KHPT
engage, innovate, empower

Azim Premji Philanthropic Initiatives

LEARNING BRIEF
Barefoot Counsellors

Reaching rural adolescent girls and women for mental health support

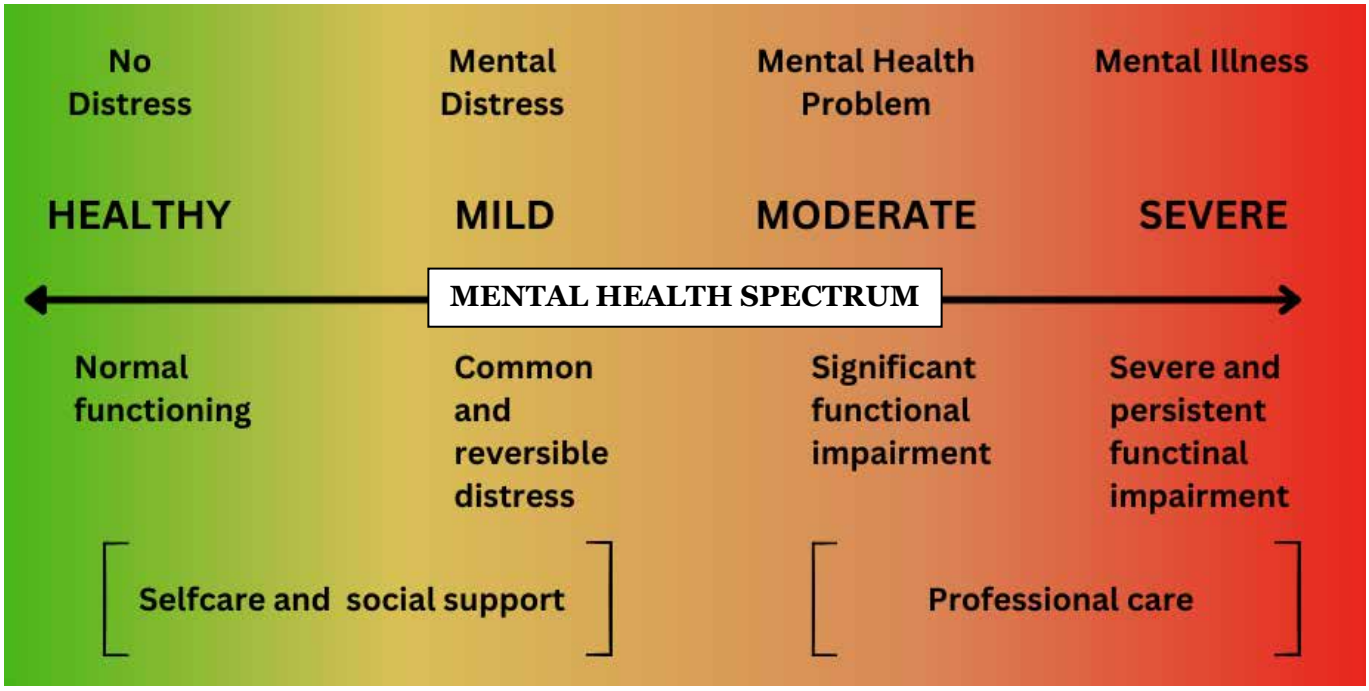
October 2024

About KHPT and Project Sphoorthi

KHPT is a not-for-profit entity, founded in 2003 to improve the health and wellbeing of communities in India through focused, scalable, evidence-driven interventions, particularly among vulnerable communities in India. Project Sphoorthi focuses on empowering adolescents by building knowledge and skills for improving their dietary patterns and nutritional status, menstrual hygiene practices, and sexual health, as well as addressing gender-based violence and improving their mental health.

Introduction

The World Health Organization (WHO) defines mental health as more than the absence of mental disorders, and as a state of well-being in which an individual realises his or her abilities, can cope with the normal stresses of life, can work productively and can contribute to his or her community. The WHO's definition of mental health acknowledges the need to move beyond our excessive emphasis on mental illness, and to pay attention to the continuum of which, mental health and mental illness fall at the two ends. Depending on the internal and external conditions affecting individuals at any given time, they may lie at any point on the continuum and shift position as their situation improves or deteriorates.



