Rashtriya Kishor Swasthya Karyakram: Community Based Approaches

Peer Education and the Adolescent Health Day

Key elements of community processes under NHM

- The ASHA and her support network at block, district and state levels.
- The Village Health Sanitation and Nutrition Committee (VHSNC) and Mahila Arogya Samiti (MAS).
- District Health Societies and the Rogi Kalyan Samitis
- Community Based Planning and Monitoring
- NGO participation

&

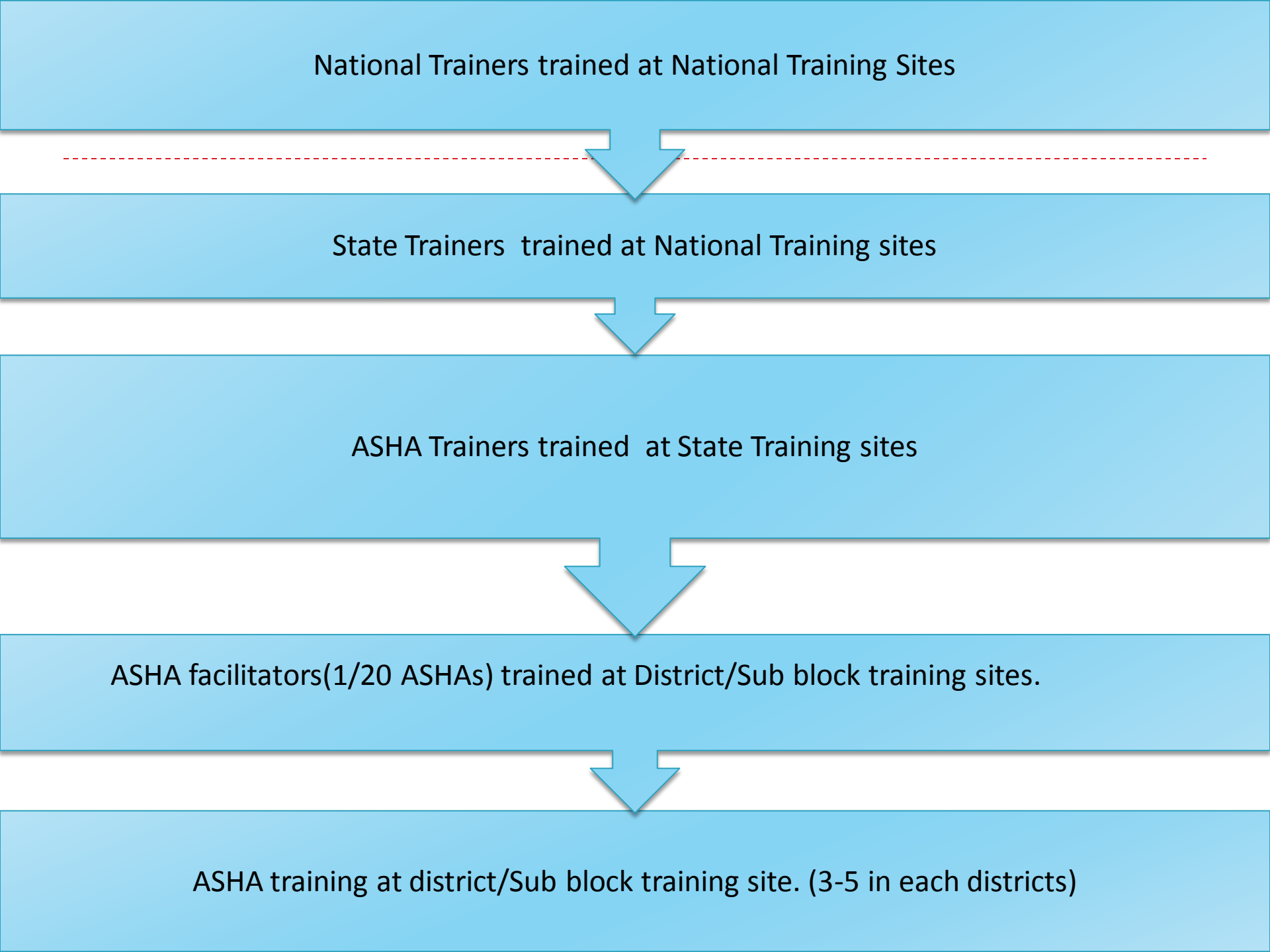
- **Peer Educators**

Important Milestones and Current Figures

2006: ASHAs for 18 high focus states and in tribal districts in others - Target 400,000 ASHAs

