RKSK –Rashtriya Kishor Swasthya Karyakram

An Exploratory Study on the Implementation Status in 10 Pilot Districts of Gujarat

June to September 2016

By

SAHAJ

The Ministry of Health and Family Welfare has launched an adolescent health programme – Rashtriya Kishor Swasthya Karyakram. The programme envisages strengthening of the health system for effective communication, capacity building and monitoring and evaluation. RKSK underscores the need for several constituencies to converge effectively and harness their collective strength to respond to adolescent health and development needs. The focus was on age groups 10-14 years and 15-19 years with an objective to improve nutrition, improve knowledge, attitudes and behavior in relation to SRH, enhance mental health, prevent substance misuse and address conditions for NCD's.

It has been piloted in 10 out of 29 districts in Gujarat since December 2014. Even after its launch, there were no signs of this program in Dahod and Mahisagar, till mid 2016. We decided to conduct a study on the present status of the program. Based on our experience on 'SABLA study' we decided to go from the top to instead of down to top. So we interviewed the CDHOs of these districts between Juneand September 2016, with the help of a structured interview tool. This tool was prepared referring the guidelines of RKSK program which was obtained from the State NGO Coordinator of Gujarat.

Prior appointments of the CDHOs in the 10 Districts were taken. Two CDHOs despite giving appointments refused to give any information and demanded an approval letter from thestate office. Eight CDHOs responded very well.

District	Date of interview	Response
Tapi	06.06.2016	Good
Mahisagar	14.06.2016	Good
Dahod	16.06.2016	Good
Narmada	20.06.2016	No response
Dang	22.06.2016	Good
Sabarkantha	01.07.2016	No response
Panchmahal	29.08.2016	Good
Valsad	31.06.2016	Good
Arvali	03.09.2016	Good
Kutch	15.09.2016	Good

Four out of the eight CDHOs asked for the guidelines as they did not have the document. One of the officers was answering questions referring the guidelines.

Major Findings

The first set of questions was on when the program was launched in their district at different levels. The responses were varying

1. When was the RKSK launched in the state?

Responses	**Number (N=8)**
One year	1
Two years	2
2014	2
10.12.2016	1
Don't know	1
No response	1

The varied responses indicate that there is no clarity on the initiation of the programme.

2. **When was it launched in your district?**

Response	**Number (N=8)**
2014	1
One year	4
Two years	2
When it was launched in Gujarat	1

3. **How many PHCs in your district are covered in your district?**

Responses ranged from 2 PHCs to 17 PHCs. But when asked which PHCs they did not know.

Responses were very vague. Only two CDHOs could name their PHCs.

4. **When was it taken to the anganwadis?**

Response was one year and two years

5. **Who is the staff involved?**

Responses ranged from Medical Officer, ASHA, Peer Leader, nurse, male health worker, anganwadi worker, female health worker but none said they all have to work together. Majority said it is the ASHA, nurse and the peer leaders who are involved in this program.

6. **Has an orientation been given to the duty bearers?**

Response: Yes from all, but answers ranged from 6 months back to one year.

The next set of questions was on services given to the adolescents and activities carried out with them.

1. Services

   Most common responses were
   - BMI
   - Counseling
   - Nutrition Education
   - Health Education
   - SRHR Education

2. Activities done with boys
   - Meetings
   - De-addiction program
   - Health Information
   - Group formed
   - Peer Leaders appointed

with girls
- Sessions on sickle cell, anemia
-Trainings
- Peer Leaders appointed
-Health services

Status of Peer Leaders and their capacity building

All of them said the peer leaders have been given trainings by CHETNA-Ahmedabad. When asked how many peer leaders are now in place, the responses varied from 4 to 1674

When asked how are they distributed in one village there was no common clarity. Two CDHOs said 4 peer leaders per ASHA and two others said 2-3 for 1000 population. Some had no answers.

When asked again about the peer leaders training, the responses were different. Only four CDHOs confidently said their peer leader have received trainings, one said it was for 2-3 days, one said 1650 peer leaders have been given trainings. Others said they were not sure how many received the training.

When asked **when was this training given?** The response varied from 6 months to one year back.

Where was this training given?
Five of them said at PHC level, two of them said at district level and one said at Taluka level.

For how many days was this training conducted?
Three of them said 5-6 days, two said one day and one - said 2-3 days. One of them said the training was actually for 5 days but they had no budget so one day training was conducted.

The next set of questions was on roles of peer leaders and staff involved in this program

Roles of Peer Leaders
- Make groups
- Understand issues
- Meetings with group
- Mobilize adolescents for health day
- Conduct sessions

What have they actually done in the last month?
- Came to the PHC with their friends
- Conduct session
- Bring the adolescents for health day

Three of them said they didn't know.

When asked what support do the peer leaders get from the system to perform their roles?
There was no response
One said they get incentives Rs. 50-100/-
One said there is no monetary support because no grant.

Role of Staff members?

Responses varied from

CDHO's role

- Coordination
- Monitoring
- Appointment of peer leaders
- Group discussions
- Implementation
- Reporting

ASHA

- Educate Peer leaders
- Mobilize them for trainings
- Make Group
- Appointment of peer leaders
- Refer to PHC
- Nutrition Education

Nurse

- Meeting with Peer leaders
- Discussions / meetings with Medical Officer
- Information on Health
- Counseling
- Refer to PHC

Who gives what services?
Health Education: Responses varied from ASHA, Female Health Worker, Nurse, and Peer Leader.
When - every month, Health camp meetings

What topics

- Sessions from HUM TUM book
- Life skills
- Physical and Mental Health
- SRHR
- Addiction
- Marriage
- Violence
- Nutrition

Counseling –**Have counselors been appointed?**
Response: Yes (Two CDHOs)
No (Four CDHOs)
Don't know (Two CDHOs)

The two officers who said that they have counselor, were asked - how many cases had they attended to, number of girls and boys talked to, the topics taken thereon,- but the CDHOs had no details.

The following questions were on Samitis
When asked on **what is the role of VHSNCs in this program?**
Responses varied from

- Motivate the Peer Leaders
- Guide the adolescents
- Coordination
- Monthly meeting

District level Kishori Samiti
There is no district and state level Kishore Samiti in any of the districts.

When asked **how do they coordinate with different departments?**
Only two officers answered the question, one said we coordinate with the Tobacco Control Program when we want to have sessions in schools or colleges.
One said we have to talk to the Education department if we want to have sessions in schools.

There were a lot of **suggestions for improving the implementation of the program**

- "Regular supply of medicines ", guidelines should reach the officials before the launch of the program.
- Need enough funds for the proposed activities
- Sports kit to bring adolescents together
- Peer Leaders Honorarium
- Training needs
- Supervision required
- Need dedicated staff
- Orientation to Peer Leaders

Majority of the officers said it is very good program but due to multiple programs coming in and more stress on reporting; much of the time is spent on collecting data. Constraint and untimely release of funds restrict implementation.

CONCLUSION

This exploratory study shows that the implementation of the RKSK is weak in the 10 pilot districts in Gujarat. The CDHOs who are in charge of all health programmes in a district did not seem to have clarity on the contents of the programme or where in their districts it was operational. There do not seem to be any standard practices – for example, number of Peer Leaders in each PHC or village or per ASHA. The only thing that they were clear about was that CHETNA a NGO had done the training of the Peer Leaders. The programme seems to be compromised because of lack of dedicated resources both monetary as well as human resources. The CDHOs had a number of suggestions for improved implementation of the programme but it appears that it is not high in their list of priorities.