Adopting a convergent approach for strengthening implementation of

Rashtriya Kishor Swasthya Karyakram

CHETNA's experiences

CHETNA™

For Women Young people Children

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Context

Improving health of adolescents is a key component of India's National Health Mission. India is home to about 253 million adolescents (10-19 years of age) who hold the future of our country. Behaviours formed at this age have a long lasting influence on health and morbidity across life, hence care during this crucial phase is important as it can significantly affect the nation's growth and development. Realizing the advantage of this demographic dividend, the Government of India launched a national programme for adolescent health in 2014. The programme titled Rashtriya Kishor Swasthya Karyakram (RKSK) aimed to educate, train and gainfully engage adolescents to match their expectations and needs. RKSK expands the scope of adolescent health programming in India beyond sexual and reproductive health to nutrition, injuries mental health, injuries and violence (including gender based), substance misuse and non -communicable diseases.

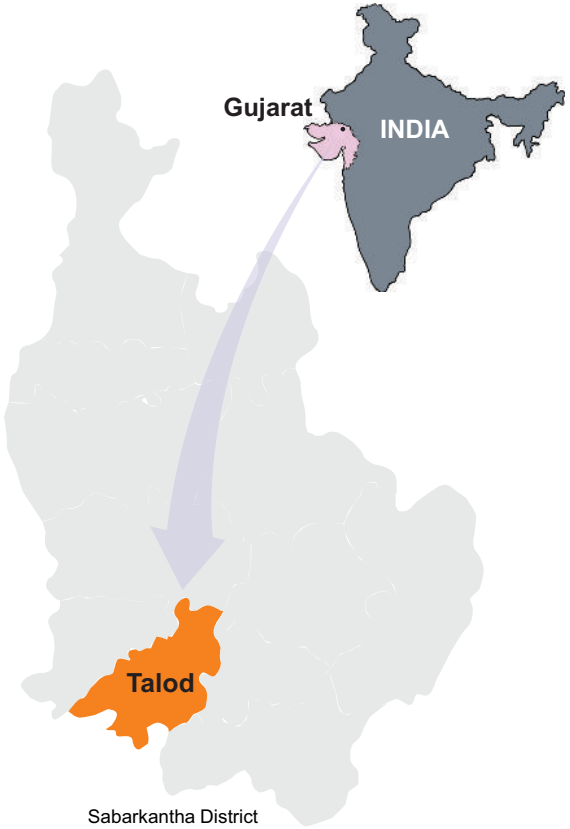
CHETNA's Adolescent Health intervention was aligned with RKSK, though with slight modifications.

This programme brief highlights our experiences of using a convergent approach to strengthen the programme implementation in rural Gujarat. It includes our reflections on what worked for us, our challenges and what is needed for improving programme outcomes.

Project Period: Three years (2013-2016)

Reach: In school and out of school adolescents (10-19 years), boys and girls, married or unmarried and vulnerable groups. The project reached to 15000 adolescent boys and girls in the intervention area.

Geographic coverage: 73 villages of Talod block, Sabarkantha District of Gujarat State.



About RKSK

RKSK (Rashtriya Kishor Swasthya Karyakram –National Adolescent Health Programme), has been developed to strengthen the adolescent component of the RMNCH+ A strategy. The RKSK strategy focuses on health promotion and prevention activities rather than on curative care for adolescents through established platforms such as front line functionaries and youth clubs. Thematic areas of the programme includes nutrition, sexual & reproductive health, injuries and violence (including gender based violence), non-communicable diseases, mental health and substance misuse.

Objectives:

- Improve Nutrition
- Improve Sexual and Reproductive Health
- Enhance Mental Health
- Prevent Injuries and Violence
- Prevent Substance Misuse

As per the programme implementation guideline, at the community level Peer Educator (PE) approach has been identified as one of the key approaches. Peer Educator's are trained on the six thematic areas of RKSK, to serve as a source of sensitization and referral to experts and services.

PEs are expected to constitute Adolescent Health Club at sub-centre level, under the overall guidance of ANM. These clubs will meet monthly to discuss issues of PEs and get support from ANM. In order to ensure the sustainability of the PEs, PEs will be linked to ASHAs who will play a facilitator's role and create an enabling environment for the PEs.

ASHAs and ANMs are expected to provide information, services and commodities at the community level and make appropriate referrals to Adolescent Friendly Health Clinics (AFHCs). They serve as the first point of contact for the adolescents.

Adolescent Health Day (AHD) is expected to be organized in every village once every quarter. During an AHD, Information about Nutrition, SRH, Mental Health, GBV, NCD, Substance misuse are imparted. Sanitary Napkins, IFA, Albendazole, anti-spasmodic tablets, contraceptives will be distributed. General health checkup, (BMI, anaemia , hypertension and diabetes) is expected to be done and referral to AFHCs is done.

