10to19
DASRA ADOLESCENTS COLLABORATIVE

10to19: Dasra Adolescents Collaborative – In partnership with National Health Mission, Jharkhand

Learnings and progress from implementation over 2018-2021

In collaboration with our Implementing Partner: **Centre for Catalyzing Change & Child in Need Institute (CINI)**

Objective of this document

The National Health Mission (NHM) of Jharkhand and 10to19: Dasra Adolescents Collaborative (10to19) have been partnering since 2018 to improve adolescent health and wellbeing in the state. Centre for Catalyzing Change (C3) and Child in Need Institute (CINI), 10to19's implementing partners in Jharkhand, have been supporting the Government in these efforts. **This document summarises the key learnings from their collaborative actions and tables recommendations for the state's health department on scaling some of the learnings and progress.**

This document is a reflection of learnings from Dasra and its implementing partners as a part of the 10to19 Collaborative, based on the experience of implementing on ground in Jharkhand. It is key to note that the learnings shared here have not been statistically validated or backed by extensive research – but are rather early outcomes and good practices that have emerged from the programme implementation, self-evaluated by the 10to19 partners themselves.

Introduction to 10to19's work in Jharkhand

Over the last three years, 10to19 - through its implementation partners, C3 and CINI - has been providing technical and implementation support to district and block officials in Gumla, Lohardagga, Simdega, and Saraikela[1] districts in Jharkhand, on multiple adolescent health and wellbeing initiatives as part of Rashtriya Kishore Swasthya Karkyakram (RKSK). Additionally, 10to19 has also been working with organisations Aangan Trust and Quest Alliance on child safety, education and empowerment in the districts of Pakur and Deogarh respectively.
These organizations were selected as key state implementation partners on the basis of their long-standing success with adolescent and child-focused programming to carry-out a multi-year grassroots program, with the first three years (2018-21) focused on field execution. The project's set-up Phase in 2018 was dominated by an extensive data collection exercise to assess the status of adolescents in all districts of Jharkhand and serve as a baseline for the districts in which 10to19 would begin implementation. Following this, implementation on ground began in late 2018 as did the work at the state level which involved the following key aspects:

- On-ground implementation in 6 districts (Gumla, Lohardagga, Simdega, Saraikela, Pakur and Deogarh) with support provided to state, district and block administrations on adolescent issues related to health, education, safety and empowerment
- Establishment of a Community of Practice of 200+ NGOs and experts aligned on adolescent issues
- Roll out of an adolescent-led campaign 'Ab Meri Baari' to increase the involvement of young people in social change and decision making

Though a substantial part of the implementation time in 2020 was compromised by the national lockdown mandated during the spread of COVID-19, 18+ months of full-scale implementation were completed.

While this document outlines the key progress across these 18+ months, it is also important to acknowledge some of the key difficulties faced in implementing our approach and a few things that didn't work as well. Firstly, as part of the original project design and planning, 10to19 had envisaged a model of comprehensive programming, which would address the needs of adolescents in all areas of their lives – health, education, employability, and agency, and surpass siloed interventions to deliver holistic programs. However, as the roll-out plans were made with partners and interventions detailed out, it was realised that comprehensive programming was too complex to be implemented from day one and was repurposed as a goal to work towards both through inter-NGO coordination as well supporting the government's convergent efforts. Secondly, 10to19 had initially planned

1. A detailed overview of each district's adolescent health and well-being indicators gathered through primary and secondary research can be found in Appendix 2.

for a district saturation model for implementation, but this could not be executed given resource constraints and as the geographical restrictions of many areas were assessed to be hard to reach, and thus partners went ahead with select blocks within their chosen districts. Thirdly, 10to19 placed a significant emphasis on building evidence and thus conducted an extensive baseline study in 2018 before starting implementation. However, as intermediate progress data was collected in 2019, it was noted that our evidence collection plan was not accurately capturing the intangible impact in areas such as agency building, mindset change etc. Further, since our measures of success were mostly articulated in the longer term, it was realised that stronger intermediate short and medium term success indicators should have been defined. Acknowledging these challenges in our approach has been central to the way in which we have designed the way forward for the Collaborative's work.

We look forward to this document becoming a useful resource for the NHM and other civil society organizations especially implementors working towards adolescent health and well-being in the state. As part of on-ground programme implementation, 10to19's efforts were anchored on three change levers - capacity building of human resources, program and process strengthening, and community engagement, with a cross-cutting focus on data-driven learning.

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10to19's Mission

Drive collaborative action towards scalable impact to ensure that adolescents are educated, healthy and empowered to make positive life choices

Interventions in partnership with state departments and/ or with on ground implementation partners, to improve adolescent, health, education and wellbeing

Capacity building of human resources

To ensure better last mile delivery of services:

- **Co-create and strengthen training content and pedagogy of training of human resources**
- **Support training delivery and roll out at various levels (from FLWs to block and district officials)**

Program and process strengthening

To ensure smooth implementation of programs and services:

- **Facilitate regular inter-department interactions, and intra-department convergence where relevant**
- **Support implementation of adolescent focused programs and service delivery innovations**

Community engagement

To increase demand and uptake of services:

- **Support implementation of community awareness, trust building and engagement activities**
- **Facilitate creation of community champions and involvement of community in decision making**

Data-based learning

Facilitate mechanisms to collect timely and actionable data, and create feedback loops at various levels of the administration to ensure evidence based decision making and course correction

A comprehensive assessment of the status of adolescents conducted by 10to19 found **low awareness among adolescents about RKSK** especially Adolescent Friendly Health Clinics (AFHCs) and Peer Educators (PEs). The findings indicated that **few adolescents had availed the service**s offered under the program. Only 1-2 percent of adolescents in the age group 10-14 and 3-7% of adolescents in the age group of 15-21 had heard of AFHCs. Less than one percent of adolescents had used the services of AFHCs. The study also found that girls face disproportionate challenges, given greater restrictions on freedom of decision making and mobility, especially among married girls. Only 58% of married girls were allowed to go unescorted to a shop or market in their own village as compared to 87% of unmarried girls and 99 percent of boys. The efforts of the district administrations and implementing partners C3 and CINI have been to improve the delivery of services under RKSK and to increase community participation and uptake of services.

Early Outcomes

Collaborative initiatives of the districts and implementing partners have resulted in increased community demand for RKSK's services. Moreover, the work has resulted in more coordinated, data driven and effective program management and delivery of the RKSK program. AFHCs in Gumla and Lohardagga saw an increase of 20% and 10%, respectively, in the total number of adolescents registered at AFHCs between 2018-19 and 2019-20 and the community focused initiatives have impacted over 40,000 adolescents. In Simdega and Saraikela districts, multiple important directives have been issued at the block and district level on RKSK implementation, which has led to training and orientation support to 1,417 FLWs who have conducted 622 Adolescent Health Days (AHDs). These efforts have directly impacted another 40,000 adolescents and 30,000 community members.