Adolescence and Mental Health

Adolescence is the period between 10-19 years when young people undergo several changes - physical, cognitive, social and emotional. Research suggests that this is also the period when several mental health problems may develop and remain unidentified, and may develop into life-long disorders.

Empirical evidence emphasizes that adolescents are more vulnerable to recurrent anxiety, depression, mood disorders, and cognitive and behavioural issues as they grow up. Additionally, gendered aspects of development also predispose girls and young women to a greater burden of mental health issues, owing to everyday experiences of violence, abuse, discrimination and neglect that they face.

Mental Health Interventions

Several initiatives have been undertaken to address the mental health of populations. A primary service available at the district level is the District Mental Health Program (DMHP), for early identification and treatment of the mentally ill. Additionally, Tele MANAS, an IVRS-based counselling service has been enabled to provide two levels of telephonic care - psychosocial support for issues such as distress, exam stress, familial problems, substance use-related issues, and other issues, and specialist care by a clinical psychologist, psychiatric social worker, psychiatric nurse, or a psychiatrist, in case of more severe concerns. However, a key challenge is the shortage of trained personnel, and a predominant focus on clinical issues compared to psychosocial issues and support required due to the lack of adequate personnel.

The Government of India (GoI) also launched the Rashtriya Kishor Swasthya Karyakram (RKSK) in 2014 to address the needs of adolescents specifically, including adolescent mental health. The RKSK program has two sets of resources to address adolescent mental health- peer educators and RKSK counsellors. However, these clinics are unable to cater to the adolescents due to a shortage of staff, peer educators not being equipped to handle adolescents' issues, and clinics functioning during the day- the adolescent girls are unable to visit as they are in school or colleges. There is also a lack of safe space for them to talk about love, sexuality, and matters that bother them due to the stigma attached to mental health.

Additionally, a lack of awareness and demand for mental health services also remains a key challenge for early identification, referral and treatment within the government system. It is within this context that the 'Barefoot Counsellor Model' was developed.

Barefoot Counsellor model

The Barefoot Counsellor (BFC) concept evolved as a result of empowered Sphoorthi girls who started providing informal support to their peers during the COVID-19 pandemic.

Since the girls were familiar with problems adolescents face at home and school and many of them had overcome similar challenges, they were easily able to connect with their peers and young women. Thus, we identified interested girls and provided them with formal training in counselling skills. Barefoot Counsellors were envisaged to fill the gap between available services for adolescent girls to address the stigma of mental health, provide psychosocial support to peers, and identify cases for escalation.

Who are Barefoot Counsellors?

Adolescent girls between **18-21**

Mostly, girls who have attended the Sphoorthi program between 2015-2018

Most BFCs are currently in college

They are paid volunteers and earn **₹ 3500/-**

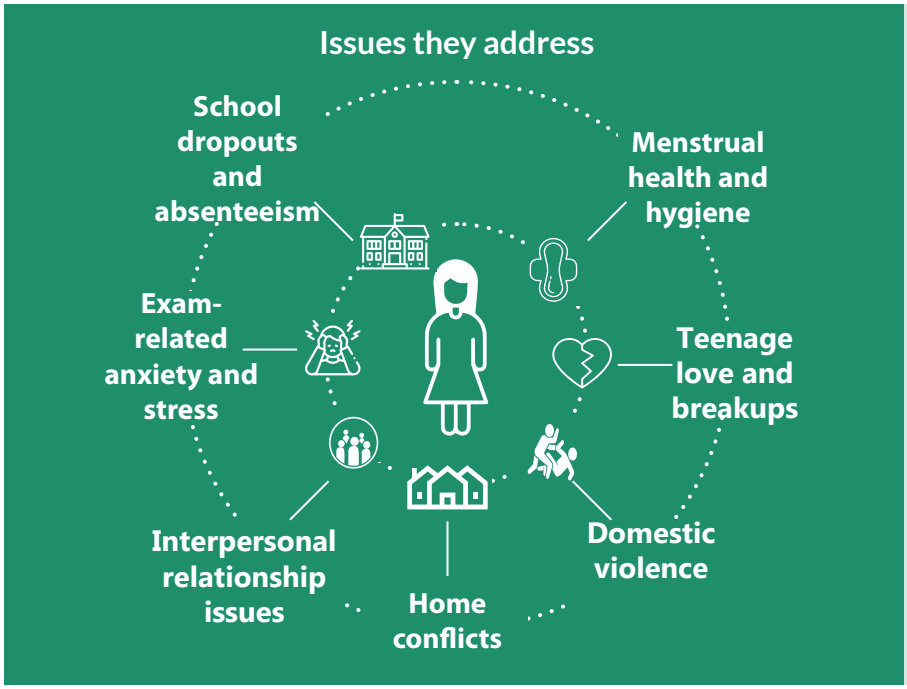
BFCs are identified from within their GPs. Each BFC handles **4-5** villages and covers the entire Gram Panchayat. On average, BFCs work **1-2** hours per day and also on weekends.