Source: Guidelines for Implementation of RKSK, Adolescent Health Division Ministry of Health and Family Welfare, New Delhi

Reflections
What worked for us?

- **Using existing opportunities and workforce:** Our past experience suggested that peers need to be trained on a continual basis, need more supervision for counselling, maintaining confidentiality and referrals. This affects the program quality. Hence instead of relying on peer educators to facilitate correct information, we made efforts to work closely with schools. We trained school teachers who took initiative to impart health education among their students. We trained ASHA and Anganwadi Workers (AWWs) jointly, who imparted nutrition and health related information especially to non-school going girls.

- **Comprehensive RKSK delivered at school settings:** The RKSK guideline mandates organizing Adolescent Health Day (AHD) every quarter at Anganwadi Centre (AWC) or during Village Health and Nutrition Day (VHND). However, organizing AHD at AWC or during VHND limits the scope and reach of the program. Hence we worked in close coordination with Department of Education and the Department of Health and Family Welfare to organize AHD at school level. This helped using the school infrastructure to impart health and nutrition related messages to school going, non-school going, married and unmarried adolescents, teachers and families at a common platform.

- **Creating a conducive environment:** Involving parents and elected members through organizing regular meetings with them helped creating a positive and supportive environment for adolescents to seek information without any fear or hesitation.

- **Strengthening monitoring mechanisms:** In order to bring change, it is necessary to work with communities. We trained the Village Health, Nutrition and Sanitation Committee members to engage them to monitor the implementation of the adolescent health and nutrition related activities at the village level, however it is difficult to say its usefulness.

- **Creating a resource pool at the community level:** Our past experience indicated that there is a need to create a human resource at the village level to impart health and nutrition information to the adolescents and respond to their day to day queries related to health and nutrition. Initially CHETNA identified PRERAK, a social animator appointed by Department of Education and Literacy to take up this role. The initiation of their involvement was positive. They were paid workers. PRERAKs were not paid for more than two years. As a result many of the PRERAKs lost interest and left midway. However there were few PRERAKS who continued to be with us and played role of local resource. School teachers also played this role effectively.

Activities that we undertook:

The project was implemented in close collaboration with the Departments of Health and Family Welfare, Women and Child Development and Education and Literacy. Functionaries of these departments were trained.

Capacity building of following functionaries was done

- ASHA and AWW (the frontline workers)
- Multi Purpose Health Workers (MPHW)
- Members of the Village Health Sanitation and Nutrition Committee (VHSNC)
- School Teachers and Cluster Resource Coordinators (CRC)

The trainings were organised at the block level and facilitated by the trainers'who had 20 plus years of work experience in the field of health and education.

In all, 22 training workshops were organized, wherein 760 participants were trained on Adolescent Health with special focus on Sexual and Reproductive Health (SRH), Nutrition, Life Skills – Counselling, Health Communication and Community Monitoring.

Highlights of the trainings:

ASHA and Anganwadi Workers	348 ASHA and AWW jointly went through five days training on all the components of Rasthtriya Kihsor Swasthya Karyakram (RKSK), which included nutrition, Sexual and Reproductive Health (SRH), Non-Communicable Diseases (NCDs), substance misuse, injuries and violence, including gender-based violence (GBV) and mental stress and adolescent health. The RKSK counsellor's module was used to impart the training.
Primary and Secondary school teachers	144 teachers of Primary and Secondary Schools who were assigned for school health programme and Weekly Iron Folic Supplementation (WIFS) programme were trained. In addition to the RKSK module contents, the trainings focused on strengthening the teachers' role of being a health communicator and counsellor. Life skill education was included in this training.

Multi-Purpose Health Workers and Cluster Resource Coordinators	Multi-Purpose Health Workers and Cluster Resource Coordinators were trained together. This was an important step towards convergence of programmes related to adolescents at the village level. The training was organized in coordination with the Department of Education and the Department of Health and Family Welfare. 41 participants remained present during the training.
PRERAK	A five days training for 30 PRERAKs was organised. The training provided the PRERAKs with in-depth knowledge about adolescents' reproductive, sexual health and nutrition related aspects. The training also focused on enhancing the PRERAKs' skills on health communication and counseling.
Village Health, Sanitation and Nutrition Committee members	Three days training for the VHSNC members was organised. In all,183 VHSNC members were trained. From the VHSNC, 5 (from 11) members were invited for three days. The training was a non-residential one and was organized at the PHC. The PHC Medical Officer along with the FHWs invited participants for this training.

