation among boys is likely due to a lack of will to attend such sessions. Most of them study in government schools. A few of them told volunteers that they had failed in either class 10^{th} or 12^{th} and are now trying to procure their degrees from open schools.

  The most challenging issue that came to light during this session was the lack of awareness among all boys about DISHA clinics. They knew about the local dispensary but rarely heard or had seen anything related to DISHA clinics. None of them knew of the RKSK scheme, which was launched by the central government in 2014. They had witnessed the distribution of IFA tablets in their schools. However, they revealed that hardly any studentstook them. The reason for this, as they informed the teamwas that they were uninformed about the purpose for taking IFA tablets.

  None of them seemed completely aware of the nutritional health requirement, nor were they informed about the risk ofanaemia. The paradox is that the government claims to have trained peer educators, however, none of them knew about any of their friends or any person in their age group who may have received any such training. One of them also told volunteers that they were actually sexually active, and one even admitted that he would go to sex workers to fulfil sexual desires. During the group interaction, it came to light that people in their locality indulge in substance abuse and there is no functional mechanism to inspect, regulate or to dissuade this young generation to give up such practices. They seemed informed about contraceptives. It appeared from the discussion that they used to watch porn videos, and they would also engage in masturbation frequently. With respect to any genital issue that they had ever experienced, most of them had not experienced a medical condition, and if they had, then they would have preferred approaching friends and family. Nevertheless, many of them were open to approach dispensaries and health care centres. There was acomplete unawareness ofpresence of counselors in the local clinics.

A4. RECOMMENDATIONS

1. **Creating awareness:**

- All efforts must be made at the ground level to create awareness about governmental schemes.
- Along with carrying out functional activities such as distributing contraceptives, sanitary napkins or IFA tablets, the consumers must be informed and sensitized tothe purpose and need to benefit from their consumption.
- These awareness programs must be carried out frequently through social media, local newspapers, local television as well as local radio channels.
- A framework must be designed to incorporate any such awareness programs as part of school curriculums.
- Schools should hold sessions highlighting the benefits of particular schemes and the detriments of a failure to adhere to it. This should be done to ensure compliance with the schemes amongst adolescents.

2. **Implementation of schemes:**

- A local task force should be constituted to assess the adolescent health requirements, facilities that they use, and to inspect awareness programs in schools, localities and health care centres.
- There must be a work assessment of peer educators.
- Police must remain vigilant on substanceabuse among teenagers.
- Private counselors, social activists as well as other private actors must be encouraged to engage inadolescent welfare programs and must serve tokeep a check on the clinics and other health care centres.
- The government should ensure the presence of female counsellors / doctors in every dispensary for the efficacious serviceon female psychological, mental, health and nutritional issues.
- The sessions held in schools should be more inclusive i.e. parents of the adolescents should all also be part of the target audience. This should be done to increase the productivity of the scheme.
- Such DISHA clinics should be opened in government schools. This would increase accessibility and accountability.

B. DISHA STAFF/ OTHER STAKEHOLDERS

The team visited the Delhi Government Dispensaries (DGD) at Raghubir Nagar and Seelampur. When the team visited, as a doctor had previously advised, the scenario at the dispensaries was the same, with a long queue of people waiting at the dispensary counter to access medicines.

B1. Raghubir Nagar

In the case of the Raghubir Nagar visit, the team did find that Auxiliary Nurse Midwives (ANMs) were available tomanage counselling services. Since the General Physician (Doctor) was busy checking patients,as part of the Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA) program, the intern decided to interview the ANMsfirst, based on the preset questions.

There were three ANMs who had their duties there and all of them waslooking after the counselling services.

Their names and contact numbersare as follows: -

Name of the ANM	Contact
Neeraj	882917210
Sudhesh	9013118870
Sharda	9971213611

One of the most important questions that were asked: “What are the different types of counselling services on offer?”. One of them answered as followed:Nutrition, Skin, Pre-marital Counselling, Sexual problems, Contraceptive, Abortion, RTI/STI, Substance Abuse, Learning Problems, Stress, Depression, Suicidal Tendency, Violence/ Aggression, Sexual Abuse, Other Mental Health Issues.

The intern then asked whether they had gone to training sessions specifically in counseling. They replied in the negative. It was a simple two-year formal training of ANM that they went after 10^{th} or 12^{th}.

One of the ANMs shared the story of an adolescent girl who had come to live in the JJ slum cluster and had been impregnated by her boyfriend. The ANM recalled scolding the girl, asking why she got addicted to sex, as it is really bad before marriage. She went on to say to her that she had done horribly wrong and that the parents needed to be told about the pregnancy. This raises several ethical concerns related to confidentiality in these clinics. These clinics are supposed to be an asset, encouraging young adolescents to seek guidance and help and avoid being judged or rebuked the staff.

It clearly showed the urgent need for the appointment of a qualified counsellor to these clinics who could do justice to the integrity of the counselling services.

"The ANMs were not to be blamed" because they've had the same traditional socialization that most of us have in our societies and families that make sex- such a big taboo to be talked upon. Even later, the General Physician appointed at that place to express the need of a counsellor at these clinics.

