More Than Brides Alliance:

Strengthening National Adolescent Health Programme in India

MORE THAN BRIDES ALLIANCE

Save the Children

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Ideas. Evidence. Impact.

Simavi

Background

Globally, the policy makers, researchers and implementing partners of Child Marriage (CM) programmes are realising the significance of combating Child Marriage in an integrated and holistic manner. They are collaborating to combat Child Marriage within a broader framework by building girls' agency regarding Sexual and Reproductive Health and Rights (SRHR), education and financial independence.

More than Brides Alliance (MTBA): A Theory of Change Approach

One such collaborative initiative of four international agencies is More Than Brides Alliance (MTBA). The Global Alliance includes Save the Children, Netherlands (SC), Oxfam Novib (ON), Population Council (PC), and Simavi as other partners and is supported by the Dutch Ministry of Foreign Affairs. There are other national alliances which include local NGOs and other stakeholders.

The Alliance aims to empower young people, in particular adolescent girls to decide if and when to get married and make informed choices about their Sexual and Reproductive Health and Rights (SRHR). Currently (2016 -2020), it is implementing an integrated and holistic Child Marriage programme named 'Marriage No Child's Play' (MNCP) in India, Pakistan, Malawi, Mali and Niger.

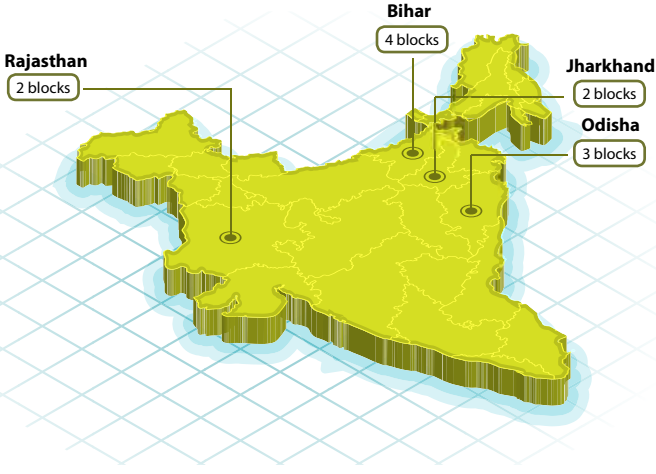
A systematic Theory of Change (ToC) which is an integrated, holistic and cross-sectoral approach developed globally, was adapted and applied to the programme. The country partners work closely with selected local Civil Society Organizations (CSOs), communities, along with the Governments at a local, state and national level.

This document aims to present the More Than Brides Alliance (MTBA) Model as an approach to the RKSK, the model being well aligned with existing government programmes such as the National Adolescent Health Programme. The Model can also be adapted with ease for implementation in districts not covered by RKSK or where it is not yet functional.

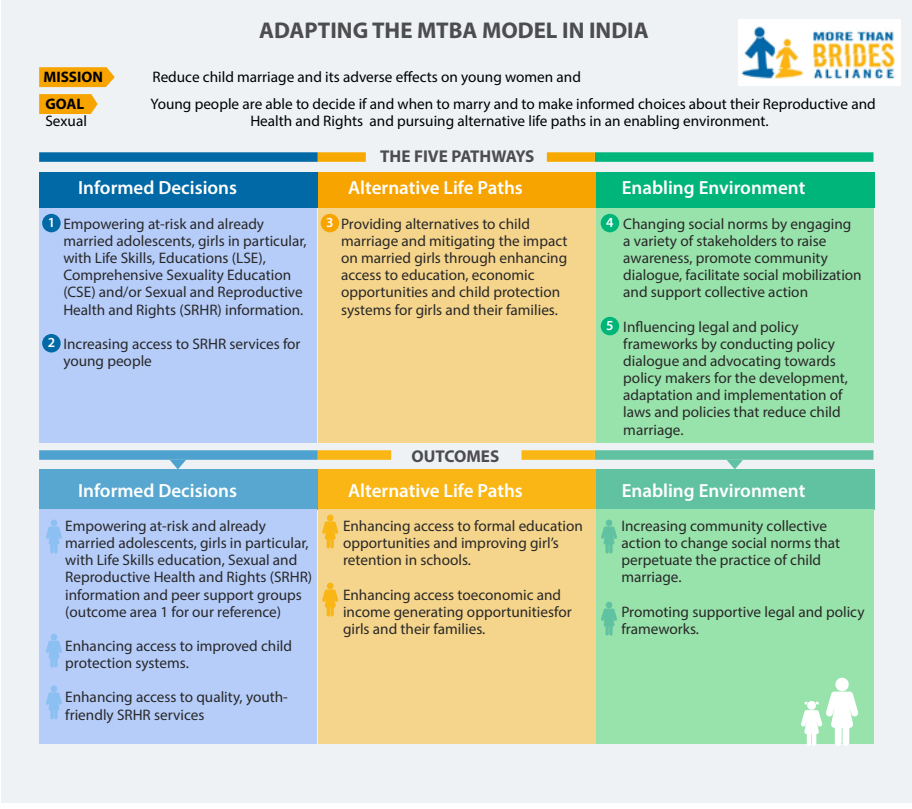
The MTBA India model thus, adapted the overall ToC to address the common social, cultural, economic and political factors that perpetuate child marriage as well as the regional contextual variations. It is based on the assumption that 'young people, especially girls, are only able to decide if and when to marry if they are empowered to make informed decisions, their protective assets are built, and if their community respects their rights.'