Way Forward:

10to19 and its partners remain committed to work for adolescent health and wellbeing in Jharkhand and will continue to further the impact of their collective work in close collaboration with the state government. A key aspect of 10to19's implementation approach going forward will be to:

- Innovate, demonstrate, codify and amplify key programme efforts or 'components' of government schemes into easy-to-adopt forms for the wider sector
- Centre all our work on adolescent-centric design and adolescent and community-led insights
- Take input from and encourage collaboration between multiple CSOs, technical experts, government bodies, funders, private players and others
- Ensure learnings from Jharkhand are amplified to the Central level and in other states for replicability

As part of this refreshed approach, 10to19 in partnership with the Jharkhand Rural Health Mission will continue supporting the design and roll-out of innovations in Adolescent Health and Wellness Days (AHWD) component of RKSK and community-level service delivery of adolescent health services. Within this, a particular focus will be built on integrating the youth perspective and increasing adolescent participation within RKSK. CINI will be working to support the AHWD roll out in 3 districts of Simdega, Saraikela and Dumka. Going forward, 10to19 will identify more such components from within existing government programmes and work with the local and state administrations to innovate in their design and implementation.

Similarly, 10to19 looks forward to supporting the roll out of the School Health and Wellness Programme, especially the engagement with Health and Wellness Messengers. Through its partners CINI, Quest Alliance and Aangan Trust, 10to19 will explore how this seamless integration of health and education programmes can be enabled and enhanced. Through all its interventions, 10to19 will ensure adolescent centricity, and design all approaches keeping adolescent and youth needs at the centre. Further, all the learnings that are collected at the state level in Jharkhand will be amplified to the central government, additional states and national civil society for replication and scale in newer geographies, showcasing Jharkhand as a leader in social sector innovations.

10to19's youth-led initiative – Ab Meri Baari – will be active over 2021 with a focus on combating the issues of teenage pregnancy and addressing adolescent SRHR with a mix of online and offline engagements. Similarly, 10to19's Community of Practice with 200+ CSO members will continue to thrive in the state. All of 10to19's work will be validated by and input will be taken from a large civil society group as well as adolescents and their communities. This is key to 10to19's approach of building collaboration within the sector across CSOs, funders, technical experts, government, private sector and other key stakeholders.

10to19 looks forward to a nurturing a strong and long-term partnership with the people and government of Jharkhand to prioritize adolescent health and wellbeing.

Key Learnings and Recommendations

Key learnings from this collaboration are relevant to NHM's operations across the state. These are summarised below, and are mapped to the noted levers of change of the initiative:

Capacity building of human resources to ensure better last mile delivery of services

Training of frontline staff is a critical component of the RKSK program. It has a high impact on the quality of service delivery, which can improve health seeking behaviour among adolescents. Trainers, especially those delivering programs focused on sensitive topics such as sexual and reproductive health, are more effective after they receive adequate and high-quality training. Updating training methods and formats and providing hands-on opportunities to trainers, results in greater capacity building and a sense of ownership at the trainer level. To enhance its current efforts, the state health department can consider:

1 **Ensure effective follow-up trainings at regular intervals for FLWs on key soft skills such as adolescent engagement.**

FLWs often interact with adolescents and their parents on sensitive topics and must create an environment that allows adolescents to share concerns without the fear of judgement. Conducting **refresher trainings regularly on critical soft skills** like engaging adolescents in groups, guiding discussions on sensitive topics and providing necessary medical care gives FLWs an opportunity to refresh their content knowledge, clarify questions and strengthen their facilitation skills. This can enable FLWs to **translate their knowledge to practice and improve the effectiveness of adolescent engagement activities.**

For e.g. FLWs in Simdega and Saraikela districts were re-oriented and trained by 10to19 partners through refresher training on the 6 core modules of the RKSK program and critical soft skills like engaging and building trust with adolescents.

2 **Designing training content that is contextual with local needs and experiences.**

Often the lack of relatability makes training materials less interesting and ineffective. Contextualising content with locally relevant examples **strengthens the link between theory and practice** and makes materials more engaging. This can **improve both meaningful participation and content retention** among participants.

For e.g. A set of three illustrated flipbooks[2] with attractive visuals and real-life scenarios have been co-developed by C3 in consultation with NHM, for FLW and Peer Educator (PE) trainings, showcasing applicability of the concepts. Each FLW and PE in Gumla and Lohardagga districts was given his/her own copy after the training to be used while interacting with the community.

Recommended action for department:

Review current training content, design and frequency. Consider redesigning/ strengthening existing training while planning for training budget and calendar of this year. The department may reach out to C3 and CINI to know more about the training content and design used with FLWs and PEs.

2. These flip books have been developed by C3 in consultation with NHM. The state administration may reach out to leverage materials for other blocks/ districts if desired

Program and process strengthening to ensure smooth implementation of programs and services

Timely identification and resolution of issues, informed decision making, and optimal budget utilization are key to ensure coordinated, uninterrupted, and high-quality delivery of services to adolescents. To further strengthen programs and processes, the department could consider:

Data-based learning

1 Conducting detailed planning at district level early on in the year to clearly assign roles, responsibilities and budget for all key activities planned.

Having clarity on the milestones to be achieved and activities to be conducted during the year is helpful in **setting and tracking clear accountability.** Adopting a participatory approach for such an exercise can ensure **faster agreement and approvals, better coordination and more optimum utilisation of resources.**

For e.g. An implementation plan for FY19-20 activities was created, through participatory workshops organised at the district and block level. The workshops were attended by a wide range of stakeholders including on-ground health workers and officials from block and district NHM. CINI guided participants to use its proprietary tool 'RKSK Technical Support Framework'[3] to create a micro plan that served as a base for program implementation and progress monitoring.

2 Using simple tools/ technology to collect data and evidence on the quality of service delivery.

Providing relevant officials with timely and accurate data provides them **better visibility into operations,** enables them to **support program and service delivery, and make decisions for effective program management.**

For e.g. Half-yearly assessments of 16 AFHCs were conducted by C3 to evaluate their infrastructure and service availability, which has helped to escalate any gaps for action to the relevant authority. This is being done using a tool[4] adapted from benchmarks set by RKSK, which includes checks for infrastructure, logistics & furniture, Information, Education and Communication (IEC) material, human-resources, commodities and consumables, equipment, services provided, outreach services, linkage and referral services, records & reports, monitoring and supervision.