- ANMs said that they have participated in outreach activities with the Anganwadis of the JJ clusters of Raghubir Nagar, by mobilizing adolescent girls and giving them awareness sessions on nutrition, menstrual health hygiene, personal hygiene etc. No ASHAs are working with them on this scheme.
- But they said that they did not distribute sanitary pads and other related medicines. Even the government dispensaries do not, though they can avail medicines from them.
- On being asked about the operation of DISHA clinics under RKSK, ANMs commented that they had only begun operating 4-5 months before. This is despite the claim on the Delhi Government Health and Family Welfare Portal that the scheme began in 2014.
- When asked about their outreach to nearby government schools, they answered that School Health Nurses (SNPs) are in charge of taking care of adolescent health and their related issues and concerns, therefore they did not visit schools.
- The DISHA clinics were only open on Saturdays between 9:00am to 12:00pm. But they do offer entry to adolescents if they happen to come with their mothers on other days.

- The number of adolescents attending the clinic was very low, usually between 12-20 every month.
- The age group of regular adolescents visiting the clinic was 13-17 years.
- Most of the individuals who used counselling services sought assistance in regard to nutrition, menstrual pain, learning problems and anemia. Cases of sexual abuse, teenage pregnancy or RTI/STIs were extremely rare or even reported.

An intern then interviewed Dr. Leena Raut, the doctor appointed to managing the clinical services of the DISHA clinic. She is an 'all in one' multipurpose doctor. On her other days on duty she looked after cases of maternal, child and elderly health problems and was usually overloaded with the patients. She also suggested that the operation of DISHA clinics is simply a secondary scheme, which are run on Saturdays as few adolescents attend.

This clearly reflects the unpopularity of DISHA clinics in nearby communities. Therefore, it is now appropriate to ensure that there is more sensitization and awareness about these clinics in the communities of Delhi.

The majority of reasons offered by girls to explain their attendance included: -

- Access to IFA tablets- to combat anaemia
- Nutrition
- Menstruation
- RTI-UTI infections
- Contraceptive Knowledge
- Immunization (Tetanus)
- Antenatal Care (ANC)

B2. SEELAMPUR

1. Safiya Begum (Imtiyaz) - ASHA worker

Safiya is an ASHA worker and a mother of four girls. She previously worked in Brahmpuri, but is now working in the Jaffarabad area. When asked about DISHA clinics, she said that the clinic she is affiliated with - at Jaffarabad Indra Chowk - has a board advertising the operation of DISHA clinics on Saturdays from 2 pm to 4 pm. However, she reports that no such clinic is actually functional. There are no doctors or peer educators present at the prescribed time to see girls and converse with them regarding

their concerns. Further there is no counseling them on matters of romantic relationships, safe sex practices, contraceptives and sexually transmitted diseases.

Safiya also added that ASHA workers were rarely provided condoms or sanitary napkins to distribute to girls and women in the area. ANMs and AWWs could provide condoms to girls who visited the dispensaries and asked for them. She noted that the last time ASHAs received condoms to distribute during field visits was over a year ago.

Upon discussing government schemes for pregnant women (like JSY, JSSK and PMVVY), Safiya informedthe team that getting the incentive payments from government officials was no less than a herculean task. When women went to register their pregnancy, officials told them that no incentive based schemes existed and they had no government directives to make payments to pregnant women. They were asked to produce letters from MLAs (in this case, Haji Ishraq) in order to proceed with registration which was no easy feat and could often take a lot of time. Moreover, ASHAs rarely received the benefits they were promised to assist women, and frequently they worked for absolutely no pay. Officials merely said that they would be paid eventually, but provided no concrete answers. In some cases, they were told that their payments would only be processed once the pregnant women had received the cash they were entitled to upon completion of ANC, delivery and postnatal care. However, as the women never saw this money, ASHAs lost their wages too. Moreover, although there have been government reports regarding increased incentives (for instance, Rs. 400 per delivery instead of the previously stated Rs. 200), there were no such increases in reality. Safiya received her last payment in April 2017. She has received no payment since in despite following all necessary protocols, including linking her Aadhaar Card as required.

Especially in regard to the Jag Pravesh Chandra Hospital, it was found that no one knew whether the clinic called DISHA was functional under RKSK or not.

The adolescent girl previously described, Arshi, who lived in Seelampur, went twice to seek consultation and treatment. But each time, she was told by the hospital authorities that there was no DISHA clinic in operation there. The plant operator named Ram Singh, to which the girl applied to during her last visit, was absolutely adamant that such a clinic existed or offered such services.

B3. FINDINGS:

- The ANMs explained that there was no alternative set up for theDISHA Clinic. It was conducted in the dispensary itself, which was already cramped.
- ANMs never had anytraining in the followingcounseling services: Nutrition, Skin, Pre-marital Counselling. Contraceptive, RTI/STI, Abortion, Substance Abuse, Learning Problems, Stress, Sexual Abuse, Depression Suicidal Tendency, Violence/ Aggression and Other Mental Health Issues etc.
- There was no qualified counselor appointed in the DISHA Clinic to provide counseling services on the above topics.
- The human resources in the dispensary included a general physician (doctor), three ANMs, who were alreay burdened with other flagship programs of the PMSMA, Indrahanush and daily data entry employees.
- No staff member was solely dedicated to the DISHA clinic.
- The opening times of DISHA Clinics throughout Delhi were only on Saturdays between 9-1pm.
- There was no outreach awareness campaign about RKSK's DISHA Clinics in the community. As a result, most people in the community were completely unaware of its existence.
- As ANMs confirmed, laboratory technicians were usually not present on Saturdays, which created trouble for both the doctor and nurses to have tests conducted for adolescents, especially that of the Hb Test. This restricted the possibility for them to be diagnosed as there would not be any test results and if they did have a condition they could not be treated at all.
- In Seelampur area, the dispensaries and hospitals the team visited provided no clear, practical information regarding the operation of DISHA clinics, or whether they were functional.
- Interviews with an ASHA worker revealed that in the Seelampur area, although dispensaries had a sign suggesting the presence of functioning DISHA clinics, there was no such facility available and no staff available for consultation at the advertised timings.

