Short Communication

Reveling Adolescent Health Day: Field experience from Rural Gujarat, India

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Abstract

About one-fifth of India's population is in the adolescent (10-19 years) age group. Morbidity and mortality occurring in this age group is mostly due to preventable causes. To reduce this burden; the RashtriyaKishorSwasthyaKaryakram (RKSK) was launched on 2014 in India addressing adolescent health needs. Adolescent Health Day (AHD) under RKSK is one of the strategies to achieve the objectives of the adolescent health program to improve preventive services and increase the awareness. This study aims to document the experiences of AHD celebration in one of the block of Gujarat state as per the guidelines of RKSK. . Convergence approach as per RKSK guidelines has been adapted to reveal AHD in three steps- i) Pre-AHD activities to assess the preparedness, ii) On-AHD to evaluate and document the process- different stations of AHD. iii) Post-AHD activities targeted to crosscheck the coverage. This model has been rolled out and validated in one of the block (Talod) of Sabarkantha District, Gujarat. Reveling AHD through convergence approach found to be successful as per the involvement of different stakeholders and exit interview of adolescents. It is recommended to adopt this approach for celebration of AHD in other parts of country.

Keywords: AHD; Adolescent; Convergence; RKSK

Introduction

More than 1.5 billion people of the world's population of 6.7 billons are between the ages of 10 and 24 years. About 70percent of the young people live in developing countries where social, economic and health challenges are greater than that of the industrialized country. [1,2] Adolescents aged 10–19 years constitute about 21% of India's population which in absolute numbers translates to 253 million. [3] Adolescents face a range of health challenges which contributes to increased morbidity and mortality not only during adolescence but also later in their lives. [4] Empirical evidence shows that more than 33% of the disease burden and almost 60% of premature deaths among adults can be associated with behavior or conditions that began or occurred during adolescence. [5,6] The health transition, together with changes in adolescent social roles, has shifted the burden from childhood infectious diseases towards adolescent injuries and health-jeopardizing behaviors in all but the poorest countries. [7]

National Youth Policy in 2014 [8] of the Ministry of Youth Affairs and Sports (MoYaS), India has stated a clear vision: "To empower youth of the country to achieve their full potential and through them enable India to find its rightful place in the community of Nations". It defines youth as age group between 15 to 29 years. It has 11 priority areas for achieving the vision including developing a strong and healthy generation. To reduce burden; the Rashtriya Kishor Swasthya Karyakram (RKSK) was launched. [9] RKSK expands the scope of adolescent health programming in India - from being limited to sexual and reproductive health, it now includes in its ambit nutrition, injuries and violence (including gender based violence), non-communicable diseases, mental health and substance misuse. [10] One of the important facet of the RKSK is to develop convergence amongst various ministries and stake holders of different programs for adolescent and the strategy focuses on age groups 10-14 years and 15-19 years with universal coverage, i.e., males and females; urban and rural; in school and out of school; married and unmarried; and vulnerable and under-served.

Adolescent Health Day (AHD) under RKSK is one of the important community based strategies to achieve the objectives of the adolescent health program to improve preventive services and increase the awareness. [11] The key principle of this program is adolescent participation and leadership, equity and inclusion, gender equity and strategic partnerships with other sectors and stakeholders. This study aims to document celebration of AHD in selected villages of Talod Block, Gujarat, India including reporting and supportive supervision by health department as per the RKSK guidelines and to demonstrate convergence for celebration of AHD among various stakeholders.

Methods

This is an observational study in 16 schools including three high schools selected randomly from Talod block of Sabarkantha

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Table 1: Convergence Committee Members for AHD at District and Block Level.

Convergence Committee at District Level	
District Development Officer (DDO)	
Members from Health Department	**Members from Other Departments**
Chief District Health Officer (CDHO) Chief District Medical Officer (CDMO – Superintendent of district hospital) Reproductive and Child Health Officer (RCHO) Faculties from local medical college- Departments of Obstetrics, Psychiatry, Pediatrics, and Community Medicine Senior Medical Officer- District Training Team Medical Officer- District AIDS Prevention and Control Unit (DAPCU) Counselor- PPTCT district hospital District IEC Officer District Program Coordinator (DPC) from District Health Society	Chairman- Mahila Bal Vikas Samiti, Jilla Panchayat Representative from Police department District Social Welfare Officer Representative of Abhayam (181) NGO representative
Members from ICDS	**Members from Education Department**
District Program Officer- ICDS	District Education Officer
Convergence Committee at Block Level	
Members from Health Department	**Members from other Department**
THO (Taluka Health Officer Taluka IEC Officer CHC- Superintendent CHC- PPTCT/ICTC Counselor	NGO representative, Private practitioners- OBG&Y, Psychiatry, Pediatrics Representative of police department Taluka Samaj Kalyan Adhikari, Local NGO
Members from ICDS	**Members from Education Departments**
Child Development Project Officer (CDPO- ICDS)	Block Resource Coordinator (BRC)- Education

AHD: Adolescent Health Day

district, Gujarat, to plan and implement the activities under AHD as per RKSK and document the experiences after its execution. Pre-On-Post AHD activities were conducted as per plan and field experiences were documented further. Ethical approval for this study has been obtained from the Institutional Ethics Committee of Indian Institute of Public Health Gandhinagar (IIPHG-IEC).