3 Regularising intra department reviews and inter department convergence.

The multiplicity of departments and stakeholders can pose challenges in managing cross-cutting programs such as those for adolescents. The success of RKSK depends heavily on effective and regular communication and collaboration across multiple functions and departments. Interactions between stakeholders within and across line departments in 10to19's work has **improved accountability, timely identification and resolution of issues, and coordination and decision making.**

For e.g. Data sharing and engagement between program managers in the health departments at state, district and block level, has resulted in more activities being planned and conducted, therefore improving budget utilization. These interactions have also enabled appointment of more front line human resources. Staff has been designated at 15 AFHCs in Gumla and Lohardagga blocks and utilisation of budget has been maximised.

4 Identifying and scaling low cost, low effort incremental changes to the service delivery process.

Small but meaningful modifications to program implementation can improve efficiencies from a time and cost perspective and also impact outcomes. Changes such as modification to a step in the process, use of a new tool or an additional checkpoint have been able to significantly **increase adolescent engagement and uptake of services.** Identifying and institutionalising such measures is important for the success of the program.

For e.g. As part of CINI's intervention, drop boxes have been set up at adolescent drop-in-centres[5] (DICs) at the village level in Simdega and Saraikela districts to allow adolescents to share their concerns with FLWs in a confidential manner. This has enabled them to be vulnerable while maintaining their privacy. Through C3's innovation piloted in Raidih, Kamdara, and Palkot blocks

3. Please refer Appendix I. The department may reach out to CINI to know more about this framework
4. This tool is proprietary of C3 and the state department may reach out to leverage materials for other blocks/ districts if desired
5. The DICs are 'safe spaces' (such as Anganwadi Centres) identified by the community for adolescent focused activities such as PE led meetings etc.

of Gumla district, a 'check box' for 'Visit to AFHC' was added to the health centre admission slip. Adolescents visiting the centre were required to get this signed off from the counsellor present at the clinic. This ensured that adolescents visiting the health centre at least visit the AFHC and have a conversation with the counsellor/ Auxiliary Nurse Midwife (ANM) about services relevant to them, at minimal additional cost to the department.

Recommended action for department:

- **Examine current process of implementation planning. Consider a participatory approach to create detailed plans that lay out key activities and milestones from the year and also assign the required roles, responsibilities and budget. The department may reach out to CINI to know more about their Technical Support Framework and approach which were used to make these plans.**
- **Examine current intra-department review meetings and inter-department convergence meetings. Consider strengthening regularity and ensuring focused agenda, based on data and evidence from the ground. The department may reach out to C3 to know more about the assessment tool they used for assessing AFHCs. Data from such assessments should be discussed in review meetings.**
- **Identify simple innovations in program/ service delivery being implemented by officials/ Front Line Workers (FLW)/ NGOs. Consider scaling viable innovations across the state.**

Community Engagement to increase community demand for and uptake of services

RKSK is a community based program and its success depends largely on a sensitised and engaged community. To increase community participation and uptake of services, there is a need to build awareness, trust, and ownership among the target populations. To engage more deeply with the community, the department can consider:

1 **Designing IEC materials to be user-friendly and interactive.**

Visual, contextualised and concise IEC materials resonate more with community members and better achieve the desired objectives such as building awareness. Materials that are designed based on user needs and use visuals to show real life examples **build better interest and awareness at the community level.**

For e.g. The illustrated flip books created by C3, which were used in training of FLWs and PEs, have also been placed at AFHCs across Gumla and Lohardagga districts to highlight key aspects of RKSK and services offered at the AFHCs which are being used by FLWs to engage with visiting adolescents/members of the community.

2 **Ensuring community demand building activities such as AHDs, adolescent group meetings etc. are held regularly.**

Forums that give adolescents an opportunity to engage with each other and learn about and understand the relevance of programs and services applicable to them can help i**ncrease their on-going demand for health services.**

For e.g. Regular AHDs and PE led sessions have led to increased awareness and demand for services offered by the AFHCs in Gumla and Lohardagga districts. C3 also used the platform of UDAAN classes to share information on AFHCs with adolescents, thereby closing the loop between sexual and reproductive health and rights (SRHR) education and service delivery.

3 **Investing time and resources in sensitizing community towards adolescent needs and involving them in decision making where possible.**

Providing a platform for adolescents and the community to understand the RKSK scheme, engage with the FLWs and RKSK staff and provide input in decisions that directly impact them, can help **build awareness, trust and ownership in the community for adolescent health and wellbeing related issues.** A strong buy in from the community on activities being conducted can have an impact on their commitment to break away from unequal societal norms and support adolescents in successfully transitioning into adulthood.

For e.g. Village level meetings were organised in Simdega and Saraikela districts with attendance from parents, adolescents, FLWs and PRI members to sensitise the community towards adolescent issues such as child marriage, SRHR awareness, substance misuse, school drop-out etc. At the end of the meeting, community members collectively identified a suitable 'safe space' (such as Anganwadi Centres) for peer-led adolescent meetings to be held at the village level which were termed drop-in centres for adolescents.

Recommended action for department:

- **Examine current IEC materials being used on the ground. Consider re-designing or strengthening existing materials to be more visual and based on real life examples. The department may reach out to C3 to know more about the flipbooks being used at the AFHCs.**
- **Identify areas where adolescents and community members can be included in the decision making process. Empower block and village level officials to engage with community members and involve them in decision making. The department may reach out to CINI to know more about the consultations conducted with community members.**

Deep Dive into 10to19–NHM partnership

The following section describes in detail some of the program initiatives being supported by 10to19's partners C3 and CINI in Jharkhand. The objective is to provide the state department with details on the learnings that have improved the uptake and efficiency of government programs in the districts of Gumla, Lohardagga, Simdega and Saraikela. We hope that this will act as a starter guide to the state in case of scale-up or expansion plans.

Using Data and Training to Strengthen Adolescent Friendly Health Clinics

Implementing partner	Centre for Catalyzing Change(C3)	**Districts covered**	Gumla, Lohardagga
Key stakeholders involved	District and block level RKSK units, community level functionaries		
Key Takeaways	• Effective training through activity-based and participatory methods is crucial in enabling front line staff to successfully deliver programs.		
Results	Since the start of 10to19's intervention, Adolescent Friendly Health Clinics (AFHCs) in the selected districts have seen increase in adolescent and community level engagement. The state NHM has also been able to reduce Front Line Worker (FLW) vacancies and increase budget allocation towards operationalization of AFHCs. AFHCs in Gumla and Lohardagga saw an increase of 20% and 10%, respectively, in the total number of adolescents registered at AFHCs between 2018-19 and 2019-20.		
Implications	AFHCs in the intervention districts are operating more effectively, with trained staff on the front line, better visibility into operations and challenges for officials, faster and more effective decision making based on data, and a more engaged community.		