4. RELEVANT GUARANTEES AND GUIDELINES

National and international laws protect adolescents in India, so that they mayhave their right to health services respected, protected and fulfilled. This is fundamental to both their overall wellbeing and ability to live a life of dignity, and is crucial for the preservation of our future society in general. This is recognised by the Indian government, other States' governments and intergovernmental organisations, as is evident below.

A. INTERNATIONAL CONVENTIONS:

"In a globe where more than 3000 adolescents die every day…[and] 1.2 million adolescent deaths per year", [7] it becomes necessary to examine the existing international framework to curve such a global catastrophe. Various studies suggest that most of the deaths take place in under developed or developing countries. The prevailing cause for these deaths is the colossal lack of available resources and social awareness to provide for the welfare of adolescents' health. These conditions create a compelling case for countries to share a common platform to discuss challenges, issues and various possible ways to combat such a horrendous situation. This was further reinforced in 2015, by the explicit reference to the improvement of adolescent health as one of the Sustainable Development Goals (SDG 3).

Challenges pertaining to adolescent health call for a dual perspective: adolescents are rights holders, and relevant stakeholders have obligations as duty bearers. At the Vienna Conference on Human Rights (1993) child rights were recognized as indivisible, interrelated and interdependent. The Convention for the Rights of the Child 1989 (CRC) seeks to provide special measures for children's protection, the fostering of their abilities and building of their capacity to evolve so they may have their rights fulfilled (Article 5). The Convention further imposes legally binding obligations upon the states to ensure equal access to rights set out in the convention (Article 2). Article 12 articulates that it is the obligation of parents and other stakeholders involved in the child's development process to develop a conducive environment to enable a child to express his or her views freely. In accordance with

[7] http://www.who.int/en/news-room/detail/16-05-2017-more-than-1-2-million-adolescents-die-every-year-nearly-all-preventable

the provisions mentioned in the CRC, states need to ensure that administrative, legislative and other appropriate mechanisms are invested in.

Health is a dominant aspect of life and must acquire due recognition on all relevant platforms for individual and group needs and issues to be addressed appropriately. In 2015, the World Health Organisation (WHO) provided solid evidence of the fragmented and poorly coordinated health strategies across the developing and under developed world. In the same year WHO laid down the standards to be adhered to while formulating nationalframeworks to address health issues. WHO recognizes the following rights for youth in its 2015 recommendations:

- Care that is considerate, respectful and non-judgmental of the adolescent's unique values and beliefs.
- Care that is respectful of the adolescent's need for privacy during consultations, examinations and treatments.
- Protection from physical and verbal assault.
- Information that is confidential and protected from loss or misuse.
- Non-discrimination, which is the right of every adolescent to the highest attainable standard of health and quality health care, without discrimination of any kind, irrespective of the adolescent's or his or her parent's or legal guardian's race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin,property, disability, birth or other status.
- Adolescent participation in care processes.[8]

At the 11thWorld Congress of the International Association for Adolescent Health in 2017, a youth charter was presented. It outlined eight key sectors to focus upon to enhance adolescent health. The prioritized areas of adolescent health as acknowledged by the youth charter are:

1. Sexual and Reproductive Health and Rights, including access to safe abortion;
2. Rights-based, age-affirming Comprehensive Sexuality Education;
3. Gender-based Violence;

[8] www.who.int/maternal_child_adolescent/documents/global-standards-adolescent-care/en

4. Mental Health and Suicide;
5. Adolescents and young people in humanitarian settings;
6. Sexual orientation, gender identity and expression (SOGIE)
7. HIV/AIDS; and
8. Non-communicable diseases.[9]

About 40 years have passed since WHO's 1978 Declaration of Alma-Ata, made at an international conference on primary health care. Yet achieving its goalsand challenging the status quo seems far from reach. Nevertheless this declaration revealed the need for urgent national and international steps to protect and promote public health. It was understood that health is a fundamental human right and improving public health is the largest social goal whose realization requires a holistic and global approach.

International stakeholders have worked tirelessly to keep adolescent health at the centre of public health frameworks in the latter part of the 20th century.However, implementation and evaluation of strategic health initiativeshave not received sufficient investment. Academic studies reflect the dark side of the current state of adolescent health. The Ottawa Declaration was signed in 1998 and itsPreamble of the said declaration speaks: "Science has now proven that to reach their potential, children need to grow up in a place where they can thrive – spiritually, emotionally, mentally, physically

And intellectually, that place must have four fundamental elements:
• A safe and secure environment;
• The opportunity for optimal growth and development;
• Health services when needed; and
• monitoring & research for evidence-based continual improvement into the future.[10]

[9] http://www.who.int/pmnch/media/news/2017/investing-in-adolescent-health/en/
[10] https://www.wma.net/policies-post/wma-declaration-of-ottawa-on-child-health/

B. PROVISIONS FOR ADOLESCENTS UNDER THE INDIAN CONSTITUTION

The Constitution of India provides that children and/or adolescents are persons before the law and are entitled to equal protection of laws, rights and guarantees.