What do they do?

- Undertake simple awareness sessions on destigmatization of mental health in schools, colleges, and in the community using simple Information, Education, and Communication materials.
- Counselling to adolescent girls and women
- Identify and connect adolescent girls and young women to relevant mental health services, such as the Sahita Careline, District Mental Health Programme, and RKSK counsellors
- Need-based home visits for counselling

A BFC conducting a session in a classroom

BFC Veena in an one-on-session with a client



BFC Uma counselled a young girl who was suffering from parental violence, was beaten when she rebelled, and was burdened with domestic chores. She helped her understand that she was not responsible for all the problems in the house.

"At home, she was treated like a puppet, and I encouraged her to talk back so her parents wouldn't hold her responsible for the problems at home."

Working Model

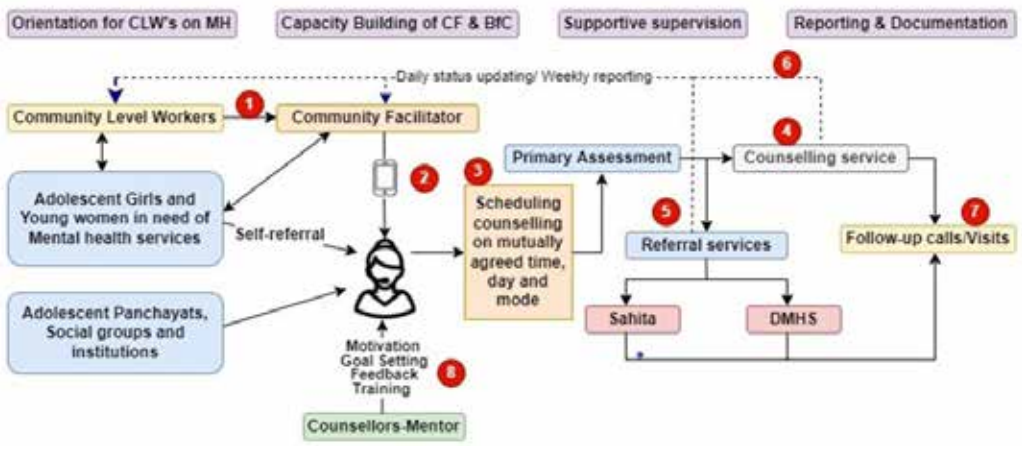
The BFC stands in the middle of the community health services of the village, Peer Educators, former Nutrition volunteers, Sphoorthi girls and frontline workers (only in a few villages) would identify and refer the adolescent girls and young women who need service to the BFCs through the phone.

The barefoot counsellors will provide in-person or telephonic peer counselling for adolescent-specific issues – e.g., handling relationships within the family and outside the family, stress management, educational challenges, violence, etc. If adolescent girls or women require support beyond peer-to-peer counselling, the adolescent counsellor will pass their information to KHPT's Sahita-careline. In case of emergencies (e.g., risk of suicide, severe depression, violence, child marriages), the adolescent counsellor will take immediate support from the Community Organizer and ASHA worker to connect them to Childline/district mental health program team. The model schematic is presented below for reference (Figure 3)

Salima* a 22-year-old woman worried that she was not conceiving. She was worried about what people would say, making her sad. But Anita a BFC continuously met Salima to bring her out of sadness.