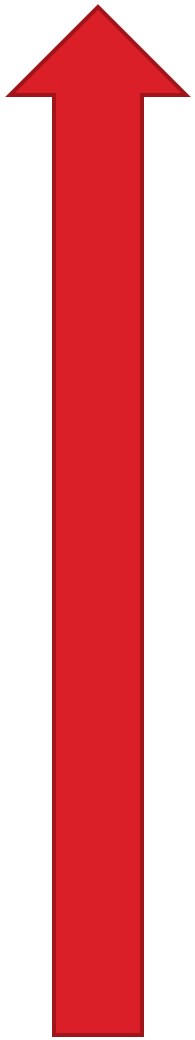
2009: Scaled up across the country. Now: 8.63 lakh ASHAs in 31 states / UTs (except in Goa, Puducherry, Chandigarh and Himachal Pradesh)

State	Proposed Number of ASHAs	ASHAs selected	% Selection
High Focus States	520725	483320	92.8%
North Eastern States	54598	54464	99.8%
Non High Focus States	357506	318417	89.1%
Union Territories	870	806	92.6%
Total	**933699**	**857007**	**91.8%**


National Trainers trained at National Training Sites
State Trainers trained at National Training sites
ASHA Trainers trained at State Training sites
ASHA facilitators(1/20 ASHAs) trained at District/Sub block training sites.
ASHA training at district/Sub block training site. (3-5 in each districts)

Support Structures for Community Processes

Formation of Dedicated Support Structures	***Position of states in 2010***		***Current Position of states -2013***
Support Structures at all Four Levels	Chhattisgarh , Uttrakhand Assam Maharashtra		Bihar ,Chhattisgarh ,Jharkhand, Madhya Pradesh, Rajasthan, Uttrakhand, Assam, Tripura Maharashtra, Haryana
Three Levels	Bihar, Jharkhand, Rajasthan Arunachal Pradesh, Meghalaya		Orissa, Uttar Pradesh Arunachal Pradesh, Manipur, Meghalaya, Mizoram, Nagaland Karnataka , Punjab
Two Levels	Madhya Pradesh , Orissa Tripura Delhi, Karnataka, Punjab,		Delhi, Sikkim, Gujarat
Only at one level	Uttar Pradesh Andhra Pradesh, Gujarat, Kerala,		Andhra Pradesh, Jammu & Kashmir Kerala, Tamil Nadu, West Bengal
None; Programme managed by Existing NRHM Staff	Manipur, Mizoram, Nagaland, Sikkim Haryana, Jammu and Kashmir, Tamil Nadu, West Bengal		



Programme Principles

- Builds on learning from the ASHA and VHSNC programme (Community based selection, good training systems, effective support including non monetary financial incentives for social recognition and motivation)
- Leverage existing community based resources- (ASHA, adolescent health meeting)
- Uses existing support and training structures created for community processes under NRHM
- Develop standard guidelines, training materials and supervisory checklists to facilitate scaling up
- Advocacy and sensitization of key stakeholders- Community and Service Providers
- Ensure that competencies are built in a set of core skills before adding additional tasks
- Adaptation to local context and learn from innovations as scaling up takes place
- Convergence with other programmes-SABLA, NYKS, SAKSHAM

Peer Education

Peer Educator Profile and Selection

- Four Peer Educators (15-19 years) /1000 population
- Community Sensitization: ANM with ASHA support
- Community based selection (VHSNC/MAS with ASHA support- ensuring representation of all communities, including in school and out of school youth,
- Community to identify a group of interested adolescents- final selection to be based on :

- - leadership and team building skills,
- - experience with community based interventions

Training Strategy

- Total of six days - flexible in timing
- Twice a week or twice a month or six days at a stretch
- Content: Gender and Sexual identity, Physical and Mental changes, Lifestyle diseases, Healthy behaviours, Dealing with Peer Pressure, Negotiation and Conflict, Accidents and Injuries, Child Marriage, Adolescent Pregnancy, RTI/STI, Violence, Rights/Entitlements and the Community Sanitation and Hygiene
- Pedagogy: Learning by doing- using case studies, group work, role plays
- Trainers: as in ASHA or through NGOs
- Outcome: Competency in Ten Core Skills