- Article 14 of the Constitution provides for equality before the law and equal protection of laws thereby making room for all persons to have an equal right to access and benefit from public services. Across the length and breadth of the nation, children and teenagers also hold this right.
- Article 15(3) allows the State to make special enactments and rules for the benefit of women and children and such enactments cannot be struck down on the ground basis of discrimination.
- Article 19(1) guarantees citizens of India the right to freedom of speech and expression, to form associations or unions, to move freely throughout the territory of India. Ignoring children's and adolescents' issues and problem will violate this right.
- Article 21 guaranteesthe right to health.. The Supreme Court, through liberal and expansive interpretation of the right to life has defined this right as includingthe right to health, dignity and medical assistance.
- Article 24 prohibits child labour, while Article 23 prohibits bonded or forced labour.[11]
- Article 39 (e) casts a duty upon the state to prevent children from being abused by economic necessity and from being forced, thereby, into occupations, which are not suited to their age and/or strength.
- Article 39 (f) reinforces an obligation on the State to provide equal opportunities and facilities to children (adolescents) to develop in a healthy manner and in conditions of freedom and dignity. Furthermore, this directive has potential to hold the State accountable for protection of childhood and youth against exploitation, and also for protection against moral and material abandonment.

[11]But the law does not provide for a blanket ban on employment of children. Children under 14 years of age can be employed barring in factories, mines or other hazardous employment including in domestic work; and adolescents in theage group 14-18years can be employed in abovementioned places under the conditions laid down in the respective industrial and labour Acts.

- Article 45 ensures that the State is obliged under this provision to take measures to ensure that the right to free and compulsory education is available to and exercised by all children till they attain 14 years of age.
- Article 47 promises that the State shall raise the level of nutrition, standard of living and public health for all.
- Article 51 (k) lays down a duty on the parents or guardians of children below 14 years of age to provide opportunities for the education to their child/ward.
- Article 51 (C) obliges the State to respect and to uphold international law and treaty obligations making all possible adjustments or changes in national law to accommodate universal principles contained under the Convention on the Rights of the Child and other child rights instruments.

C. DOMESTIC LAWS

***Indian Majority (Amendment) Act*, 1999**

Section 3 of the Indian Majority (Amendment) Act, 1999 provides that the age of majority for every Indian citizen shall be deemed to be attained by him/her on completing the age of eighteen years and not before. Those minors who are less than 18 years of age are dealt with differently by different statutes.[12]

***Right of Children to Free and Compulsory Education Act*, 2009**

The Right to Education Act, 2010 gives a statutory guaranteeof the fundamental right of every child between the ages of 6-14years to education.[13]This Act provides for the development of school curriculums in accordance with the values enshrined in the Constitution, and which would ensure all-round development of the child, increasing the child's knowledge, potential and talent and creating an environment in which the child is free of fear, trauma and anxiety through a system of child friendly and child centred learning.

However, poor enforcement of the law and its lack of specific provisions to ensure the physical and mental health of adolescents has failed to address the issue

[12]https://indiankanoon.org
[13]Constitution 86th Amendment Act, 2002 inserted new article 21A:"21A. The State shall provide free and compulsory education to all children of the age of six to fourteen years in such manner as the State may, by law, determine".

holistically. Anadolescent whether enrolled in a school or not experiences wide-ranging psychological, emotional, physical and mental transitions which need attention at school in addition to being attended to by parents, guardians or private caregivers.Education is a toolby which adolescents, who at threat of a multitude of dangers, can become intellectually bright and holistically healthy adults.

***Medical Termination of Pregnancy Act*, 1971**

The MTP Act of 1971 and the 2002 amendments to the Act have ensured women's right to terminate an unwanted pregnancy safely and confidentially. It allows women to seek a termination of pregnancy in a wide range of circumstances.If the pregnancy has resulted from rape, if the pregnancy has adverse health consequences for the woman, if there is evidence of fetal malformation, or if the pregnancy was the result of contraceptive failure, a woman may be eligible to seek a termination. Pregnancies of up to 20 weeks may be terminated legally; however, the concurrence of at least two physicians is required for pregnancies of more than 12 weeks' gestation. While the Act makes no distinction between the rights of the married and the unmarried, it does require that women under 18 must have parental consent.

Section 3(4) of the act specifies that no pregnancy of a woman, who has not attained the age of eighteen years, or, who, having attained the age of eighteen years, is a lunatic, shall be terminated except with the consent in writing of her guardian.

The aforementioned provision negates the confidentiality aspect and does not ensure the privacy of adolescents and makes difficult to exercise their right to terminate their pregnancy as mandated by the policy of Adolescent Reproductive and Sexual Health (ARSH), which can have adverse effects on their health.