Overview

As part of the collaboration with NHM Jharkhand, C3 is providing technical assistance to strengthen the implementation of RKSK. It is supporting the operationalization of 16 AHFCs - 11 in Gumla and 5 in Lohardagga.

Areas of support:

Capacity building of human resources to ensure better last mile delivery of services:

1 **Collaborating on training design and delivery:**

- An initial assessment by 10to19 showed that health functionaries at the district and block level were not familiar with the RKSK program and AFHC guidelines. To address this, a mentoring program was co-designed to **provide program implementers with a better understanding of**

the RKSK program and their role in effective implementation. Workshops were conducted which included an orientation to RKSK's operational mandates, budget allocations, outreach provisions and the charter of services mandated under the AFHCs.

- 10to19's assessment also found a **lack of trained counsellors at all AFHCs.** Where counsellors had not been appointed, enthusiastic Auxiliary Nurse Midwife (ANM) and Multipurpose workers (MPW) were identified and trained to serve as Adolescent Health Counsellors and provide first-level counselling support. This has helped **ensure continuous and high quality service delivery** to adolescents visiting the clinic. Given the familiarity of ANMs in the community, this has also helped reduce the stigma associated with family planning and other SRHR services offered at the clinics.

Program and process strengthening to ensure smooth implementation of programs and services:

1 Enabling data based learning:

- A half-yearly assessment of AFHCs is being conducted by C3 in partnership with NHM to **provide officials visibility into the state of select AFHCs and to enable identification and resolution of issues being faced.** The assessment is carried out using C3's proprietary tool[6] which collects data and information on infrastructure, logistics, Information, Education and Communication (IEC) material, human resources, commodities and consumables, equipment, services provided, outreach services, linkage and referral services, records & reports, monitoring and supervision.

- District, block and community functionaries are being supported by C3 in collection of day-to-day operational data from AFHCs. Data on registrations, visits, services availed etc. is being compiled in prescribed formats and being reported quarterly on the Health Management Information System (HMIS). This has **ensured a continuous feedback loop of data and evidence and provides the officials visibility into operations and availability of services.**

2 Facilitating accountability mechanisms:

- At the district and block level, regular meetings of health functionaries are being organised to review and discuss data reported from AFHCs. This has facilitated **timely identification and resolution of issues and long term corrective** action such as appointment of more human resources and increased budget allocation towards operationalization of AFHCs.

- Intra-departmental convergence meetings have been used as an effective platform to **gain commitment from stakeholders to collectively mobilise and encourage adolescents to access RKSK services.** These forums are attended by officials across levels and functions, as well as from line departments other than health and community functionaries. These stakeholders are oriented on the RKSK program and the range of services offered at AFHCs and the role they play in effective implementation.

3 Supporting program innovations:

In Raidih, Kamdara, and Palkot blocks of Gumla district, it was observed that adolescents were visiting the health centres but not consulting AHFCs during their visits. An AFHC 'check mark' was added to the Health Centre admission slips for anyone between the ages of 10-19. As a result, adolescents entering the health centre at least visit the AFHC and have a brief conversation with the counsellor/ANM present on services relevant to them. This simple and low cost innovation has helped significantly **increase adolescent engagement at these clinics.**

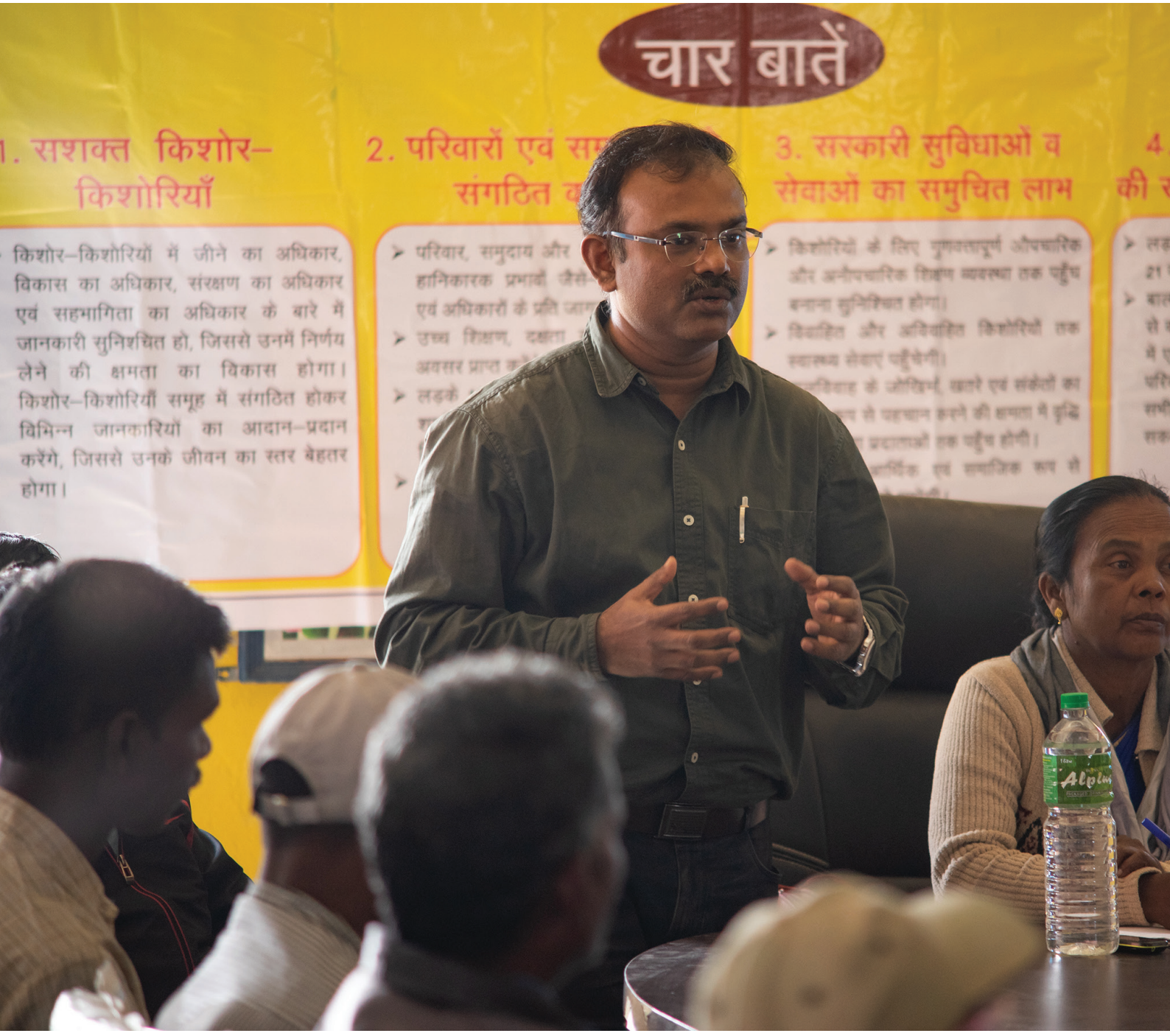
6. The tool has been developed based on the benchmarks for establishing AFHCs, as included in the RKSK operational guidelines

Community engagement to increase demand for and uptake of services:

1 Supporting implementation of awareness/ narrative building activities:

- 10to19's initial assessment found that adolescents in the intervention districts were unaware of the RKSK programs and services available to them. To boost awareness, a set of three illustration-based flip books have been given to the AFHCs to be used for their own and the community's reference at the clinics. The flipbooks have been designed to be visually engaging and easy to understand. They cover the six key themes[7] of RKSK as well as the counselling and clinical services available at the AFHC. They have **created significant visibility of the services offered at the clinics** and eased the counselling process for health service providers.