Observational Findings

Formulation of Convergence Committee

District level convergence committee formation was done with health, education, Integrated Child Development Services (ICDS) and other departments. List of members of the district level convergence committee has been shown in Table 1. A similar committee has been formed at the block level to ensure better coordination between stakeholders and planning of celebration of AHD in selected schools.

Revelling AHD: The study framework

The entire activity has been conducted in 3 Phases (as shown in Figure 1)

- Pre AHD to assess the preparedness,
- During AHD to evaluate and document the process
- Post AHD to evaluate follow up actions taken by system

Pre AHD activity

The process took place 2-3 weeks prior to AHD and involved about 20-30 stakeholders

a) Convergence meeting at district HQ (DDO, CDHO, PO-ICDS, Taluka Health Officers, Selected Medical Officers from PHCs, Senior Medical Officer- District training team & local Medical College Team), which include review of current situation, Orientation of members, Micro plan (staff deployment, roles and responsibility of various department staffs, mobility, logistics arrangement, supervision mechanism and follow up mechanism), IEC materials used, Discussion on the proposed Model for conducting AHD, Involvement of NGOs from the local area and VHSNC members.

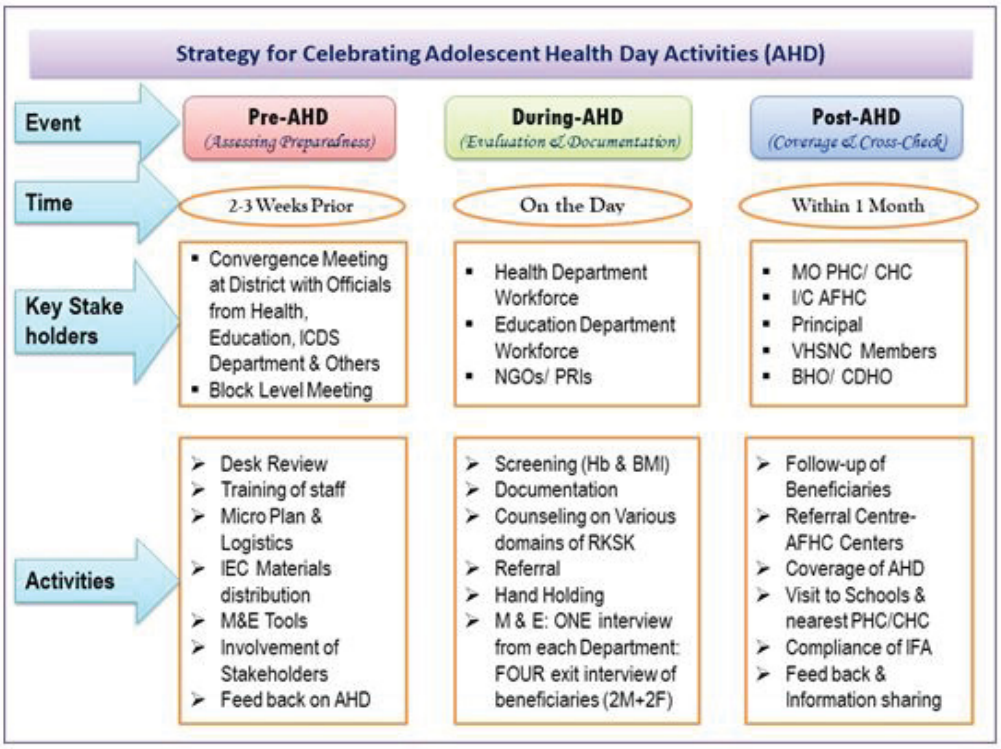
b) Similar kind of convergence meeting at block level was conducted which took care of detailed planning and logistics arrangement.

During AHD activity

Adolescent Health Day was carried out by local school teachers, Accredited Social Health Activist (ASHA), Anganwadi Worker (AWW), Auxiliary Nurse-Midwife (ANM), Multi-Purpose Health Worker-(MPHW) under direct supervision of Female Health Supervisor, AYUSH MO, MO-PHC and Taluka Health Officer (THO). AHD activities such as; screening of all adolescents for nutritional status using Hemoglobin estimation and Body Mass Index, Counseling on nutrition and menstrual hygiene and sexual and reproductive health, Referring the adolescents with abnormal nutrition status to the respective Adolescent Friendly Health Clinic with appropriate referral note and recording essential details in prescribed formats of RKSK: SIX exit interview of beneficiaries (3 Male+3 Female) was carried-out to understand the demand side satisfactory levels and further needs. More than 50 stakeholders actively involved during this process.