Partner organisations of the MTBA in India include Save the Children (SCI), Population Council and Simavi' s partners Bihar Voluntary Health Association (BVHA), Child in Need Institute (CINI), Network for Enterprise Enhancement and Development Support (NEEDS), and Voluntary Health Association of India (VHAI).

The MTBA Model



The MTBA model serves as meaningful solution to end Child /Early Marriage. The Model presented in the graphic below shows how the Alliance partners in India have worked to achieve the seven outcomes related to the five pathways of empowering girls and boys to take informed decisions. This empowers them in creating alternate life paths for themselves and most importantly. The model helps in creating an enabling environment by engaging stakeholder groups to change gender and social norms.[1]



[1]Note: For detailed information refer to an elaborate learning document on the Model developed by MTBA.

The experiential learning from implementing the model reveals that though comprehensive, the model is technically viable and can be adapted to suit local and regional needs with ease.

The programme has been effective in building the agency of girls who are speaking out, negotiating with family and community members regarding child/early marriage and demanding better services for adolescents. They are also forming federations which complete the transformation from being individual agents of change to promoting collective action. Girls are also participating proactively at government programme meetings where they are bringing up SRHR and child marriage issues. However, similar to other externally funded interventions, the five-year programme has come to a close. Thus, it is vital for all stakeholders who are a part of the enabling environment to continue to support the girls in their progress.

The government as the primary service provider, along with other stakeholders needs to ensure continuity in this process of change. Girls and boys who are now empowered with information and skills need to be hand held and supported to reach out to larger groups of peers.

RKSK for Improved Adolescent Health

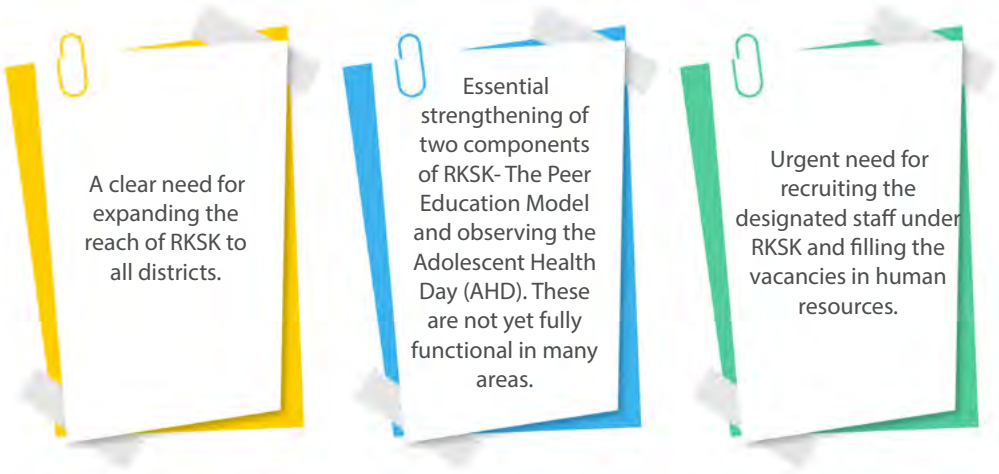
In India, the National Adolescent Health Programme, also known as Rashtriya Kishor Swasthya Karyakram (RKSK), was launched by the Ministry of Health and Family Welfare (MoHFW) under the National Health Mission.

RKSK is a comprehensive programme that aims at achieving better health outcomes for all adolescents. It promotes youth empowerment, community involvement and access to high quality services. It introduces community-based interventions through peer educators and is underpinned by collaborations with other ministries and state governments.