"To lift her spirits, I told her about my aunt, who after nine years of marriage had given birth to a child. I also let her know that she was only 22 years old and still has time to conceive."

Figure 3. Model schematic of the barefoot counselling



Capacity Building

The BFCs received a month-long virtual training on peer counselling and mental well-being from the Samvada-Baduku Community College, Bengaluru.

The 5-module Kannada curriculum was designed based on adolescent-centric issues in a rural context. The capacity building was participatory which included art, theatre and group discussions. The BFCs were trained to use the Symphony app, a nifty, easy-to-use app that captured all the clients' details, counselling sessions done, referrals etc. This platform helps store all the data and makes it easy for the BFCs to retrieve all the details whenever necessary.

MODULE 1
Understanding Self
Reflecting on own life experiences, identifies and society and rethinking of dream and aspirations

MODULE 2
Understanding Youth from a feminist lens
Dillema of youth, anxiety, gender and class, challenges related to education, youth and social structure

MODULE 3
Approaches to peer counselling
Methods of peer counselling, understand and being non-judgmental, reflections and experiences with respect to caste, class and gender

MODULE 4
Understanding youth support services
Support services for the youth including government services

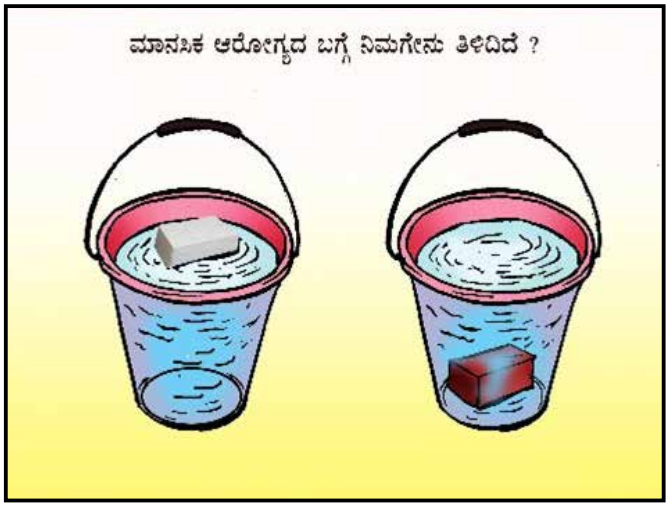
MODULE 5
Understanding Self
Famiiliarizing participants with counseling practices, positive peer pressure skills of empathy

Constant capacity-building activities and meetings have helped the BFCs tackle a myriad of clients' problems and provide solutions. One of the most common issues they are confronted with is love and breakups. To handle such complex cases, a special training session was arranged for them. It was intended to make the BFCs understand the importance of 'self-priority' and apply it to cases related to love and relationships. BFCs are trained to put their clients at the centre of such conversations and prioritise their needs. As a result, the clients would think, decide, and be responsible for it.

Job Aids to BFCs

The BFCs were provided with a flipchart containing basic information on mental health. Through simple activities, the BFCs de-stigmatize mental health, talk about well-being, problems, and coping techniques. Additionally, BFCs were taught how to use the flipchart and how to make it interactive.

The flipchart given to our BFCs

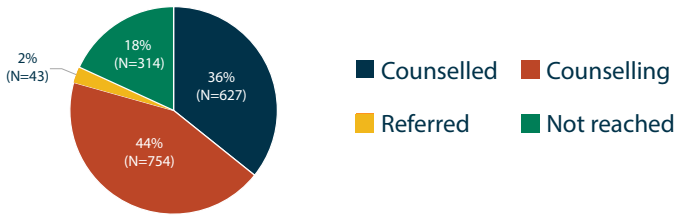


Participatory activity to sensitize community on mental health issues

In Numbers

In the section below, we present an overview of the peer-counselling services provided by our BFCs, including the number of persons contacted for counselling and the concerns raised by young women and girls.