Reflections shared by participants post training

"During my adolescent phase, my mother restricted me to speak to boys and mingle with them. I repeated this aspect with my daughter. This training has provided me an opportunity to understand the issue from the perspective of an adolescent. After I return home, I will teach my daughter about menstruation, safe sex and importance of saying 'no' rather than telling her not to talk to boys. I would like to be her friend, so she can share her challenges and confusions with me" – ***ASHA***

"This was for the first time we participated in a training that was different from our regular "curriculum" based trainings. Such motivational trainings should be organized twice in a year. Even I had not spoken to my children about changes during adolescence, but now I definitely will."– ***School Teacher***

"My periods have not started even at the age of 17 years. I learnt from [the] SANGAM programme about pubertal changes and [the] menstrual cycle. I went to [an] Anganwadi and met ASHA and FHW. I was counselled on anaemia and was given IFA. I now have my periods." – **Adolescent girl**

"I wanted to complete my higher education but could not as I was told that girls do not study and [they] perform household work. My brother could complete his studies. Though I am happy for him but [I] want the answer [of] why this discrimination." **– Adolescent girl**

Key findings of the learning from the trainings:

A team from the Indian Institute of Public Health (IIPH), Gandhinagar reviewed the trainings. The review findings revealed the usefulness of the trainings in knowledge enhancement.

Amongst ASHAs, AWWs and PRERAKs, it was observed that there was an increase in knowledge for all the topics taken up during the trainings. After the training, 80% of ASHAs were well versed with information related to nutrition and reproductive health. About 65% ASHAs had correct knowledge about physical, mental and emotional changes that occur during the adolescent phase. Also they better understood about the multiple factors responsible for adolescents not accessing the services from public health system. There was a significant increase in knowledge regarding complication of early pregnancy and child birth. Prior to training only 20% believed that masturbation is a normal behaviour which increased to 80%. More than 70% could give correct answer related to Non Communicable diseases.

Similar pattern was observed amongst the Anganwadi workers. On an average, more than 85% could give correct answers related to nutrition and reproductive health of adolescents. More than 70% gained knowledge about Non Communicable Diseases (NCDs). However, 55% mentioned the need to bring changes to one's lifestyle so as to prevent NCDs.

Post training, ASHAs and AWWs mentioned that being warm, non-judgmental and displaying a positive non-verbal behaviour were important characteristics of a counsellor. Listening was listed as an important skill for a counsellor. After the training they also believed that providing sufficient time and privacy during counselling were prerequisites for an effective counselling process.

For the first time, the PRERAKs had received training on adolescent health and nutrition. Their pre training knowledge was poor. But post the training; more than 50% could give the correct answer – indicating gain in knowledge.

Health education sessions at the village level

Regular health education sessions were organized with school going and non-school going adolescent girls and boys. The focus of these sessions was nutrition, personal hygiene and environmental sanitation, prevention of illness, know your body, changes occurring during the adolescent phase, reproductive system, prevention of sexual and reproductive infections and substance abuse. These sessions were made interesting and interactive using the special health education material that was developed by CHETNA such as aprons on reproductive system of woman and man, booklet on personal hygiene, gender and girls health, interactive kit on prevention of substance abuse etc.

Frequent reiteration of these topics was taken up to retain the knowledge of the adolescents. As a follow up to these sessions, parents were contacted during home visits or during the structured parents meeting to inform them about the importance of building health and nutrition knowledge especially for the adolescents.

The dissemination strategies were:

- One to one interaction: The field team appointed by CHETNA, the Teacher, ASHA and AWW used every opportunity to talk to adolescents on various issues of health and nutrition during their one to one interactions. These opportunities emerged during home visits or when they were approached by the adolescents seeking information or clarifications.
- Group education sessions with non-school going girls: Once a month, the frontline workers (AWW, ASHA), facilitated the educational session on the designated day.
- Group educational sessions with non-school going boys: CHETNA field team organized session late in the evenings when boys are available in the village.
- School classroom sessions during the school hours: These were organized by the trained teachers. As a follow-up to these sessions, parents were contacted during home visits or during parent meetings to inform them about the importance of health and nutrition, for adolescents.

Organizing Adolescent Health Day

A total of 175 Adolescent Health Days (AHDs) were organized in all the 72 villages, reaching out to 80%(16,252) adolescents. Services provided on AHD included, registration, general health check-up and referral to Adolescent Friendly Health Clinics (AFHCs) for counselling and clinical services, information dissemination through interpersonal communication on nutrition, SRH, and substance abuse, specifically tobacco use; provision of iron-folic acid (IFA) and Albendazole tablets.

