Original Article

Situational Analysis of Rashtriya Kishor Swasthya Karyakram at One of the Districts of Gujarat

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Abstract

Background: Rastriya Kishor Swasthya Karyakram (RKSK) is a holistic approach implemented for betterment of adolescent health. Barriers in the implementation can be identified by conducting the situational analysis of any program. The present study is a part of the multi-centric study conducted at Sabarkantha district for situational analysis of RKSK. To assess the implementation of various components under RKSK at various levels of health facilities, 2) to identify the barriers faced by services providers in RKSK implementation, and 3) to identify the perception of beneficiaries regarding RKSK. **Materials and Methods:** A Cross-sectional study using a mixed method approach was conducted to review the implementation of the RKSK program at Sabarkantha district. In-depth interview of health personnel involved in implementation of RKSK was conducted using pre-structured and pre-tested interview guide. Ongoing sessions of Adolescent Friendly Health Clinics (AFHCs) were examined, and exit interview of adolescents was conducted. Adolescents residing within limits of the defined facility were also interviewed. Frequency and percentages were used for descriptive analysis, and a thematic qualitative analysis approach was used for qualitative aspects. **Results:** RKSK was implemented successfully at Primary Health Centers. Infrastructure for AFHC was inadequate particularly at higher care facilities. Weekly Iron Folic Acid Supplementation (WIFS) was successfully implemented in the district. Overall sessions conducted at AFHC were found to be satisfactory. Adolescents interviewed in the community were satisfied with the services delivered to them under RKSK. **Conclusion:** For better implementation of RKSK, there is a need to focus on certain issues such as inadequate infrastructure of AFHCs, the lack of trained counselors, unavailability of sanitary pads, and inadequate participation of adolescents from the community in availing RKSK services.

Keywords: Adolescent health, barriers, implementation, Rastriya Kishor Swasthya Karyakram (RKSK)

Introduction

Adolescents (10–19 years age group) cover 20% of the total population in India.[1] It is a period of rapid physical, psychological, and behavioral changes. Many national programs are targeted toward this particular age group considering multiple needs. The Adolescent Reproductive and Sexual Health Strategy (ARSH) was implemented from the year 2005 to 2013.[2] Subsequently, Rashtriya Kishor Swasthya Karyakram (RKSK) was launched in the year 2014 by the Ministry of Health and Family Welfare (MoHFW).[2,3] It reflects the government's commitment to protect and support adolescent health and well-being. It proposes a holistic model which includes community-based health promotion and prevention along with strengthening of preventive, diagnostic, and curative services across the levels of health facilities.[4,5]

An important component of RKSK is to develop convergence among various ministries and stakeholders of different programs for adolescents. The program focuses on age groups of 10–14 years and 15–19 years, males and females, urban and rural, school-going and out-of-school, married and unmarried, and vulnerable and under-served.

RKSK highlights the importance of strong monitoring and evaluation systems in order to ensure the greatest impact to

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adolescent populations in India.[6] Various barriers observed in poor implementation of the program related to adolescent health are the absence of proper guidance, parents' ignorance, the lack of skills, and insufficient services from the health-care delivery system.[7] The present study is intended to find out the current situation, challenges faced by service providers in implementation of RKSK, and beneficiaries' perception pertaining to RKSK at Sabarkantha district of Gujarat. Sabarkantha district is having all kinds of geographic and socio-cultural characteristics belonging to urban, rural, and tribal areas. Findings of the study will benefit in enhancing capacity building of service providers involved in current adolescent health programming.

Materials and Method

A cross-sectional study was conducted using a mixed method approach to review the implementation of the RKSK program at various health facilities of Sabarkantha district. This study was a part of the multi-centric study supported by the State Health System Resource Center, Gujarat. Health personnel involved in implementation of RKSK were interviewed by investigators. Adolescents residing within limits of the defined facility were also included in the study. Visits for desk review and field activities were performed during the month of September–October 2021.