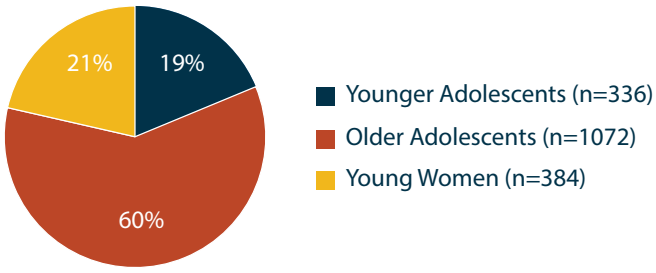
Total calls: **4,011**
No. of persons covered: **2,040** (adolescents and young women)
Total Barefoot Counsellors: **34**



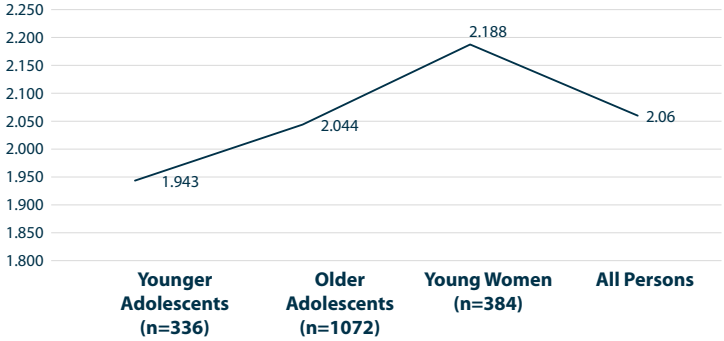
Here is an overview of the issues addressed among those counselled

- Education **42.30%**
- Gender-Based Violence **18.80%**
- Health **15.24%**
- Inter-personal relationship (Family) **5.67%**
- Inter-personal relationship (Love) **5.02%**
- Mental Health **13.29%**

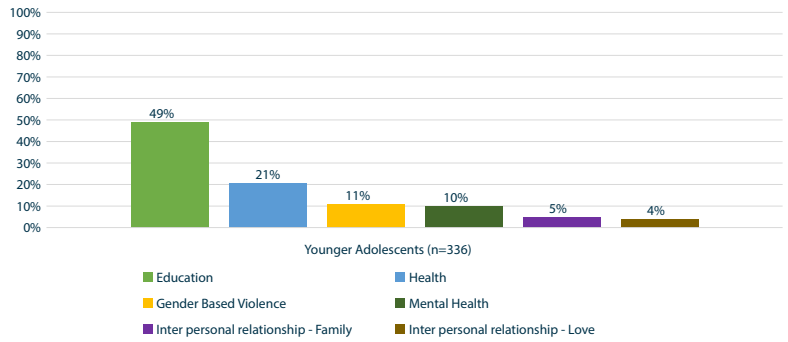
Share of adolescents and young women covered by BFCs



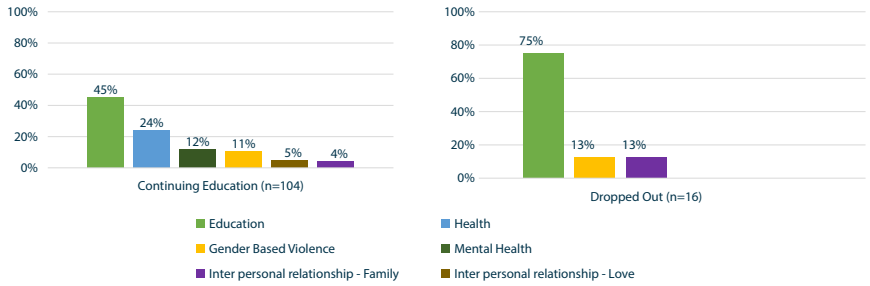
Average no. of calls for adolescents and young women (n=1792)



