Lessons learned from nimble adaptations to organisations' responses to the sexual and reproductive health (SRH) needs of adolescents in the context of the COVID-19 crisis

Country: India

Centre for Catalyzing Change (C3)

Centre for Catalyzing Change (C3), earlier known as Centre for Development and Population Activities (CEDPA)) was launched in 1987 in India. For more than three decades, C3 has strived to create an environment that improves girls' and women's conditions. The organization's strategies stress mobilizing, educating, and empowering girls to achieve their full potential. C3's work is centered on ensuring that girls and women access quality reproductive health services.

Were you delivering services to young people before the COVID-19 crisis?

In collaboration with the Government of Jharkhand State, India, we have been working to improve adolescent health outcomes in the state. Under the partnership, we support the State Project Management Unit (SPMU) and District Project Management Units (DPMUs) in designing, implementing, and monitoring a needs- and capacity-based package of health and social interventions under the National Adolescent Health Program of the Rashtriya Kishore Swaasthya Karyakram (RKSK).

Through facilitators trained by our team, including government functionaries, we have been engaging with communities and facilitating the implementation of government programs, including RKSK, that provide life skills and health education to both in-school and out-of-school adolescents. Our two-pronged strategy involves (i) leveraging the program and community-level platforms to reach adolescents and sensitize them to promote their access to services, in addition to (ii) sensitizing frontline workers– such as auxiliary nurse midwives (ANMs), accredited social health activists (ASHAs), and anganwadi workers (AWWs)– to reach adolescents with health-promoting information, counseling, and need-based services.

What new approaches did you use to respond to and overcome the barriers created by the COVID-19 pandemic to still reach young people?

Situation analysis: Keeping in mind the lockdown and social distancing protocols, we conducted a modern communication technology-based survey -a computer-assisted personal interview (CAPI)- to assess adolescent need for information and services. The organization used mobiles, and Google forms to collect sociodemographic information, their knowledge about COVID-19, the status of access to basic and essential health services during the lockdown, and the impact of the COVID-19 pandemic on education, household finances, mental health and wellbeing, and migration in and out of rural areas in the country.

Based on the analyzed data, we adapted our intervention strategy to rely on digital platforms. The initiatives we took in collaboration with the respective State Governments of Chhattisgarh, Jharkhand, and Odisha were:

Mentoring peer educators with social distancing: We maintained telephonic contact with peer educators and the field coordinators of C3. In addition, peer educators conducted small in-person group meetings following the social distancing norms. These meetings were conducted to monitor peer educators' activities, orient, update and address their issues and concerns.

Digital media for health education*:* We developed digital modules for online training on COVID-19 and adolescent issues. In addition, developed short COVID-19 messages in simple local language for dissemination through WhatsApp. These consisted of ten short audio/video stories on prevalent adolescent problems and possible solutions during the pandemic. These were shared through telephonic conversations between peer educators and adolescents, followed by a public service announcement (PSAs) on the topic. These public PSAs were disseminated among frontline workers, teachers, and peer educators.

Telephonic access to services*:* We advocated for the use of government helplines to include adolescent issues. We also involved counselors from adolescent-friendly health clinics (AFHCs) in telephonic counseling services.

Ensuring supplies to adolescents: We used digitally collected data to supply sanitary napkins by ASHAs in alignment with local needs. Furthermore, we helped prepare and implement a microplan for distributing iron-folic acid tablets and hygienic napkins to frontline workers. We supported the mobilization of adolescents on pre-decided dates, times, and venues so that ANMs/ASHAs could distribute these to all adolescent girls across the district.

Intersectoral convergence: In September 2020, we supported the Nutrition and Health Education (NHE) sessions organized under the Nutrition Month (Poshan Maah) activity of the Department of Women and Child, Government of Jharkhand.

Why did you decide to use these approaches?

Information gathered from our survey guided the direction of our activities. The data showed that adolescents were well-informed about COVID-19 and needed precautions, and had good access to the public distribution system of essential food items. However, their low perception of individual risk to the COVID-19 infection and stress due to domestic violence was a cause for concern.

Adolescents' major challenges included reduced access to health education services, specifically to sanitary napkins. Their families faced financial instability due to the impact of the pandemic and subsequent lockdown on employment. We, therefore, used other modes of reaching adolescents that did not involve in-person interactions. We collaborated with other departments and tapped into opportunities offered through our programs, thus expanding our reach and strengthening intersectoral responses to adolescent health and wellness needs.

How are you working to find out if these approaches are in fact having the desired impact?

We have a data platform for the National Adolescent Health (RKSK) Program implementation in the districts where we are present. We regularly analyze and review this data. In addition, the data is routinely used for six-monthly reviews of program activities at the district level. While routine data collection has been affected due to staff's inability to visit the field regularly, telephonic monitoring of activities has been undertaken.

With the lifting of the lockdown, especially for essential services, we hope to do more rigorous monitoring using indicators that reflect new digital platform-based initiatives.

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