The RKSK program is implemented at all health care levels, namely, district hospital (DH), sub-district hospital (SDH), community health center (CHC), and primary health center (PHC). Rapid review of various aspects of RKSK was performed at selected health facilities. Considering time and financial constrains, six facilities were selected for the study. Equal representation of all talukas of the district was considered during selection of the facilities. Details of the same are given in the Box 1:

Talukas	Facilities selected
Himmatnagar	DH
Khedbrahma	SDH
Idar	CHC
Vijaynagar	CHC
Prantij	PHC
Talod	PHC

Preliminary visit was conducted for pilot testing of proforma prepared for collection of data. One visit for desk review was conducted at District Health Office, Sabarkantha. The details were entered in the check list prepared for the desk review. Considering the recent pandemic of coronavirus disease 2019 (COVID-19), activities related to all health programs were affected in the year 2020–21. Therefore, data for the year 2019 were taken from the facilities to evaluate the implementation of RKSK services.

In-depth interview (IDI) of **key informants** involved in adolescent health services was conducted at each facility. Informed verbal consent was taken from all the key informants prior to the interview. Where more than one key informant was involved in delivering RKSK service, random selection of key informant was performed for IDI.

Key informants included at PHC:

1. Medical officer
2. Female health worker (FHW) or multi-purpose health worker (MPHW) or auxiliary nurse mid-wife (ANM) or counselor
3. Peer educator
4. ASHA.

Key informants included at DH, SDH, and CHC:

1. Medical officer
2. FHW or MPHW or ANM or counselor.

The medical superintendent was consulted at DH, SDH, and CHC for desk review of the respective health facility. Ongoing session activities were monitored, and findings were collected in the pre-designed and pre-tested questionnaire. Exit interview of any one beneficiary was taken from each facility. Community-based interview of any one adolescent boy and one adolescent girl who have ever used RKSK services was conducted in the field areas of all selected facilities. Adolescents were selected randomly from the area. Written consent from the guardians of adolescents was taken prior to data collection. Inclusion and exclusion criteria for selecting adolescents in the community were as below:

- Inclusion criteria:
  1. Participants who gave informed consent for the study.
  2. Participants who reside within selected health facility area limits.
- Exclusion criteria:
  1. Intellectual disabled adolescents who were having difficulties in. Communication was excluded from the study.

Data entry was performed using Microsoft Excel 2010 (Microsoft Corp, Redmond, WA, USA). Frequency and percentages were used for descriptive analysis. The thematic qualitative analysis approach was used; all interviews were documented on paper, and transcripts were prepared. Themes identified were barriers in implementation of RKSK and suggestions for improvement of RKSK implementations. Sub-themes were regarding human resources, infrastructure, logistics, and beneficiaries.

Results

Desk review

A total of 12 review meetings were conducted at the district level in the year 2019. Supportive supervisory visits were conducted quarterly for SDH, monthly for CHC, and twice monthly for PHC. Reports related to RKSK services such as the adolescent friendly health clinic (AFHC) quarterly report and reporting of adolescent health day were regularly sent to the state office. Weekly iron folic acid supplementation (WIFS)

reports and menstrual hygiene scheme (MHS) monthly reports were not being sent as separate reports but included as part of AFHC quarterly reports. Details of beneficiaries who availed the benefits of RKSK in Sabarkantha district for the year 2019 are mentioned in Table 1.

There was availability of RKSK operational framework, training manuals, and IEC materials on all thematic areas at the district level. Mass media activities were conducted in 2019 radio programs in coordination with UNICEF, Health Day celebrations, Poshan Divas, Menstrual Hygiene Day, and so on with active involvement of schools. IEC activities were being performed in coordination with Education Department, ICDS, and the Health Department.

A total of 1396 adolescent health days and 909 AFHC were conducted in the year 2019. The stock of IFA tablets and albendazole tablets were regularly supplied from the state.

The number of trained health personal involved in RKSK implementation in the district is mentioned in Table 2. Counselors were appointed at the Taluka level and assigned duties of all PHC for implementation of RKSK activities. MHS was not being implemented effectively in the district because of unavailability of sanitary pads.

Adolescent Friendly Health Clinic: There was no fixed day for AFHC at DH and SDH levels, whereas at CHC and PHC, there was conduction of AFHC twice weekly on fixed days. At DH, those adolescents who visited the center for their illnesses were counseled and treated as and when they visited the center.