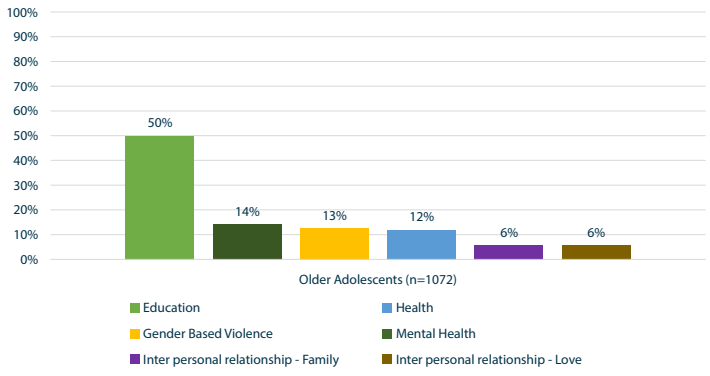
Major Issues Among Counselled Younger Adolescents



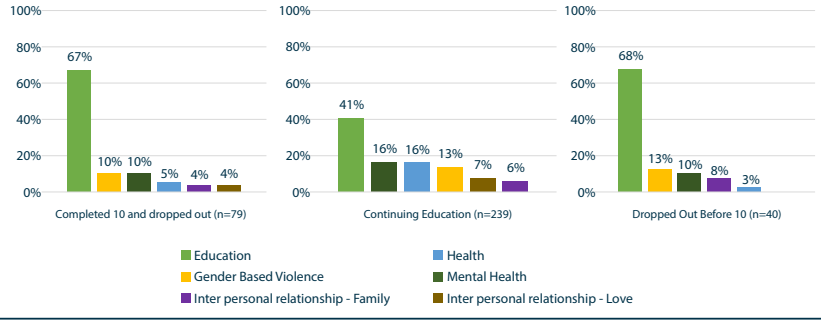
Counselled Younger AG-Issues among those continuing education and dropped out



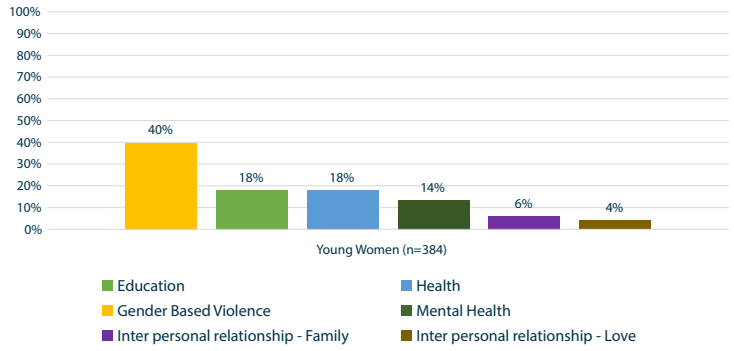
Major Issues Among Counselled Older Adolescents



Counselled Older AG- Issues among those continuing education, dropped out, completed secondary schooling and dropped out

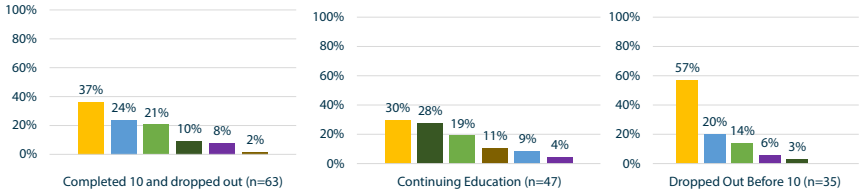


Major Issues among Counselled Young Women



Education
Health
Gender Based Violence
Mental Health
Inter personal relationship - Family
Inter personal relationship - Love

Counselled Young Women - Issues among those continuing education, dropped out, completed secondary schooling and dropped out