- Community engagement platforms such as Adolescent Health Days (AHDs) and adolescent group meetings have been regularised by CINI's interventions. They have been effectively used to create awareness about AFHCs, resulting in increased adolescent engagement in these districts and higher footfall at the clinics.



7. The six key themes of RKSK are Reproductive and Sexual Health, Nutrition, Mental Health, Injuries and Violence including Domestic and Gender-Based Violence, Substance Misuse and Non- Communicable Diseases

Using Effective Training Methodologies and Content to Leverage Peer Educators as Change Makers Within Their Communities

Implementing partner	Centre for Catalyzing Change(C3)	**Districts covered**	Gumla, Lohardagga
Key stakeholders involved	Peer Educators (PEs), Front Line Workers (FLWs)		
Key Takeaways	• Effective training through contextualised, and visually engaging content is crucial in enabling front line staff to successfully deliver programs.		
Results	Over the course of their intervention period, starting in July 2018, C3 used illustrated flipbooks to facilitate the training of 3700 FLW and 3,796 PEs in the districts of Gumla and Lohardaga. Through such community-based activities, C3 was able to facilitate an engaging dissemination of the RKSK modules to over 26,000 adolescents.		
Implications	PEs and FLWs in the intervention districts have a stronger understanding of RKSK components and are better equipped to engage with adolescents on these important issues.		

Overview

C3 has focused on adopting an adolescent-friendly approach to training content and design, to ensure that PEs and FLWs understand the information deeply and relay it effectively to adolescents in the community.

Areas of support:

Capacity building of human resources to ensure better last mile delivery of services:

1 **Supporting content development:**

- 10to19's initial assessment found that PEs in the intervention districts were not adequately prepared to play their roles in the community, and there was scope to strengthen training for them. A set of three illustration based flip books were prepared, in consultation with the government, on the six key themes of RKSK as well as the counselling and clinical services available at the AFHC. The flipbooks have been designed to be visually engaging and easy to understand. They have also played the role of a demonstrative aid for FLWs and PEs after the training. Each of the PE and FLW who attended the district-mandated training were provided with their own set to be used while engaging with adolescents and community. These flipbooks have received appreciation from FLWs, PEs, state governments and the community. They have been successful in **creating significant visibility of the services offered at the clinics at the community** level. As shared by a PE from Gumla district - **"Being a Peer Educator, I have been entrusted to transact session in my Kishor Samooh (peer group) meetings on a regular basis. The set of 3 flipbooks on RKSK given to us during PE training is very helpful for me. I can refer flip book for transacting sessions on various topics during samooh meetings. It is easy to understand and use. There are simple examples and case studies in the flip book which help my group members to understand and related with the topics easily."**

Peer Educators holding samples of flipbooks; ANM cum counsellor conducting a video call with an adolescent from the community

Driving Effective Implementation of RKSK and Stronger Decision Making Through Convergence and Sustained Engagement

Implementing partner	Child In Need Institute (CINI)	**Implementation districts**	Simdega, Saraikela
Key stakeholders involved	District NHM Cell, Block NHM Cell		
Key Takeaways	• Detailed and participatory planning, regular reporting of progress data and intra-department review meetings ensure effective accountability and program management. In addition, increasing effectiveness of training through activity-based and participatory methods further supports front line staff to successfully deliver programs and services on the ground.		
Results	This intervention has created accountability across all levels of the health department, higher utilization of the RKSK funds and regularised the roll-out of relevant activities. Since 2018, 18 directives at the District, and 37 directives at the block-level have been issued towards RKSK implementation. This has led to directly reaching out to 1417 FLWs, conducting 622 Adolescent Health Days (AHD) since 2018, directly impacting close to 40,000 adolescents and 30,000 community members.		
Implications	There is more clarity among officials and FLWs on the activities to be conducted during the year, and better visibility at the department level on the need for resources and support in implementation. This has improved overall budget utilisation and increased accountability of district and block officials, as well as FLWs.		

Overview

Since 2018, CINI has been supporting district administrations of Simdega and Saraikela through technical assistance aimed at regularizing, and strengthening delivery of RKSK programs and services.

Areas of support:

Capacity building of human resources to ensure better last mile delivery of services:

1

Supporting content development:

- CINI provided support to the NHM to enhance existing training modules with **real life examples and activity-based inputs** to help enhance retention for participants. Collaborating with the NHM, CINI undertook designing of the content and facilitated printing and distribution of the new material.

Collaborating on training design and delivery:

- Recognising that FLWs need on-going support in engaging with adolescents, CINI supported NHM in re-orienting them on the 6 core modules[8] of RKSK as well as critical soft skills such as convening groups effectively, creating safe spaces for adolescents to share their concerns, and providing relevant health services as needed. These sessions **refreshed their knowledge** on RKSK activities and **better equipped them to engage on sensitive topics** of adolescent health and well-being as well as carry out activities such as AHDs, VHNDs and PE led sessions more effectively.

8. The modules include sexual and reproductive health, nutrition, mental health, injuries and violence including domestic and gender-based violence, substance misuse, and non-communicable diseases.