Weekly Iron Folic Acid Supplementation: At the PHC level, distributing iron folic acid tablets was performed to adolescents on a weekly basis either through schools or by involving ASHA workers.

Menstrual Hygiene Scheme: Because of non-availability of sanitary pads from a higher level, MHS was not implemented at any facility. However, at PHC Poglu of Prantij Taluka, sanitary pads were distributed to the beneficiary from other budgetary heads.

Table 1: Beneficiaries who availed RKSK services in Sabarkantha district for the year 2019

Beneficiaries of RKSK	Adolescent Girls	Adolescent Boys
Year (2019)	16022	15925
Monthly Average (2019)	1335	1327

A. In-depth Interview of Key Informants involved in RKSK implementation

All the medical officers (MOs) of the visited facility were trained for RKSK. There is a need to conduct refresher training for already trained staff. Staff involved in counseling activities at AFHC were interviewed. No dedicated counselor was appointed at DH for counseling services of RKSK. Barriers faced by service providers at primary, secondary, and tertiary care levels are depicted in Table 3. Suggestions given by service providers for better implementation of RKSK were also narrated in their words, as shown in Table 4.

Findings from in-depth Interview of ASHA workers:

During the visit of PHC, ASHA workers were interviewed regarding services rendered by them for RKSK and difficulties faced in RKSK implementation**.** They were mainly involved in WIFS and facilitation of adolescent health days. The menstrual hygiene scheme was not implemented because of unavailability of sanitary pads.

Difficulties faced by ASHA workers in implementing RKSK

"Community participation has been reduced due to COVID-19 situation in current times"

"Adolescent girls are demanding for sanitary pad as they used to receive sanitary pads previously"

"We do not have enough IEC materials related to RKSK"

Suggestions by ASHA workers for better implementation of RKSK

"There should be uninterrupted supply of sanitary pads"

"I would like to have refresher training for RKSK"

Findings from IDI – Peer educators:

Peer educators were interviewed during visit to PHCs. Peer educators were selected randomly at each visited PHC. They were involved in conducting health education sessions and adolescent health day celebration along with ASHA workers. They all were trained for RKSK and have received a kit which includes a cap, a water bottle, a mask, a T-shirt, and sanitizers. No IEC materials related to RKSK were available with them at the time of visit. They were attending adolescent friendly health club meetings on a regular basis. They were also involved in health education activities on different aspects such as menstrual hygiene, nutrition, and substance abuse.

Table 2: Details of trained health care personal involved in RKSK implementation at visited facilities

Facility	Number of facilities	Superintendent	Medical Officer	Female Health Worker	ASHA	Peer Educator	Counselor
DH	1	1	2	NA	NA	NA	1
SDH	2	2	2	NA	NA	NA	2
CHC	7	7	7	NA	NA	NA	4
PHC	32	NA	32	32	979	1392	NA*

*The counselor is appointed at the Taluka level and assigned duties of all PHCs.

Table 3: Barriers reported by service providers (medical officers and counselors) in implementation of RKSK

Theme	Sub-theme	Responses
Barriers in implementation of RKSK	Human Resources	*"Many other tasks and responsibilities are there with us which hamper the RKSK implementation in proper way"*
		"There is a need for dedicated Counselor who is trained in RKSK activities for delivering RKSK services at PHC."
		"Training related to RKSK was given long back"
	Infrastructure	*"Inadequate infrastructure specially at CHCs for conducting counseling of adolescents at AFHCs"*
		"It is good if privacy is maintained for adolescents at AFHCs"
		"No separate, dedicated room to conduct counseling at sub district hospital"
	Logistics supply	*"Irregular supply of sanitary pads hampers the implementation of Menstrual Hygiene Scheme"*
		"Without IEC materials counselling services cannot be delivered effectively"
		"Vehicle is required for transportation while giving services to adolescents residing in scattered and difficult to reach areas"
	Beneficiaries	*"Adolescents are not approaching AFHCs for their problems directly as they are not having awareness regarding the same"*
		" Resistance in utilizing services both by adolescents & their parents"
		"IFA tablets are not consumed effectively by beneficiaries"
		"Resistance among adolescents are there while discussion of issues related to substance abuse (Tobacco, alcohol etc.)
		"Adolescents are not coming on the Fixed day for counseling, they approach the facility (CHC) only if they are having some health related issue"