RKSK envisions enabling all adolescents in India to realize their full potential by making informed and responsible decisions related to their health and well-being. Also by accessing the services and support they need to do so. It realigns the existing clinic-based curative approach to focus on a holistic model based on a continuum of care for adolescent health and developmental needs.

Rationale for supplementing RKSK with the MTBA Model

During the implementation of the MNCP programme, working together with various government structures and programmes (including RKSK) revealed that there were several gaps that could be bridged through collaboration with MTBA Alliance partners. These include:



At present, the frontline workers (ANM), who are responsible for mentoring the adolescents are already overburdened and are hence, unable to meet the growing needs of adolescents. For example-Observation of AHDs is dependent mostly on the ANM who already has multiple responsibilities.

- Higher involvement of adolescents in AHDs.
- Effective and regular use of IEC products developed by the government.
- Systematic reviews of AFHCs and AHDs.
- Filling gaps in recruitment for the position of Adolescent Counsellors specifically for RKSK, which will provide both clinic based and outreach services in the community.
- Adequate use of infrastructural resources such as the sub centres (that could otherwise be used as safe spaces for young people).

Areas of Support to RKSK by MTBA Partners

Although RKSK is also a holistic approach addressing multiple risks and vulnerabilities of adolescent girls and boys, the MTBA model adds value. This includes capacity building on life skills, SRHR and financial and career planning through alternative life paths of education, skill building and livelihood.

- There is ample scope for capacity building of frontline workers in addressing the needs of Adolescent Peer Educators in facilitating peer groups and conducting awareness sessions.

- Since the MTBA partners have effectively mobilised and engaged vulnerable out of school adolescents and their families (creating an enabling environment) and linking them to vocational training and livelihood opportunities, they can supplement the RKSK effectively. Trained and empowered adolescents will take on the responsibility of communicating messages to peers, resulting in a ripple effect.

- The Government will be able to implement in a wider area reaching more adolescents since the core objectives are similar.

Other areas where the MTBA Alliance partners can strengthen RKSK implementation are:

- ***Supporting efficient adaptation and use of structures/resources*** for RKSK (providing walk-in AFHS) to fill the gaps in service provision. For example, in Jharkhand, existing sub centres were re-designed as Information Dissemination Centres for adolescentswith IEC, games and other equipment. They enlisted the support of ASHA and ANM to facilitate the centres with considerable success.

- ***Facilitating convergence*** with local self-government (PRI /ULB), Department of Women and Child Development (ICDS service providers), the Health Department (ANM, ASHA) and the Department of Education (at the core of RKSK). There is a huge opportunity of working in a collaborative GO- NGO partnership, bringing NGO partners, government officials, line departments and frontline workers together on the same platform.

- ***Participating in a review*** of the indicators for monitoring support to RKSK at the field level.

- ***Creating an enabling environment*** to ensure outcomes of RKSK since partners have been working to strengthen the child protection systems.

- ***Engaging Discussion Leaders (Peer leaders in RKSK) in varied activities***, who then can be effectively involved in AHDs and other platforms of convergence in the community through building of agency and ownership. Thus, AHDs can become more participatory with a shift of responsibility to adolescents themselves.

- Engaging in direct implementation in the community (scope provided in the NHM guidelines for RKSK) as well as the NGO partner.

Aligning the MTBA Model with the National Adolescent Health Programme

The table below presents how the MTBA Model effectively supplements the government's effort in an integrated and systematic way with active involvement of local communities. This helps in bridging the critical gaps between communities and government systems. There is no duplication of the system, rather the components fit into the system to strengthen the programme.

MTBA Components	Alignment with RKSK	Role of NGO /CSO
Issues addressed under RKSK - Enable Sexual and Reproductive Health - Improve Nutrition (Malnutrition and IDA) - Provide Life Skills Education - Mental Health (recommended) - First aid related to injuries (recommended)	- Enable Sexual and Reproductive Health - Improve Nutrition (Malnutrition and IDA) - Enhance Mental Health - Prevent injuries and violence - Prevent substance misuse - Address non-communicable diseases	- Use technical expertise in varied thematic areas for capacity building of service providers and adolescents
Target population (10 – 19-year-old adolescents) - Girl- centric with limited focus on boys –formation of boy's groups and capacity building of Discussion Leaders - Strategic and planned inclusion of boys, married adolescent boys /couples recommended - Focus on girls at risk of getting married early and vulnerable married adolescents - Focus on creating an enabling environment including 'all of society'	**Target population (10 – 19-year-old adolescents** – male and female, urban/rural, in school/out of school and married /unmarried - Special focus on vulnerable and marginalized groups	- Vulnerability mapping tools at the community and institutional level for tracking of adolescents at risk - Community based tracking system by CPCs and Peer Groups - Capacity building of members of community based child protection systems

