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

Society for Nutrition, Education and Health Action (SNEHA)

The Society for Nutrition, Education and Health Action (SNEHA) was established in 1999 in Mumbai with the goal of improving health-seeking behavior among underserved communities and improving the quality of public health services. SNEHA is a non-profit organization that works with women, children, and public health and safety systems. The organization works in urban informal settlements to reduce maternal and neonatal mortality and morbidity, child malnutrition, and gender-based violence. SNEHA's work is based on these principles: evidence-based, scaling up through partnerships, and sustainability.

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

We have been working directly with adolescents through our programs in urban slums to influence their physical health, social attitudes and to promote gender equity. Our strategies to achieve these objectives include community mobilization, collective learning, screening and linkages to mental health services, strengthening health systems' response to adolescents' needs, and the creation of a cadre of peer educators as change agents and support providers for adolescent education.

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

Needs assessment: Our team at SNEHA collected data for a qualitative study on emerging needs and issues of adolescents in the slums of Dharavi and Kalwa in Mumbai through telephonic interviews of frontline workers, interns in tertiary care municipal hospitals, and adolescents and their parents. This information was complemented with information gathered by our staff during their daily interactions with adolescents and their parents for telephonic follow-ups on counseling and mental health issues, and telephone-based or online sessions with adolescents.

Sessions for adolescents: Based on the identified needs and the support we agreed to provide to slum adolescents, we conducted sessions on sex and gender, sexual and reproductive health and hygiene, and emotional resilience to seventy-two adolescents per day through videos and WhatsApp group calls. Under our Empowerment, Health, and Sexuality of Adolescents (EHSAS) initiative, group education sessions are conducted for both boys and girls on reproductive health including sessions on menstruation and menstrual hygiene. Girls are encouraged to keep track of their physical, emotional, and mental health changes during menstruation using menstrual diaries. This data is analyzed to help identify information needed and problems requiring intervention.

Mental health screening & psychosocial support: We developed a short screening tool used telephonically to identify instances where adolescents needed psychological support. We provided telephonic counseling by clinical psychologists to the identified cases. Our clinical psychologists have provided mental health counseling to 111 adolescents and have held sessions with the parents of the identified adolescents.

Sessions with change agents: We held telephonic sessions with designated change agents aged 15-17 years old using the municipality website, helplines, civic action toolkit, hygiene, and assistance for COVID-19.

Provision of sanitary napkins: We linked up with the NGO 'Red Is the New Green' to distribute sanitary pads in the community. Our team collected the pads and deposited them in a centrally accessible location in the community. A group of boys, despite their own and their families' initial objections, were encouraged to distribute these to households with adolescent girls. These boys were trained on safety measures to be followed during the distribution of sanitary napkins to households listed out by the program team. The aim of involving these boys was to break the taboo around menstruation, normalizing the needs of adolescent girls during this time of the month and linking this service provision with the dignity of adolescent girls.

Why did you decide to use these approaches?

Data gathered from the qualitative study we conducted showed that adolescents living in slums lacked information on the pandemic, and were fearful about quarantine, isolation, and the stigma attached to the illness. Additionally, at a systemic level, there was a shortage of masks, soaps, and sanitary napkins, as well as a lack of personnel to identify and track symptomatic COVID-19 cases. Our organization volunteered to create awareness about safety norms and government directives, provide psychosocial support, and distribute supplies.

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

We collected data by telephone calls and kept track of our activities. In the first two months of the COVID-19 pandemic, we were able to contact 1130 adolescents and their parents. A total of 30 youth facilitators were trained in self-care. They were actively working on COVID-19 awareness-raising and managed to reach 417 families in two months. These youth facilitators also created videos on emotional resilience and managed to reach out to 1087 families across Dharavi and Kalwa. In addition, we distributed 26,080 sanitary napkins to 1273 adolescent girls in this period.

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