The point on 'parental consent' defeats the entire purpose of ensuring adolescents, who have access to reproductive sexual health services as mentioned under ARSH and RKSK schemes, have their privacy protected.[14]

[14] tcw.nic.in/

***Domestic Violence Act*, 2005**

The Protection of Women from Domestic Violence Act came into force on 13th September, 2005. Section (b) of the act defines 'child' as any person below the age of 18 years and includes any adopted, step or foster child.[15] The Act provides a very comprehensive definition of domestic violence.Besides acts of abuse, it includes the threat of physical, sexual, verbal, emotional or economic abuse. The Act indirectly provides protection to children, who may also be victims of domestic violence, and also extends its protection to women who are sisters, widows or mothers.[16]

***HIV/AIDS Bill*, 2006**

The *HIV/AIDS Bill*, 2006, recognizes the right of children and young persons to access health services and information in their own right i.e., as individuals in their own capacity and not as a protected class of persons. Further the bill recognizes the right of children and young persons to improved access to HIV/AIDS Services for testing.The act also deals with issues such as human rights, special provisions for women, children and young persons, disclosure of information, social security, procedure in court and implementation.[17]

Definition of the 'Child'

Another important issue that remains unaddressed is the definition of a 'child',as different laws have different definitions – the *Child Marriage Restraint Act* defines a child as males who are under 21 years and females who are under 18 years while the *Immoral Traffic Prevention Act* considers those below 16 years of age as a child, while the *Juvenile Justice (Care and Protection of Children) Act* considers any individual who is below 18 a child (Jejeebhoy and Santhya 2011).The Indian Penal Code (IPC) contains no definition of the word "child".The age of sexual consent for a girl is 16 years under Section 375 of the IPC while for married couples the age of consent is presumed to be 15.Therefore, there should be a uniform definition of child in all legislation for the sake of uniformity and for the sake of protecting all children against child abuse.

[15] National Commission for Women, ncw.nic.in
[16]Integrated Child development Scheme, http://icds-wcd.nic.in
[17]Ministry of Women and Child Development, Government of India, *India: Third and Fourth Combined Periodic Report on the Convention on the Rights of the Child*, Government of India, 2011; also available at wcd.nic.in/crc3n4/crc3n4_1r.pdf

D. KEY POLICIES ADDRESSING THE SEXUAL AND REPRODUCTIVE HEALTH CONCERNS AND RIGHTS OF YOUNG PEOPLE

The National Population Policy (2000)

- The National Population Policy (2000) has confirmed the importance of protecting adolescents in terms of early marriage, teenage pregnancy and the use of contraceptives for spacing. It strongly recommends action to enforce the *Child Marriage Restraint Act* in order to reduce teenage pregnancies.
- It recommends the need for adolescents' access to sexual and reproductive health information, counselling and services that are affordable and accessible.

National AIDS Prevention and Control Policy (2002)

- It emphasizes the need to promote a better understanding of HIV infection and safer sexual practices among young people.
- The Policy stresses a variety of measures to prevent risky behaviour among young people including awareness building and condom promotion
- It advocates for the provision of HIV/AIDS education in schools and colleges through curricular and co-curricular activities.

The National Youth Policy (2014)

- The policy recognizes diversity among young people. It also acknowledges that within different age brackets within the age group of 16-30 years, the need of young people aged 16-21 years, 21-25 years and 26-30 years are different.
- The policy coordinates the approach to all sections of youth development, for basic nutrition and health services, especially related to reproductive and sexual health services; promotion of a healthy lifestyle, free of substance abuse and other unhealthy addictions, and dissuasion from engaging in harmful sexual practices.

National Policy for Children (2013)

- This policy was initiated to promote programs and schemes for children all over the country. The aforementioned policy recognises every child below the age of 18 as a

child who holds undeniable rights to survival, nutrition, health, development, education, protection and participation.

- The National Commission for Protection of Child Rights and State Commissions for Protection of Child Rights are made responsible to ensure that the precepts of the policy are adhered to in all sectors and at all levels.
- The Ministry of Women and Child Development will be the nodal ministry for overseeing and coordinating the implementation of the policy and will lead the review process.

National Health Policy (2002)

- The National Health Policy (2002) does not identify adolescents separately. Adolescents are grouped with children and pregnant women, which results in a misrepresentation of their concerns.

- The age specific health needs of the adolescents and young people are not focused on. It touches upon areas of awareness building among children attending school and college.

National Nutrition Policy (1983)

This policy aims to neutralise gender discrimination. In its implementation places greater emphasis on education as a tool to address the concerns of malnutrition and under nutrition.

National Education Policy (1992)

- This national policy on education aims at eradicating illiteracy, particularly in the age group of 15-35years.It discusses how population education may motivate young people about family planning and responsible parenthood in the light of population stabilisation.

- Various programs under this policy include – Sarva Shiksha Abhiyan, National Programme for Education of Girls at Elementary Level, Rashtriya Madhyamik Shiksha Abhiyan, and Inclusive Education for the Disabled at Secondary Stage and Saakshar Bharat for adult education.

National Policy for Empowerment (2001)

- This policy clearly identifies how gender discrimination appears in different stages of a woman's life with a specific mention of adolescents. It also focuses on the nutritional needs of women at all stages of life.
- It also focuses on the nutritional needs of women at all stages of her life. Early marriage in the light of maternal mortality has been given its due recognition.

The 12th Five-Year Plan

The 12thplan emphasizes the need to address the health, nutrition and development needs of adolescents. It recognises the diversity among adolescents and the challenges especially faced by adolescent girls,which includes early marriage, poor access to reproductive and sexual health, under nutrition, gender inequality, violence etc.