Program and process strengthening to ensure smooth implementation of programs and services:

1 Supporting implementation planning:

- To strengthen the yearly planning exercise, CINI helped facilitate workshops in to plan for implementation activities of FY19-20. Using a participatory approach, stakeholders created a micro plan for each district and block with details of activities, objectives, responsibilities, and budgets for the year under each RKSK component using CINI's proprietary RKSK Technical Support Framework (refer Appendix I). With participation from a wide range of stakeholders, such as Civil Surgeon, District Program Manager (Health), District Program Coordinator, Block Medical Officer In-Charge, Block Program Manager (Health), and Block Accounts Manager, this exercise **enabled faster agreement and planning, leading to more activities in the year and better budget utilization at the department level.**

2 Enabling data-based learning:

- A cadre of Panchayat facilitators, contracted by CINI, were tasked with supporting FLWs to collect and **report regular and accurate on-ground data on aspects of both demand and supply.** Data on community demand was collected using metrics such as attendance for AHDs, while availability of infrastructure and funds disbursement provides insight into the supply side. This data was **regularly reviewed by block and district level officials** and was used to **guide decision making.**

3 Facilitating accountability mechanisms:

- District and block level review meetings were held every month. Minutes from these meetings were forwarded to stakeholders at state and were discussed and followed up in regular departmental meetings, facilitated by CINI. These meetings were anchored on data reported from the ground, and **enabled faster and more informed decision making,** e.g. faster action on fund disbursal and execution of activities as per plan.

Use of Participatory Approach to Build Community Ownership of Adolescent Issues and Increase Uptake of Adolescent Health Services like RKSK

Implementing partner	Child In Need Institute (CINI)	Implementation districts	Simdega, Saraikela
Key stakeholders involved	Front line workers (FLWs), adolescents, parents, teachers, PRI members, etc.		
Key Takeaways	• Engaging adolescents, parents, and community in sensitization and decision making creates a strong enabling environment to address adolescent focused issues effectively		
Results	Since the commencement of CINI's field work in Feb 2019, the intervention districts have seen increased awareness, sensitization and ownership for adolescent health and wellness among community members. 172 adolescent safe spaces have been identified at village level, and appropriately embellished with IEC materials on nutrition, gender-based violence, substance misuse, while information on adolescent health services has also been made available through these centres. The setting up of these adolescent safe spaces, or 'drop-in centres' (DICs) has enabled 581 peer groups, led by 800 peer leaders to reach out to close to 40,000 adolescents to through regular peer-led sessions over this period.		
Implications	Adolescents in the intervention districts are becoming more engaged in their own development and are gaining confidence and sense of agency through adult-adolescent interactions in platforms like VLCPCs and PRIs.		

Overview

CINI supported two districts in Jharkhand to drive village level demand for services using a participatory and prevention-led approach. CINI's focuses on strengthening existing systems by making them more functional and by involving primary duty bearers (such as parents, service providers and local governance bodies) in decision making on adolescent health and wellbeing.

Areas of support:

Community engagement to ensure better last mile delivery of services:

1 Support implementation of community engagement/ empowerment activities:

- CINI helped organise village level community sensitisation meetings which saw attendance adolescents, parents, health workers, and PRI members. These served the purpose of orienting the community to the RKSK program as well as an opportunity to collectively identify a 'safe space' for adolescents to convene, which in most cases ended up being the pre-existing Anganwadi Centres (to be used after their usual operating hours). These spaces have been termed as 'drop-in centres'. These meetings **played a key role in creating community buy-in,** which in turn helped **manage concerns and backlash that is expected when adolescents are engaged on sensitive topics** such as sexual and reproductive health and rights.
- In an attempt to overcome hesitation among adolescents to discuss sensitive issues and open up about their concerns, drop boxes have been set up at the drop-in centres that **allow adolescents to share their vulnerabilities** with the FLWs through written notes, and get referred to the relevant services.
- As a pilot innovation, eight of these drop-in centres were also used as multi-purpose spaces to impart various skills to adolescents, such as remedial coaching and self-defence. While these had started to show early success, with the onset of COVID-19, these efforts have been put on hold.

2 Enabling data based learning:

- In the intervention districts, FLWs and village level stakeholders such as PRIs, parents and teachers came together to create 'Social Resource Maps' - an assessment and tracking tool for adolescent vulnerabilities and social issues in the village. Through a colour coding system, the maps mark homes of all adolescents in the village, calling out specific vulnerabilities (risk of child marriage, child labour, school dropout etc.) and identifying all resources available in the village for their support (panchayat office, Anganwadi Centre, schools etc.). These maps have **helped PEs and FLWs identify and follow up on vulnerable cases** and ensure adolescents participate in RKSK activities such as AHDs and VHSNDs.

If you would like to know more about the interventions described in this document or have any questions, please reach out to the 10to19 Collaborative through any of the following channels:

Website: www.10to19community.in Email: 10to19community@dasra.org

Appendix 1.

10to19's implementation partner CINI has developed this Technical Support Framework as a base document to guide implementation planning for various components of the Rashtriya Kishor Swasthya Karyakram (RKSK) scheme. This framework was used a reference document for participatory workshops conducted with officials in the districts of Simdega and Saraikela to create micro-plans for implementation in FY19-20. These micro-plans have served as a helpful starting point for progress monitoring and accountability tracking for the department, including budget utilization.

CINI's RKSK Technical Support Framework is presented below as a reference document. This can be used by field level functionaries to plan implementation, as done in the intervention districts of Simdega and Saraikela. The department may reach out to CINI to know more about the framework, its applicability and their approach to participatory planning.

Technical Support Framework for Strengthening RKSK in Jharkhand

RKSK Components	Targeted Indicators	CINI's Intervention (to be used as reference by government and CSO implementers to plan their own interventions/activities)
1. Peer Led Adolescent Empowerment	1.1. Improved coverage of adolescent girls through adolescent groups. 1.2. PE selection done for all groups in a democratic process. 1.3. Structured adolescent engagement plan under RKSK in place and being executed by the health system. 1.4. Auxiliary Nurse Midwife (ANM) – Peer Educator (PE) sessions (in the presence of Sahiyaa), regularised through Adolescent Friendly Clubs (AFC). 1.5. 'At Risk' cases are being screened at the adolescent groups and referred to Adolescent Friendly Health Clubs (AFHC) for service linkages.	a. Capacitating frontline service providers (especially Block Trainer Team members, ANMs and Sahiyaas), on the 'adolescent well-being and empowerment' model through existing platforms at cluster and block level. b. Institutionalise vulnerability tracking mechanism within the government system through ANMs and Village level child protection committees (VLCPC). c. Develop the adolescent engagement package and getting buy-in from the Dept. of Health (RKSK cell). d. Create a cadre of master trainers at the district level on the adolescent engagement package (meeting cycle and communication pack). e. Provide necessary support in developing the Micro Plan for AFC through with the 'adolescent engagement package will go down up to the Adolescent groups. f. Monitor the rolling-out of the 'adolescent engagement package' in a cascade model from district to the adolescent group level and ensure quality assurance through a tracking and feedback system.