Key Tasks

- Build a collective of 15-20 young people
- Weekly information sharing meetings on a series of topics: (Using PE kit)
- Facilitate organizing of Quarterly Adolescent Health Day and mobilize group members to attend
- Refer to AFHC/and or helpline as necessary
- About four days a month to be spent on key tasks (in addition to initial training)

Support

- Village level: ASHA and VHSNC- first point of contact, logistic issues; oversight of PE meetings in village
- Sub centre Level: ANM- Monthly Adolescent Friendly Club Meeting
- At sub block level: ASHA facilitator- PE meetings during village visits
- Non monetary financial incentives- public awards that promote social recognition and serve as motivation
- Exposure visits
- Enable sensitization of support structures

Implementation

- Either directly or through NGOs
- Preparatory activities: three months
- Scale up in a phased manner
- Interaction with VHSNC
- Convergence with WCD/Education
- Link with vocational training institutions

Monitoring

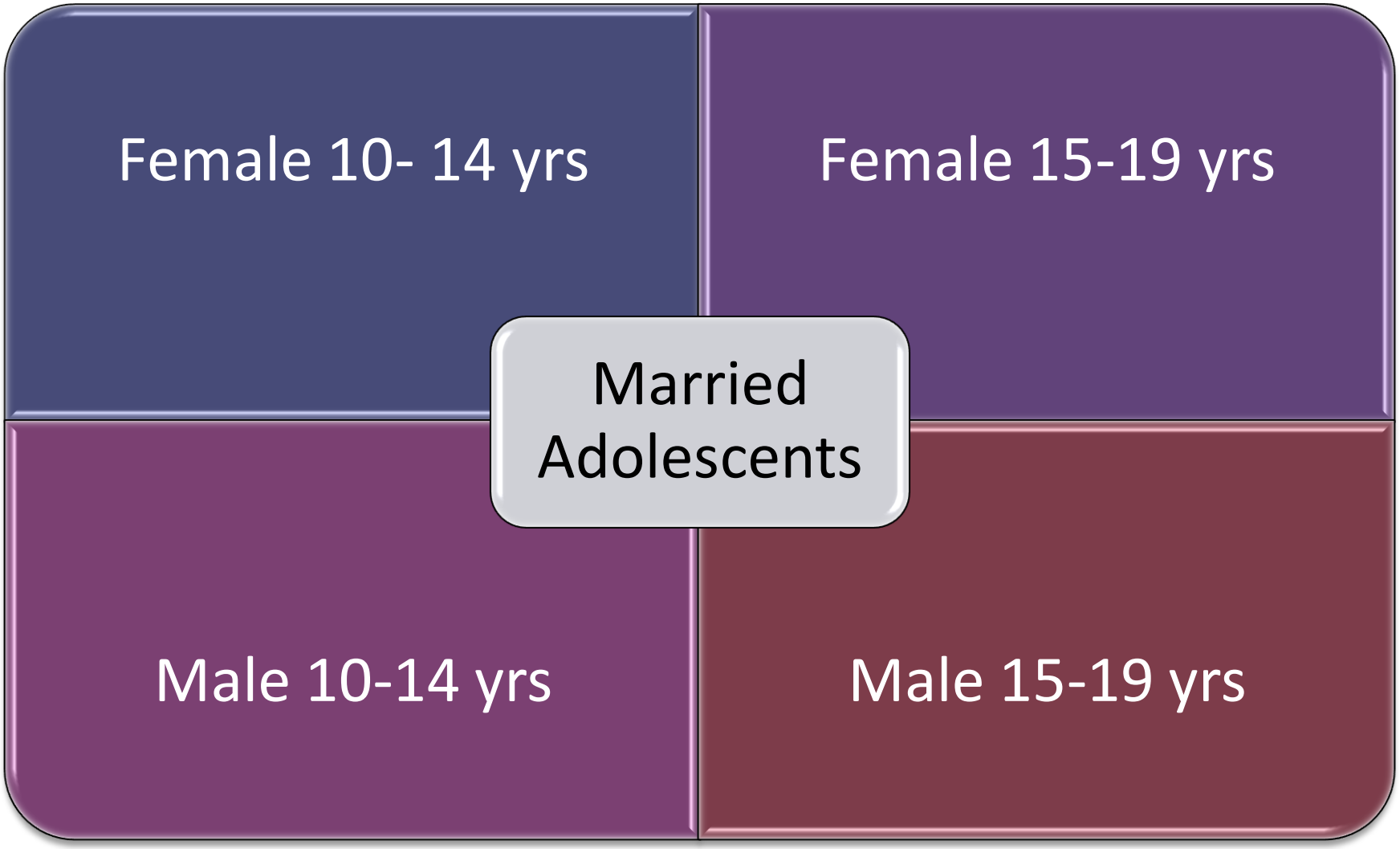
- PE:
  - Session Diary for work planning
  - Monthly progress report, consolidated by ASHA/ASHA facilitator to Block Community Mobilizer
- BCM's monthly meeting with ASHA facilitators – attended by the CHC counsellor – discussion and handing over of reports
- District AH nodal officer and state AH nodal officer
- MO/IC visits- at least two groups a month