E. OTHER POLICIES AND PROGRAMMES

India is home to one of the largest adolescent populations in the entire world. The adolescent population plays a significant role in shaping its demographic dividends. The first comprehensive policy addressing the educational needs of children in the age group 6 to 14 was envisaged in the National Education Policy of 1986 (NEP). The NEP accepts that education is fundamental to the overall development of a child and hence aimed at achieving the following through the Integrated Child Development Scheme:

- Universal enrolment.
- Achieving universal retention in schools for children up to 14 years.
- Develop quality of education that facilitates learning.[18]

Practices such as child marriage, teenage pregnancy and lack of adequate knowledge with respect to health are rooted in Indian family culture. Various health topics such as menstruation and masturbation remain absent from public discourse.
Mostadolescent deaths occur due to preventable diseases. There is a dire need to address adolescent health in India to achieve health development and to counter

[18] http://www.childlineindia.org.in/National-Policy-on-Education-1986.htm

stereotypical beliefs. The relevant government policies that seek to improve the status of adolescent health in India are given below:

1. **Adolescent Reproductive and Sexual Health Program (ARSH):**

   This program intends to shape the existing health sector of India. By reorganizing the current health system it emphasises meeting the sexual and reproductive needs of adolescents, delaying child marriage, preventing early age pregnancy and addressing STIs and RTIs. The ARSH strategy focuses on building a conducive environment, supportive structure, creating knowledge, enhancing service providers' capacity and setting up a monetary mechanism to support adolescents. Under ARSH policy counseling services are provided at primary, secondary and tertiary level. It also aims to promotethe use of contraceptives, preventing STIs and RTIs and reducing morbidity and mortality.

2. **School Health Program:**

   This program was promulgated to specifically address the health needs of the school-attending children. It aims at early management of diseases, common deficiencies and disabilities. It involves an annual screening to school-going children aged 6 to 18 years. It seeks to address physical, mental as well as nutritional issues coupled with educational needs.[19]

3. **Kishori Shakti Yojana:**

   Bringing females aged 11 to 18 on a platform to enable them to become a recognised contributing members of society. It aims at promoting awareness about health, hygiene, family care and nutrition. The significant focus of the program is to achieve universal retention of girls in school. The program seeks to provide equal opportunity to realise their full potential, to strengthen skill development and enhance self-perception.[20]

4. **Integrated Program for street children:**

   This program seeks to provide assistance to develop skills of street children and to enhance their abilities and knowledge. Under this scheme program details such as

[19] http://www.nhm.gov.in/adolescent-health/shp.html
[20] http://wcd.nic.in/kishori-shakti-yojana

city level surveys, contact programs offering counseling, guidance and referral services, non-formal education programs, programs for vocational training, ICDS or Anganvadi programs for children older than six years, prevent destitution of children and provide them shelter and nutrition.[21]

5. **Adolescent Education Program:**

The Adolescent Education program (AEP) is an important initiative that aims to empower young people with accurate, age appropriate and culturally relevant information, promote healthy attitudes and develop skills to enable them to respond to real life situations in positive and responsible ways. The National Council of Educational Research and Training (NCERT) co-ordinates the program and works through both curricular and co-curricular formats to contribute toward the holistic development of young people in pursuance of the National Curriculum Framework, 2005. The National Popular Education Program (NPEP) is being implemented in 30 States and Union Territories. It aims to develop awareness and positive attitudes toward population and development issues leading to responsible behaviour among students and teachers and, indirectly, among parents and the community at large. Imparting authentic knowledge to learners about ARSH concerns, encouraging positive attitudes and developing appropriate life skills for responsible behaviour are also objectives of NPEP.[22]

6. **National Program for Youth and Adolescent Development:**

This program aims to develop and promote leadership skills among young people. Apart from this, the program seeks to channel young people's energy towards the nation building process.[23]

7. ***Narcotic Drugs & Psychotropic Substances Act*, 1985:**

This legislation not only prohibits the sale of drugs to minors but also abolishes the usage, production, cultivation or possession of any narcotic, psychotropic drugs and substances. It covers a wide area of operation as it applies to every citizen inside and outside India as well as persons working on ships and aircraft registered in India. Narcotic substances include all types of plant–based products

[21] https://www.india.gov.in/integrated-programme-street-children-ministry-women-and-child-development
[22] http://mhrd.gov.in/adolescence_programme
[23] https://pibindia.wordpress.com/tag/national-program-for-youth-and-adolescent-development/

such as opium, codeine, heroin and synthetic narcotics such as methadone, pethidine as well as cannabis, coca and cocaine.[24]

F. EXAMPLES OF BEST PRACTICE TARGETING ADOLESCENT HEALTH

1. India

Since the development of the NAHS in 2014, several states have begun to implement programs to address health problems for adolescents at a systemic level with funding from international organisations and the National Health Mission. In Madhya Pradesh, the state government initiated the 'Lallima' program, targeting 7.4 million adolescent girls "integrating social mobilisation and interpersonal counselling by an Anganwadi worker, community theatres, distribution of iron and folic acid tablets, deworming and menstrual hygiene management". [25] In upper Assam, 8951 adolescent girls, aged 10-19, were encouraged to participate in 63 tea gardens across 298 Aganwadi centres to build capacities on life skills, nutrition, education, distribution of IFA tablets, kitchen gardens and health education sessions. Other states have implemented different awareness strategies. For example in West Bengal, with the assistance of UNICEF, the 'Life Skills Education' manual, which included material on health, hygiene, menstrual myths and practices, which could be rolled out on digital programs and through outreach programs in schools.