RKSK Components	Targeted Indicators	CINI's Intervention (to be used as reference by government and CSO implementers to plan their own interventions/activities)
2. Adolescent Health Day (AHD)	2.1. Improved budget utilization under AHD at the district level. 2.2. Abidance of AHD micro-plan (especially in the hard-to-reach areas, as identified by the district administration). 2.3. Services related to (i) screening; (ii) distribution; (iii) information and (iv) referral, delivered as per the RKSK guidelines. 2.4. AHD communication package for the frontline service providers, in place. 2.5. AHD monitoring system developed and regularised.	a. Facilitate a process of development of a Standard Operating Procedure (SoP) for AHD in collaboration with State RKSK Cell. b. Orientation of service providers on SoP for AHD. c. Facilitate AHD micro planning at the district and block level. d. Support State RKSK cell in developing the Communication package for AHD. e. Advocacy for supportive supervision visits to AHD by district and block officials (including Block Trainer Team members) using a standard supervisory checklist and technical support in designing a real time tracking system (may be a mobile based app for the ANMs).
3. Adolescent Friendly Health Clinics (AFHC)	3.1. Functional AFHC (Yuva Maitri Kendra) at all the Community Health Centres as per the guideline 3.2. Trained Counsellor in place 3.3. Footfall of the adolescents / referral cases at AFHCs	a. Support AFHCs for having all relevant resource materials related to adolescent well-being and empowerment at AFHC (developing AFHC as a resource centre). b. Advocacy for recruitment of dedicated Counsellors at AFHC (1 male and 1 female counsellor in an ideal scenario). c. Training of counsellors for acquiring knowledge on adolescent well-being and empowerment as well as counselling skills. d. Advocacy and hand holding support for putting a referral tracking system in place (Adolescent well-being card, referral register, referral slip).
4.Weekly iron folic acid supplementation (WIFS) and Menstrual hygiene	4.1. Improved understanding of service providers (Teachers, ANM, Anganwadi Worker and Sahiyaas) on WIFS and MHM. 4.2. Supply chain for iron folic acid (IFA) tablets and sanitary napkins improved.	a. Training of teachers (facilitators) on WIFS and MHM. b. Supply chain bottleneck study followed by dissemination of findings and recommendation at district and state level. c. Putting a tracking system in place within the government system, for supply chain of IFA tablets and sanitary napkins. **...continued on the next page**

RKSK Components	Targeted Indicators	CINI's Intervention (to be used as reference by government and CSO implementers to plan their own interventions/activities)
4.Weekly iron folic acid supplementation (WIFS) and Menstrual hygiene	4.3. Government system pushing for increased consumption of IFA tablets by adolescent girls. 4.4. Government system doing a communication campaign for improving menstrual hygiene practices amongst adolescent girls.	d. Advocacy for improved serve delivery and supply chain on IFA and sanitary napkins, through Adolescent Girls at various platforms. e. eTechnical support to the districts in designing and executing a community-based awareness campaign on IFA consumption and menstrual hygiene practices.
5. Overall program management aspects of RKSK	5.1. RKSK – Management Information System (MIS) in place 5.2. Block level RKSK implementation plan in place by ensuring inter-departmental convergence. 5.3. Regular review of RKSK at the district level.	a. Technical support to the state RKSK cell in developing/ improving the MIS. b. Block level planning workshop on RKSK. c. Ensure convergence of Department of Education and Department of Women and Child Development with Department Health at district/ block level. d. Facilitate and advocate for regular review meeting at the district level. Sharing findings by project team for addressing implementation gaps.

Appendix 2.

District Profiles: Overview

The National Health Mission (NHM) of Jharkhand and 10to19: Dasra Adolescents Collaborative (10to19) have been partnering since 2017 to improve adolescent health and wellbeing in the districts of Gumla, Lohardaga, Simdega and Saraikela. The following document gives a snapshot of the demographics and key health, education, and child protection related indicators for the districts.

At the start of its work in Jharkhand, the collaborative conducted a baseline among girls and boys from the age group of 10 to 21. The survey covered 325 villages and urban wards from the collaborative's six intervention districts and a representative comparison set from the remaining 18 districts. Interviews were conducted with 41,394 households. The table below captures some key health indictors from this study for the districts outline above:

Health indicators, 10to19 survey 'Status of Adolescents in Jharkhand, 2018" – combined status of Gumla, Lohardaga, Simdega, Saraikela					
Indicator	Boys (10-14)	Boys (15-21)	Girls (10-14)	Unmarried girls (15-21)	Married girls (15-21)
Heard about ASHA (%)	61.6	75.6	79.8	91.7	94.3
Received services from an ASHA (%)	6.3	4.1	11.7	13.9	47.0
Heard about RKSK (%)	0.3	1.4	1.3	3.8	1.8
Heard about AFHC (%)	0.8	2.9	2.2	7.0	5.2
Used AFHC services (%)	0.0	0.2	0.1	0.3	0.0
Number of survey respondents	3,473	3,150	4,104	3,237	1,999

District profile: Gumla

Gumla is one of the 24 districts in Jharkhand and is further divided into 12 administrative blocks. As of Census 2011, the district had a total population of 1,025,213 which is 3.11% of the total population of Jharkhand. The district had a sex ratio of 993 females per 1000 males, and a literacy rate of 66%. Details of the district's adolescent population (Census, 2011) are given below:

Total adolescents (age group 10-19)	Total adolescents in the age group 10-19 (as a percentage of total district population)	Girls in the age group of 10-19	Girls in the age group of 10-19 (as a percentage of total adolescents)
2,38,668	23%	1,17,768	49%

Key Indicators

The table below lists key metrics from available government sources on adolescent health and wellbeing in the district:

Key health, education, and child protection indicators, as per government reports				
Theme	Indicator	Gumla	Jharkhand	India
Health	Women age 20-24 years married before age 18 years (NFHS4, 2015-16)	24%	38%	27%
	Women age 15-19 years who were already mothers or pregnant at the time of the survey (NFHS4, 2015-16)	10%	12%	8%
Education	Enrolment secondary classes (9th and 10th) (UDISE+, 2018-19)	12%	13%	15%
	Enrolment higher secondary classes (11th and 12th) (UDISE+, 2018-19)	6%	8%	10%
Child protection	Reported cases of sexual violence against children under POCSO Act (0-18 years) (NCRB 2019)	30	654	47,335
	Reported cases of child labour (0-18 years) (NCRB 2019)	15	18	770

District Profile: Lohardaga

Lohardaga is one of the 24 districts in Jharkhand and is further divided into 7 administrative blocks. As of Census 2011, the district had a total population of 4,61,790 which is 1.4% of the total population of Jharkhand. The district had a sex ratio of 985 females per 1000 males, and a literacy rate of 56%. Details of the district's adolescent population (Census, 2011) are given below:

Total adolescents (age group 10-19)	Total adolescents in the age group 10-19 (as a percentage of total district population)	Girls in the age group of 10-19	Girls in the age group of 10-19 (as a percentage of total adolescents)
1,15,124	25%	56,316	49%