Key Implementation Approaches

MTBA Components	Alignment with RKSK	Role of NGO /CSO
- Access to SRHR service by - Strengthening AFHCs, VHND, AHD - Referral systems and outreach - Linkages and Networking - Capacity building	- Family Based Approach – Adolescent Friendly Health Clinics providing counselling and clinical services - Adolescent Health Resource Centre at the District Hospital	- Collaboration in strengthening the facilities and making them functional with availability of services and increased access by adolescents and their families
Focus on community /facility-based approach With interventions to facilitate access to education (enrolment and retention in schools) - Facilitating safe spaces in schools - Networking with SMCs **Recommended:** Two-pronged operationalisation through: a) school-based approach and b) community facility-based approach	**School based Approach (access to specific programmes/schemes)** - Strengthening of school health promotion activities - Health Screening of adolescents (RBSK mobile health teams) - Electronic health records provision - Provision of services such as Weekly Iron and Folic Acid Supplement (WIFS) programme - De-worming during National De-worming Day (NDD) - Provision of sanitary napkins - Age-appropriate vaccination - Skills of basic first aid / emergency care for teachers - 2 teachers designated as Health Ambassadors - Adolescent Health and Wellness Day (Weekly)	- Strengthening the service provision in schools - Facilitating outreach counselling services - Capacity building of teachers, SMC members on thematic areas - Community mobilisation to access outreach services

Peer Education Approach - Creation of Peer Groups - Selection of Discussion Leaders /Peer Leaders and their capacity building - Creation of safe spaces in schools	**School based Peer Education Model** - Enlisting Peer leaders – Sathiyas (15-19 years) who mobilise their peers and increase awareness and knowledge of health issues - Support AHWDs	- Listing, training of Peer leaders / Saathiyas - Capacity building of PEs and Frontline workers
Community / Facility Based Approach - Creation of safe spaces in community places such as Youth clubs, Sub-centres, ICDS centres – Information Dissemination Centres or Learning Centres - All of society approach – enabling community members and institutions for greater impact and involvement of parents, religious leaders, stakeholders	**Community Based Approach** - WIFS (ASHA/AWW) - De-worming (ASHA/AWW) - MHS (ASHA to coordinate) - Peer Educator Programme – formation of peer groups **For out of school, vulnerable adolescents** - Coordinate with SABLA PEs - AHDs held quarterly - Adolescent Friendly Clubs at sub-centres under ANM	- Facilitating availability of products and services - Negotiating for improved supply chain management - Peer leader training and inclusion of MTBA model educators in the RKSK program - Strengthening of celebration of days and provision of services - Strengthening of youth clubs from past expertise of creating youth clubs from scratch

CALL TO ACTION: The Way Forward

The MTBA Model shares a similar vision for adolescents as articulated in its five pathways. It also aligns very effectively with the RKSK programme strategy (as presented in the table above).

The MTBA model's peer education approach and intervention has been designed and planned in line with the RKSK framework and guidelines. The entire process of formation of peer groups, peer education through DLs, with the local service providers driving the intervention is very similar to the MTBA model.

Further, the MNCP programme has also equipped the IDCs as learning and recreational hubs for adolescents at the community level. To sustain the initiative, PRI members, service providers, youth club and local NGO/CSO were involved in project activities, so that after completion of the project the activities will continue.

Recommendations

- Accelerating the process of implementation of the RKSK programme in all areas
- Acceptance of the MTBA model as in perfect synchronisation with RKSK and allowing the absorption of skilled Discussion Leaders as Sathiyas in the programme
- Recognising the need for immediate recruitment of human resources as provided under RKSK (e.g., Block Adolescent Health Coordinator)
- Focusing on inclusion of 'all of the society' in the RKSK approach, specifically including parents, community members, and religious leaders
- Reviewing the role that NGOs can play in strengthening the programme and working out areas of collaboration; supporting NGOs financially in supplementing RKSK programme or in the process of direct implementation (as mentioned in the guidelines)
- Addressing livelihood opportunities for out of school adolescents (15 -19years) through linkages to appropriate schemes
- Strengthening the process of monitoring and review of the programme components in schools, communities and facilities for greater impact under the leadership of the District Magistrate or Deputy Commissioner; involving the respective Government line departments in the process of monitoring

MORE THAN BRIDES ALLIANCE

India Partners

Save the Children

CINI help the mother help the child...

Voluntary Health Association of India

NEEDS EXIST TO IMPACT

BVHA