The government of Gujurat commissioned a budget analysis, comparing Gujarat with Maharashtra, Tamil Nadu and Karnataka, states that have comparatively high levels of health and nutrition indicators, and concluded that there was a definitive correlation between greater budget allocation to investment in Adolescent programmes and healthier populations. These are just some of the innovative approaches that are being taken by state governments, in collaboration with both national and international actors, and the sheer scale and holistic approach has already yielded high participation rates, particularly among adolescent girls.

[24] https://blog.ipleaders.in/analysis-narcotic-drugs-psychotropic-substances-act-1985/
[25] UNICEF, *Annual Report 2017: India,* p. 31.

2. Globally

Tackling adolescent health issues, particularly those related to sexual practices and the risk of HIV, STI transmission and unwanted, have led to several national efforts and campaigns across developing countries.Overall, academic studies have found that the majority of adolescent sexual health reproduction interventions "have had a positive impact on…knowledge and attitudes, and more often than not have had a positive behavioural impact".[26] It seems to also indicate that apathy or no action on these issues will neither solve the issue nor lead to an increase in the level of sexual activity. A Lancet report indicated that in order to maximise the capacity of health clinics for adolescents "more must be done in the way of community outreach for facility-based, services or, alternatively, finding ways of providing these services in less threatening/more socially acceptable environments".[27] Nevertheless, there are several examples of programs that have been successful in this endeavour.

a. Tajikistan

In 2006, the government of Tajikistan established, scaled up and integrated the 'Youth Friendly Health Services' program, which is comparable to the NAHS. Its aim was to change and address risky behaviours in youth through the provision of quality and friendly services, which were directly embedded in the existing health system. From the outset, youth volunteers and peer-to-peer outreach workers, were involved in the establishment of the centres, decorating them and starting flash mobiles in order to disseminate information about their existence, location and the package of free services on offer.[28] Part of the success of the program rested on the collaborative efforts of the public health system, adolescents, NGO workers and civil society. Almost half of the program's clients were alerted to the services through outreach activities. In the period 2010-2013, 71 327 adolescents accessed services through the program and there appeared to be a trend of 1.7 time annual increase.[29] The majority of clients came from 'vulnerable groups', particularly female adolescents. The program also instigated a regular monitoring

[26]The Lancet, 'The Effectiveness of Adolescent Reproductive Health Interventions in Developing Countries: A Review of the Evidence', 2003, p. 22.
[27]Ibid.
[28] UNICEF, 'Youth Friendly Health Services Program in Tajikistan 2006-2013', 2014, p. 8.
[29]ibid, p. 10.

mechanism and throughout the period adjusted elements of the program and training techniques to respond to gaps revealed by the data. The continued success of the program is universally acknowledged however UNICEF admitted that long-term sustainability rested on further government spending.

b. China

In anticipation of World AIDS Day, a pilot programme in Jiangsu in China sought to improve and enhance the efficacy of existing health services on offer to adolescents through a 'Walk-in HIV testing' day at school clinics, community health centres and Voluntary Counselling and Testing Centres. The experience also aimed to determine how high the 'quality' and 'friendliness' of existing services were in creating a safe space for youth. Also, the programme served to increase awareness among the 700 youth who attended, health practitioners, and other service deliverers about the specific needs of adolescents in the area, in order to improve future services. This is a good example of how to simultaneously conduct research on the health needs of adolescents, provide testing and raise awareness within the community generally.[30]

c. Brazil

In Brazil, it is evident from a case study in Fortaleza, of a young boy named Rodrigo Xavier, that the potential for peer educators to create a positive effective change is great.[31] At age 15, Rodrigo was trained as an 'Adolescent Health Agent', and was trained in both health and communication skills to facilitate comfortable discussions with his peers about sex, pregnancy, drugs, HIV and alcohol. He became a point of contact for several adolescents, and began to direct them to health clinics to have testing done, and even in some cases adolescent girls who were nervous about the experience had him accompany them. Rodrigo is a perfect example of how peer educators may operate as a hub point of contact to both educate and serve as a gateway to access other health services.

[30]UNICEF, *Annual Report 2017: China*, p. 52.
[31]Kent Page, 'Young Health Volunteer Tackles HIV Among Adolescents in Brazil', UNICEF, July 2014, https://www.unicef.org/infobycountry/brazil_74426.html.

5. CONCLUSION

It is evident from the findings of this fact-finding mission that the current state of the operation, or rather lack thereof, of DISHA clinics is grossly inadequate and failing to meaningfully impact adolescents and communities across districts in Delhi.There is a dire need to address the poor health indicators among adolescents and the DISHA program could certainly fulfil a pivotal role in this strategy. In theory, its aspirations are comprehensive

However, on the ground it is clear that adolescents are unaware of the clinics' existence, are hesitant to address these issues in general and are insufficiently informed about their health needs and risk-taking behaviours. Staff from ANMS, doctors and ASHAs, who are tasked with managed and working in DISHA clinics are both untrained and currently incapable of providing a non-judgmental environment in which adolescents' privacy and wellbeing come first and foremost. Further, the very fact that the opening hours of these clinics are so negligible signifies a lack of genuine financial, social and political investment in the initiative.