Adolescent Health Day

Key Objectives

- Improve coverage with preventive and promotive interventions
- Increase awareness among parents and other key stake holders on adolescent health needs
- Increase awareness among adolescents about the determinants of adolescent health
- Improves awareness of other AH related services - AFHCs
  - Primary responsibility lies with ANM for organizing AHDs
  - Frequency – quarterly on a convenient day following VHND ;
  - Can coincide with Kishori Diwas in SABLA districts (linkages with SAKSHAM and NYKS districts) ;
- Venue - AWC or any community space

Target Groups



AHD

- Organizers (PE, ASHA, AWW, *MO/IC, Counsellors*) to mobilize adolescents, parents and other stake holders to assemble at the venue
- ANM- to provide services and educate the target groups about preventive and promotive aspects
- Successful AHD – includes attention to the following:

- **Information** : IEC/ IPC on Nutrition, Sexual and Reproductive Health, Mental Health, Gender Based Violence, Non communicable diseases and Substance Misuse- (***Infotainment)***
- **Commodities** – Sanitary Napkins, IFA, Albendazole, anti – spasmodic tablets and contraceptives
- **Services** – Registration , general health check up (BMI, anemia and diabetes), referral to AFHC

AHD

- IEC/ IPC topics to be specific to target audience specific e.g – separate for boys and girls and two age groups, married adolescents (nutrition, SRH, mental health, violence, trauma, substance abuse, prevention for NCD,

- ***Emphasis on communication with parents and other stakeholders*** during AHD to –
  - Provide information on resolving concerns of adolescents
  - Develop/ enhance skills on communicating with adolescents.
  - Educate / sensitize on the resources available for assisting in managing adolescent issues

- ***Timely referral to AFHCs***

Checklists for organizers

ANM

- AHD is held regularly
- Supplies / drugs/ instruments/ communication material are available
- Reporting of AHD to MO
- Coordinate with FNGO

PE

- Listing of all adolescents by visiting households
- Identifying adolescents with specific needs
- Mobilize for attending AHD
- Communicate objectives, venue , date and benefits of AHD
- Encourage discussions with Service providers

ASHA

- Coordinate with PE, ANM, AWW, other CBO
- Guide PEs to mobilize adolescents to attend AHD

AWW

- Help ASHAs and PEs in mobilization
- Make AWC available for AHD
- Coordinate with , PE, FNGO, ASHA and ANM

PRI

- Coordinate to invite all members of VHSNC to support and attend AHD
- Coordinate participation of school teachers , parents , PRI members and other influential leaders
- Provision for clean drinking water, proper sanitation and convenient approach to the AWS
- In case of non availability of AWC help in identifying alternative venue

FNGO

- Coordinate with service providers, village PRI etc to finalize date/ venue for AHD and communicate with other organizers
- Inspect the venue for AHD to ensure that venue has privacy for health checkups, if not then to make necessary arrengements
- Discuss with Pes, ASHAs and AWW to mobilize adolescents

Monitoring and Supervision

Monitoring

- Each district and block to record number of AHD planned and held
- ANM to maintain register for data collection and fill format after each AHD.
- Formats compiled at block and district level on a monthly basis
- State level compilation on a quarterly basis.

Supervision:

- Programme managers at Block , district and state level to visit the venue of AHD and monitor the activities using a checklist

Road Ahead

- Complex Intervention and evolving programme – balance between programme pace in different states
- Need to understand contextual issues and design technical support as appropriate
- Create effective linkages to leverage non health inputs to meet aspirations of target groups
- Plan for replacing PE as they grow out of the cohort
- Evaluations: regard to timing and methodology
- Knowledge networks- to learn and share implementation experiences
- Partnerships with NGOs, Academic and Research Institutions

THANK YOU