Post-AHD activity

Coverage and compliance of referral activity was conducted followed by AHD with MO PHC/ CHC, Principal, VHSNC Members, CDPO under the leadership of THO. Following key activities were done during these periods; Data compilation of all reports of PHC including referral, follow-up of Beneficiaries who were referred during AHD and ensuring that they avail the required services, Visit to Schools and Nearest PHC/CHC to



AHD: Adolescent Health Day, ICDS: Integrated Child Development Services, IEC: Information Education and Communication, M&E: Monitoring & Evaluation, NGO: Non-Governmental Organisations, PRI: Panchayati Raj Institution, Hb: Haemoglobin, BMI: Body Mass Index, RKSK: Rashtriya Kishor Swasthya Karyakram, MO: Medical Officer, PHC: Primary health Center, CHC: Community Health Center, AFHS: Adolescent Friendly Health Clinics, VHSNC: Village Health, Sanitation and Nutrition committee, BHO: Block health Officer, CDHO: Chief District Health Officer, IFA. Iron Folic Acid

Figure 1: Strategy for celebrating Adolescent Health Day.

validate regarding the uptake of services. Findings were also shared with district official in a meeting under the leadership of District Development Officer.

Discussion and Recommendations

Challenges for convergence and coverage

Certain challenges were faced such as less importance given by the school teachers/ education department for the AHD activity. As there is a requirement of involvement of larger task force for celebrating an AHD, it has been found that lack of motivation among the task force for the same. Advocacy with District/ Block Convergence Committee for better coordination amongst all departments remain a great challenge for the system. There must be other challenges while implementing the same in other states.

As reported dropout rate for the district is about 10-15%, AHD was organized at schools to cover maximum number of adolescents. Even this study showed the coverage of 68 to 70 % coverage of planned beneficiaries. Efforts should be made to maximize this coverage with reference to localized strategy. Out of school adolescents should be mobilized to schools for AHD by ASHA and AWWs. However, involvement of out of school boys remains a challenge. Peer educators may help in mobilizing out of school boys. Taking into the consideration the further learning from AHD implementation, it should be decided that whether separate sessions on Sundays are required to cover more and more out of school boys and girls at the community place.

AHD: Theme-wise celebration

Since there are six priority areas to be covered on AHD as per RKSK guidelines, it is difficult to address all six priorities on every AHD. Therefore, thematic AHD could be the potential solution for the same i.e., six priorities could be divided amongst four AHDs in a year for that area. Different combinations of themes should be tried based on local need and resources.

Recommendations for RKSK Guidelines

As per RKSK all cases requiring referral should be send to nearest Adolescent Friendly Health Clinic (AFHC), but follow-up mechanism of the same is missing in the RKSK guideline. Benchmarks for BMI of adolescents need to be specified in the guidelines; currently this is not specified in the RKSK guidelines.

There is dearth of detail about Terms of Reference (ToR) not available in RKSK guidelines; therefore there is an urgent need to develop the same for smooth rolling out throughout the nation.

Conclusion

Reveling AHD through pre-on-post convergence approach found to be successful as per the current experience. Active

participation of students and school teachers enabled adolescent to understand their current health status. Convergence with other stakeholders aided to conduct this AHD smoothly and successfully. It has been recommended to validate this approach in other parts of country. Since it is a national wide event and takes places in different areas separately, it has been recommended to lunch a systematic evaluation of this event in the national wide

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Conflict of Interest

All authors disclose that there was no conflict of interest.

References

1. Gupta MD, Engelman R, Levy J, Luchsinger G, Merrick T, Rosen JE. The state of world population 2014. United Nations Population Fund (UNFPA).
2. Fatusi AO, Hindin MJ. Adolescents and youth in developing countries: Health and development issues in context. Journal of Adolescence 2010; 33: 499-508.
3. Srinivas V, Mankeshwar R. Prevalence and determinants of nutritional anemia in an urban area among unmarried adolescent girls: A community-based cross-sectional study. Int J Med Public Health 2015; 5: 283-288.
4. National Rural Health Mission. Government of India. Background note on Adolescent Health, 2009.
5. Progress for Children: A report card on Adolescents. United Nations Children's Fund (UNICEF) April 2012.
6. National Health Mission, Ministry of Health and Family Welfare, Government of India. Rashtriya Kishor Swasthya Karyakram (RKSK) Program.
7. Resnick MD, Catalano RF, Sawyer SM, Viner R, Patton GC. Seizing the opportunities of adolescent health. The Lancet 2012; 6736: 60472-60473.
8. National Youth Policy. Ministry of Youth Affairs and Sports (MoYaS), Government of India, 2014.
9. Press Information Bureau, Government of India. Press Information Bureau, Government of India Web site. [Online]. New Delhi; 2014 [cited 2014 January 22 [Press Release issued at 13:48 IST].
10. Johnson LR. Rashtriya Kishor Swasthya Karyakram (RKSK). Academic Medical Journal of India. 2014; 2: 42.
11. Rastriya Kishor Swasthya Karyakram: Operational framework-Translating strategy into programs. National Health Mission, 2014.