Table 4: Suggestions given by service providers (medical officers and counselors) for better implementation of RKSK

Theme	Sub-theme	Responses
Suggestions	Human Resources	*"Recruitment of trained human resources especially counsellor is required at PHC"*
		"Dedicated counsellor for individual CHC is needed as counsellor is overburdened with charges of other centres"
		"Refresher training of existing staff will be helpful"
		"Medical officers from Rasthriya Bal SwasthyaKaryakram (RBSK) can be involved in some of the RKSK related activities"
		"Adequate referral of adolescent from grass root level by ASHA worker and peer educators will be helpful"
		"Effective coordination between various departments (Medicine, Pediatrics, Gynecology) at District Hospital will be helpful in effective service delivery"
	Infrastructure	*" Building of adequate infrastructure (dedicated, isolated room) for providing RKSK services in order to maintain privacy of adolescents"*
	Logistics supply	*" We should be provided with IEC materials for giving effective counseling services"*
		"Regular supply of sanitary pad is must for implementing MHS in proper way"
		"Availability of vehicle for transportation at remote areas for delivery of RKSK activities"
	Beneficiaries	*"Awareness generation among adolescents related to RKSK services at DH, SDH and CHC"*
		"Focused approach on ARSH as myths & misconceptions highly prevalent in adolescent"
		"More involvement of parents of adolescents for effective utilization of services related to RKSK"

Suggestions given by Peer Educators for better implementation of RKSK

"Refresher Training should be given to us on regular basis"

"It will be good if we receive some incentive for conducting RKSK activities"

"Sanitary Pad should be supplied regularly for effective implementation of MHS"

C. Findings from Session Observation of Adolescent Friendly Health Clinics

Sessions of AFHCs were observed at CHC and PHC. At SDH in particular, no AFHC sessions were conducted. At DH, SDH, and CHC levels, no 'fixed time' was allocated to AFHCs. Adolescents attending out-patient departments (OPDs) for their illnesses were referred to AFHC for Counseling. Infrastructure (considering privacy) was not adequate at all the levels except for PHCKherol, where a separate room was there for AFHC. At PHC, the counselor was assigned only for 1 day per week for counseling of adolescents. Overall sessions were conducted satisfactorily by staff. Issues related to nutrition, IFA, prevention of substance abuse, and contraception were discussed in requisite details. Issues related to sexual health were not discussed at par. The time given for counseling was adequate. The GATHER (greet, ask, tell, help, explain, and return) approach was practiced effectively except for the advice related to follow-up.

D. Findings from Exit Interviews of Adolescents who have attended AFHC

From all health facilities (except SDH), one adolescent was randomly selected and interviewed, who has attended AFHC. On an average, the time given for counseling of the adolescent was 15 minutes. Most of the adolescents who are attending

the health facility for their illnesses were referred to AFHC for counseling. Waiting time was an issue to some of the adolescents because of ongoing OPD services particularly at higher centers. As per them, they do not have to travel far for attending the health facility. The main topics covered during the visit were nutrition, menstrual hygiene, IFA, and substance abuse. The overall satisfaction level of beneficiaries was good in getting RKSK services.

E. Findings from In-depth Interview of Adolescents conducted in the Community

A total of six adolescent boys and six adolescent girls were interviewed to assess knowledge about RKSK services and its utilization. Services utilized by them were health education sessions, WIFSs, and counseling sessions at AFHCs. They were receiving WIFS from the school. The ASHA worker was delivering IFA tablets to adolescents who were dropped out from the school. Even during closure of the school because of the COVID-19 pandemic lockdown, ASHA used to deliver IFA tablets to all at their home.

Suggestions given by adolescents for improvement of RKSK services are as below.