Education
Health
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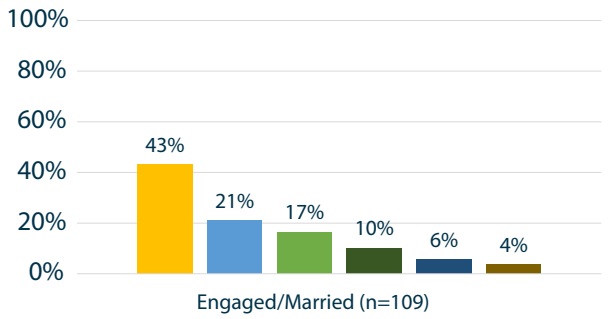
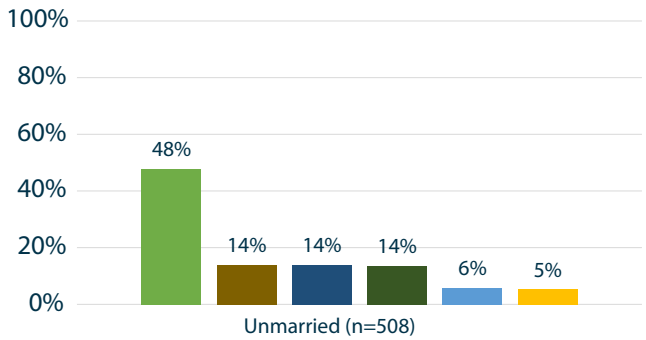
Major issues among married AG and young women





Education
Health
Gender Based Violence
Mental Health
Inter personal relationship - Family
Inter personal relationship - Love

Multinomial Logistic Regression Results

Key Results

01 Among young women, the risk of having GBV and Interpersonal Relationship Issues is six times higher compared to educational issues

02 Among young women, the risk of having mental health issues is three times higher compared to educational issues

03 Among girls and women currently pursuing education, the risk of having Mental Health issues is 4.8 times higher compared to educational issues

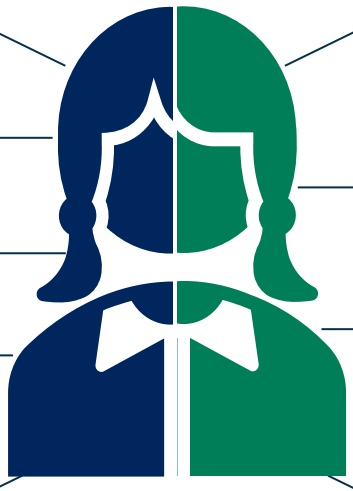
04 Among girls and women currently pursuing education, GBV and Interpersonal Relationship issues is 1.93 times higher compared to educational issues

*Based on results derived from a multinomial logistic regression analysis (significant at 90% CI)

BFCs' Reflections

Being a BFC has helped the girls to reflect on their personalities and address their issues more consciously, considering the potential consequences. Moreover, they have become more confident after undergoing training and meeting clients.

BEFORE	AFTER
I was a quiet person	The training equipped me with the skills to talk with everyone
I would talk in between when someone is talking	I have realized the importance of listening to people without interrupting them, which is necessary for a BFC
I was very judgmental	
My temper shot up soon and made me weep	I have been training myself not to judge people
I never had a good conversation with my mother	I notice my relationship with my mother is much better and I talk well with her



Challenges

- The dynamic age of adolescence creates an attrition challenge. Attrition rates among the BFCs were high as they wanted to move away from their villages to pursue higher education and various other reasons. This also creates a challenge for re-establishing a positive relationship with existing clients is challenging for both the BFC and its clients.
- The age and inexperience of adolescent girls also makes it difficult for them to address certain issues that are beyond their level such as love, relationships, suicides, and religious beliefs due to fear of community backlash. Since the clients are from the same or nearby villages, one mistake could put the BFCs at risk of being barred from the villages.
- Limited understanding of mental health in rural contexts is a barrier for adolescent girls to be able to receive counselling. Peer adolescent girls who require counselling, but must seek their parent's approval find it difficult to access or continue with the counselling services. With people often only associating mental health issues with erratic behaviour and labelling individuals as 'mad', there is not adequate acknowledgement of issues such as stress, anxiety, and other mental health issues, for which adolescent girls may require support.
- In some cases, families who are aware of their daughters' mental health issues are reluctant to seek support from BFCs because they do not want the community to find out. Even though BFCs assure them of confidentiality, they still hesitate to seek help.
- The District Mental Health Programme (DMHP) is aware of the BFC model and does accept clients referred by them. However, the BFCs do not receive feedback on the clients' status from the DMHP because the clients do not disclose that they have been referred by the BFC. If the client does disclose this information, then the BFCs would be able to receive updates on the clients' treatment status from the DMHP.

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