Coordination and experience sharing at community level and at system level

- Regular one to one meetings with the village leaders were organized, especially with the Sarpanch to update her/him about the programme and elicit their support in programme implementation.
- Liaison and interaction with PHC staff was done so as to organize health education sessions at The Anganwadi Centre and during the Mamta Taruni Day.

- Regular meeting at District level with Chief District Medical Officer (CDHO) and Reproductive and Child Health Officer (RCHO); and at the block level with PHC Taluka Health Officer and Medical Officers were organized to discuss the progress, develop action plan and challenges to jointly arrive at solutions.
- At the end of the intervention, a district level dissemination meeting was organized with District Development Officer, CDHO, Taluka Health Officer, and other concerned officials and staff of Sabarkantha district, to present the activities of the intervention and findings of the AHD celebration, share experiences and discuss rollout strategy at district level.

Challenges faced

- The PRERAKs being the key human resource at the village level, CHETNA had envisagd their role to specifically disseminate health and nutrition information among adolescents. The initiation of their involvement was positive. They were paid workers and the role they had to play in the present project matched with their mandate. However, owing to irregular payments from the Department of Education and Literacy, this approach did not work. PRERAKs were not paid for more than two years. As a result many of the PRERAKs lost interest and left midway.
- Connecting with non-school going boys was a major challenge. RKSK needs to look into the possibility of convergence with the livelihood programmes. Also the dissemination of health and nutrition information needs to be done through the skill building programmes being implemented by the government.
- In some schools, there was a resistance to discuss the issue of SRH.
- Strengthening the services of adolescent friendly health clinics was another challenge anticipated by CHETNA. Adolescents were not very comfortable in accessing services from the Adolescent Friendly Health Clinics and hence remained virtually unused.
- Training of VHSNCs was time consuming as in majority of the villages they were not active. Majority of time was utilized in reviving them leaving less scope for understanding their role in promoting and monitoring of the programme.

What is needed for effective implementation of RKSK?

RKSK believes that, for the inter-connected nature of of the diverse needs of adolescents, one shoe may not fit all. Hence, it is critical that different strategies be planned for adolescents who are school going, non-school going, married, unmarried, rural, urban or for migrants.

Investing in Capacity Building

- The trend indicates that school enrolment is increasing. This means more number of children will be in schools. It is therefore imperative that the adolescent programme needs to include the school going children. To ensure active participation of school going adolescents, training of teachers is critical. We recommend institutionalising health and nutrition session during the school timings.
- Peer Educators approach may not be ideal to disseminate information at the village level. In the present project, building capacity of PRERAKs was a very promising approach. However, due to administrative and financial constraints of the department, the approach could not be sustained. It still needs to be explored in the state where the programme is implemented effectively. As

an alternative, CHETNA jointly trained ASHA and AWW and other young leaders by using counsellor's training module developed under RKSK. This proved a useful strategy to disseminate health and nutrition information at the village level.

- Capacity building needs to be done on a regular basis and strategically, along with mentoring support. It cannot be a onetime event. It needs to be planned on a regular basis. Financial allocation and human resource for the training must be a priority.

Building on the learnings to strengthen implementation

- It is important to consider that non-school going adolescent girls and boys are working and therefore one cannot assume that they would be available for trainings during the day time. Based on the local requirements, there is a need to bring in flexibility within the programme to get in touch with adolescent girls. Certain non-negotiable approaches are one to one contact and group discussions and educational classes during evenings and nights.

- Adolescent Health Day is an effective strategy, if it is organised regularly. Our experience of involving school teachers in organising Adolescent Health Day was a promising strategy.
- Involvement of community members and stakeholders are non-negotiable components. Regular meeting with School Management Committee, parents, other community members and elected members is crucial.
- Integrate the component of empowerment and gender equality in all the trainings and health education sessions.
- Create mass awareness about the health and nutrition entitlements for themselves and for the adolescents.

Identifying areas of convergence

- Inter Departmental Convergence is required for successful implementation of adolescent health programmes. Involvement of Department of Education together with other departments is critical.
- The age group overlaps for Rastrya Bal Swathya Karyakram (RBSK)* and RKSK programmes. There is a need to converge these two programmes by reallocating the role of the village level stakeholders and the structure of service delivery.

Post implementation efforts

CHETNA was invited by the district officers to train 225 Medical Officers who made health and nutrition information accessible to 15000 school going adolescents throughout the district. The material developed under the project got replicated and used during the educational sessions.

*The objective of the programme is that of early identification and early intervention for children from birth to 18 years to cover 4 'D's viz. Defects at birth, Diseases in children, Deficiency conditions and Developmental delays including Disabilities.

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