Key Indicators

The table below lists key metrics from available government sources on adolescent health and wellbeing in the district:

Key health, education, and child protection indicators, as per government reports				
Theme	Indicator	Lohardaga	Jharkhand	India
Health	Women age 20-24 years married before age 18 years (NFHS4, 2015-16)	29%	38%	27%
	Women age 15-19 years who were already mothers or pregnant at the time of the survey (NFHS4, 2015-16)	10%	12%	8%
Education	Enrolment secondary classes (9th and 10th) (UDISE+, 2018-19)	13%	13%	15%
	Enrolment higher secondary classes (11th and 12th) (UDISE+, 2018-19)	7%	8%	10%
Child protection	Reported cases of sexual violence against children under POCSO Act (0-18 years) (NCRB 2019)	0	654	47,335
	Reported cases of child labour (0-18 years) (NCRB 2019)	0	18	770

District Profile: Simdega

Simdega is one of the 24 districts in Jharkhand and is further divided into 10 administrative blocks. As of Census 2011, the district had a total population of 5,99,578 which is 1.8% of the total population of Jharkhand. The district had a sex ratio of 997 females per 1000 males, and a literacy rate of 57%. Details of the district's adolescent population (Census, 2011) are given below:

Total adolescents (age group 10-19)	Total adolescents in the age group 10-19 (as a percentage of total district population)	Girls in the age group of 10-19	Girls in the age group of 10-19 (as a percentage of total adolescents)
1,30,303	22%	64,408	49%

Key Indicators

The table below lists key metrics from available government sources on adolescent health and wellbeing in the district:

Key health, education, and child protection indicators, as per government reports				
Theme	Indicator	Simdega	Jharkhand	India
Health	Women age 20-24 years married before age 18 years (NFHS4, 2015-16)	15%	38%	27%
	Women age 15-19 years who were already mothers or pregnant at the time of the survey (NFHS4, 2015-16)	5%	12%	8%
Education	Enrolment secondary classes (9th and 10th) (UDISE+, 2018-19)	13%	13%	15%
	Enrolment higher secondary classes (11th and 12th) (UDISE+, 2018-19)	6%	8%	10%
Child protection	Reported cases of sexual violence against children under POCSO Act (0-18 years) (NCRB 2019)	11	654	47,335
	Reported cases of child labour (0-18 years) (NCRB 2019)	0	18	770

District Profile: Saraikela Kharsawan

Lohardaga is one of the 24 districts in Jharkhand and is further divided into 7 administrative blocks. As of Census 2011, the district had a total population of 4,61,790 which is 1.4% of the total population of Jharkhand. The district had a sex ratio of 985 females per 1000 males, and a literacy rate of 56%. Details of the district's adolescent population (Census, 2011) are given below:

Total adolescents (age group 10-19)	Total adolescents in the age group 10-19 (as a percentage of total district population)	Girls in the age group of 10-19	Girls in the age group of 10-19 (as a percentage of total adolescents)
2,20,757	20.7%	1,05,646	47.8%

Key Indicators

The table below lists key metrics from available government sources on adolescent health and wellbeing in the district:

Key health, education, and child protection indicators, as per government reports				
Theme	Indicator	Saraikela Kharsawan	Jharkhand	India
Health	Women age 20-24 years married before age 18 years (NFHS4, 2015-16)	33.2%	38%	27%
	Women age 15-19 years who were already mothers or pregnant at the time of the survey (NFHS4, 2015-16)	14.8%	12%	8%
Education	Enrolment secondary classes (9th and 10th) (UDISE+, 2018-19)	14%	13%	15%
	Enrolment higher secondary classes (11th and 12th) (UDISE+, 2018-19)	8%	8%	10%
Child protection	Reported cases of sexual violence against children under POCSO Act (0-18 years) (NCRB 2019)	19	654	47,335
	Reported cases of child labour (0-18 years) (NCRB 2019)	1	18	770

Empowering India's adolescents has long been one of the most significant of India's development challenges. Despite India being home to more adolescents than any other country, many of them face adverse social and economic challenges that complicate their transition from childhood to adulthood.

Dasra is catalyzing India's strategic philanthropy movement to transform a billion lives with dignity and equity since 1999. The 10to19: Dasra Adolescents Collaborative (DAC) is a high-impact platform that unites funders, technical experts, the government, and social organizations to reach 5 million adolescents, and move the needle on four outcomes key to adolescent empowerment: delaying age at marriage; delaying age of first pregnancy/birth; completing secondary education; and increasing agency.

DAC employs a two-pronged approach to directly reach adolescents through holistic and scalable programs implemented by Aangan Trust, Quest Alliance, Centre for Catalyzing Change and Child in Need Institute to achieve the four key outcomes at the state level in Jharkhand. Simultaneously, DAC is also building a national movement to make adolescents a priority by anchoring a Community of Practice, comprising of adolescent focused non-profits who collaborate on insights and data focused projects, exchange learnings, and work on collective advocacy interventions and solutions.

DAC is supported by Bank of America Merrill Lynch, Children's Investment Fund Foundation, the David & Lucile Packard Foundation, Kiawah Trust, Tata Trusts and USAID, among others.

If you would like to know more about the interventions described in this document or have any questions, please reach out to the 10to19 Collaborative through any of the following channels:

Website: www.10to19community.in
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Centre for Catalyzing Change (C3), formerly known as Centre for Development and Population Activities (CEDPA), India, started working in India in 1987. Since then, C3 has emerged as a key change-making organization working towards empowering girls and women across various high-burdened and resource-poor states of India so they can access opportunities, realize their rights, become self-sufficient, and achieve gender equality. At C3, we design solutions that mobilize, equip, educate and empower girls and women to meet their full potential. A significant component of our work is building and boosting the leadership skills and self-confidence of adolescent girls, and educating them on health, gender equality, nutrition, hygiene, and civic responsibility. We also connect them to employment opportunities, and offer financial and digital training to shape their futures. Through our interventions, we have touched the lives of over 1,900,000 girls across the country.

If you would like to know more about C3's work as described in this document or have any questions, please reach out through any of the following channels:

Website: www.c3india.org
Email: contact@c3india.org

Child in Need Institute (CINI) is an Indian non-government organisation founded in 1974 by Dr. Samir Chaudhuri, a paediatrician, with other professionals from different disciplines. Over nearly five decades, CINI has engaged in participatory, convergent, and preventive rights-based programming for children in the areas of health, nutrition, education, and protection. CINI reaches a population of 7 million in Indian states like West Bengal, Jharkhand, Assam and Odisha through direct interventions and in other states through technical assistance, networking and advocacy.

If you would like to know more about CINI's work as described in this document or have any questions, please reach out through any of the following channels:

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