Adolescent Boys:

"More awareness about RKSK services should be generated at community level"

"More number of health education sessions will be beneficial"

"Participation of adolescents in RKSK can be generated by conducting games, quiz in the community and also by rewarding them with prizes"

Adolescent Girls:

"Sanitary pad should be supplied on regular basis at free of cost or at nominal price"

"Incentive should be provided to adolescents for active participation in RKSK services"

"Ensuring adequate privacy during counselling sessions so that adolescents can talk freely about their problems"

Discussion

RKSK has been implemented in Gujarat to deal with adolescent health issues. The present study revealed the current scenario in implementation of RKSK at Sabarkantha district at all the levels of facilities. It was observed that AFHCs are running successfully on a fixed day basis at the primary health center level. Wadhwa *et al*.[8] also mentioned in their study that AFHCs are a successful approach in delivering adolescent health services. The infrastructure of AFHC needs to be improved at secondary and tertiary levels. Although at the PHC level AFHCs were built as per the guidelines, there was common consensus by all the service providers that infrastructure should be strengthened for AFHCs. Adolescents interviewed in the study were also demanding for the same. Bali *et al*.[9] mentioned in their study that attention is needed while designing/building adolescent corners to ensure privacy and confidentiality of adolescents.

WIFS was uniformly followed at the PHC level. There is a need to supervise the proper consumption of IFA tablets as opined by the medical officers involved in implementation of RKSK. The menstrual hygiene scheme was not effectively implemented at the time of the study period because of unavailability of sanitary pads from the higher levels. A study in Haryana showed that the implementation of WIFS and MHS components was successful.[3] Khapre *et al*.[10] also mentioned in their study that there is a need for strengthening supervision, ownership, training, and regular meetings of stakeholders for effective implementation of WIFS.

There was a need for refresher training of all the staff involved in RKSK implementation. A similar observation was made by Bali *et al*.[9] in their study. Non-governmental organization (NGO) involvement in implementation of RKSK was not up to the mark in the study area. Parida *et al*.[11] mentioned in their study that there is a need for involving NGOs for the well-being of adolescents. On the contrary, in the West Bengal study, the involvement of NGOs was found to facilitate innovation and convergence across different stakeholders.[3]

A few good practices observed at the PHC level included active involvement of adolescents during various health education sessions by means of different games, quiz, and so on. Health Day celebrations were also conducted on Poshan Divas and No Tobacco Dayand Menstrual Hygiene Day for creating awareness among the adolescents. It was suggested by the service providers of all the levels to generate more awareness in the community related to RKSK so that more adolescents can avail RKSK services. A similar recommendation was there in the study conducted by Joshi *et al*.[12] Although the overall implementation of RKSK at Sabarkantha district is satisfactory, there is a need to address certain issues such as increasing involvement of adolescents, building up of infrastructure for AFHC, recruitment of trained counselors, regular supply of sanitary pads, and addressing the key issues such as sexual and reproductive health in better ways. Satiya J in their study revealed that much effort will be needed to increase the outreach and coverage of adolescent health services.[13] Kansara *et al*.[14] mentioned in their study that utilization of existing workforce would be advantageous for strengthening the program implementation. A multi-dimensional approach is required covering all the adolescent health problems with special emphasis on mental health, behavior change communication, and positive social environments.[15]

Conclusion and Recommendations

RKSK implementation was conducted successfully at primary care levels in Sabarkantha district. For further betterment of the program, there is a need for a dedicated counselor at each facility and refresher training of existing staff working

for RKSK. The infrastructure for AFHC was found to be inadequate, particularly at higher care facilities. Overall sessions conducted at AFHC were found to be satisfactory. MHS was not implemented because of unavailability of sanitary pads. WIFS was successfully performed at all the facilities. However, there is inadequate utilization of IFA at the beneficiary level. Adolescents interviewed in the community were satisfied with the services delivered to them under RKSK. It will be good to prioritize a few components of adolescent health such as issues related to sexual health as it was not discussed uniformly at all the levels. Some of the hurdles experienced by service providers in RKSK implementation were inadequate infrastructure of AFHCs at higher centers, a lack of trained counselors, unavailability of sanitary pads for effective implementation of MHS, and meager response from adolescents from the community in availing RKSK services.

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Conflicts of interest

There are no conflicts of interest.

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