Recommendations:

- **Create awareness among adolescents at the ground level through community campaigns on the availability of DISHA clinics and other governmental schemes.**
- **Distribute more contraceptives, sanitary napkins, IFA tablets, other medicines and devices with accompanying information on their purpose and use to ASHAs and other social health activists to provide to adolescents.**
- **Enhance DISHA clinics' capacities in order to create a safe space for all adolescents, mirroring other national programs.**
- **Use social media, local newspapers, local television as well as local radio in order publicise campaign messages related to public health issues for adolescents.**
- **Integrate education on these issues into school curriculums and ensure that ASHAs and ANMs also participate in local outreach to schools and colleges.**
- **A local body should be established to monitor all available adolescent health schemes and determine whether communities' health needs are being met, including assessment of peer educators.**

- **Police should be informed of the current rise in substance abuse amongst teenagers and remain vigilant to tackle the problem.**
- **Qualified counsellors must be made available at DISHA clinics to specifically address the needs of individual adolescents.**
- **Female nurses, doctors and counsellors should always be available at clinics and dispensaries in order to ensure that young women feel comfortable disclosing personal problems in the clinic setting.**
- **Communal sessions discussing public health concerns and current government schemes for adolescents should be regularly held and involve and empower adolescents, their parents, teachers, doctors and other health practitioners. This requires leadership from both local councils, school management and clinic employees.**

6. PICTURES

HRLN interns interacting with adolescent Girls at Seelampur Temple.

HRLN interns along with adolescents and Asmita Social Welfare Organization members at the Seelampur Temple.

HRLN interns interacting with Adolescent Boys at Seelampur Temple.

Entrance to the DISHA Clinic located at Seelampur


स्वास्थ्य सेवा निदेशालय
दिल्ली सरकार सीलमपुर औषधालय
समयः सुबह 8:00 बजे से
सांय 2:00 बजे तक
किसी भी सुझाव व शिकायत के लिए समर्क करें
1- प्रभारी चिकित्सा अधिकारी - 011-22826102
2- मुख्य जिला चिकित्सा अधिकारी - 011-22116203
3- निदेशालय स्वास्थ्य सेवाएं - 011-22309220
PWD M 222
पोलियो रविवार
2 जुलाई 2017
कमरा 1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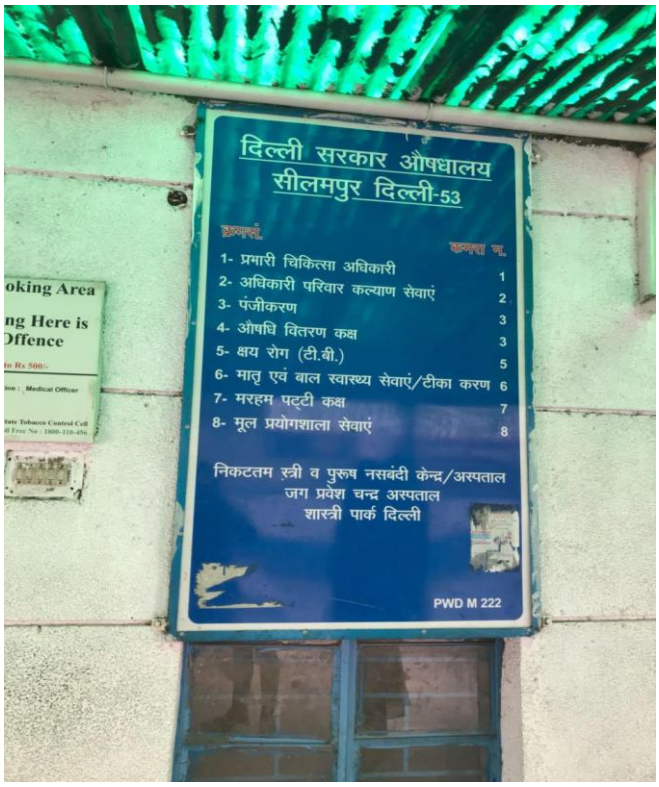
किशोरावस्था स्वास्थ्य सेवायें उपलब्ध
प्रत्येक शनिवार दोपहर 12 बजे से 2 बजे तक
ADOLESCENT HEALTH SERVICES AVAILABLE
EVERY SATURDAY 12.00 PM TO 2.00 PM
LAB
ROOM
3


दिल्ली सरकार औषधालय
सीलमपुर दिल्ली-53
1- प्रभारी चिकित्सा अधिकारी 1
2- अधिकारी परिवार कल्याण सेवाएं 2
3- पंजीकरण 3
4- औषधि वितरण कक्ष 3
5- क्षय रोग (टी.बी.) 5
6- मातृ एवं बाल स्वास्थ्य सेवाएं/टीका करण 6
7- मरहम पट्टी कक्ष 7
8- मूल प्रयोगशाला सेवाएं 8
निकटतम स्त्री व पुरुष नसबंदी केन्द्र/अस्पताल
जग प्रवेश चन्द्र अस्पताल
शास्त्री पार्क दिल्ली
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