



OPEN ACCESS

Volume: 5

Issue: 4

Month: October

Year: 2026

ISSN: 2583-7117

Published: 01.10.2026

Citation:

Dr. Apoorva Dubey "Implementation of RKSK Adolescent Substance Use Counselling Services in Three High-Burden Districts of Madhya Pradesh: A Cross-Sectional Study" International Journal of Innovations in Science Engineering and Management, vol.5, no.4, 2026, pp. 1-6

DOI:

10.69968/ijisem.2026v5i41-6



This work is licensed under a Creative Commons Attribution-Share Alike 4.0 International License

Implementation of RKSK Adolescent Substance Use Counselling Services in Three High-Burden Districts of Madhya Pradesh: A Cross-Sectional Study

Dr. Apoorva Dubey¹¹Master of Public Health, SAM Global University, Bhopal, Madhya Pradesh, India

Abstract

Background: Adolescent substance use is an important public health concern, particularly in socially and economically vulnerable settings. The Rashtriya Kishor Swasthya Karyakram (RKSK) includes adolescent-friendly counselling and preventive services intended to address substance misuse.

Objective: To evaluate the implementation of RKSK adolescent substance use counselling services in Shahdol, Rewa, and Sidhi districts of Madhya Pradesh, with particular emphasis on awareness, Adolescent Friendly Health Clinic (AFHC) utilization, counsellor availability, privacy, perceived usefulness, and implementation barriers.

Methods: A descriptive cross-sectional quantitative study was conducted among 100 adolescents aged 10–19 years in selected areas of Shahdol, Rewa, and Sidhi. The districts were purposively selected and respondents were recruited using purposive/convenience sampling. Data were collected using a structured questionnaire covering awareness and utilization, service quality, and implementation barriers. Descriptive statistics, including frequencies and percentages, were used.

Results: Forty-two percent of respondents were partially aware of RKSK counselling services, while 28% were fully aware. Although 44% had visited an AFHC at least once, 38% knew about AFHCs but had never visited. Counsellors were reported to be always available by 24% and available only sometimes by 41%. Privacy was reported as always maintained by 35% and sometimes maintained by 39%. Peer educators were the most commonly reported source of information (34%). Counselling was considered very useful by 31% and moderately useful by 40%. The largest reported implementation barrier was lack of awareness (37%), followed by shortage of counsellors (24%) and social stigma (19%).

Conclusion: RKSK provides an important institutional framework for adolescent substance-use prevention and counselling, but implementation remains constrained by incomplete awareness, low service utilization, inconsistent counsellor availability, gaps in privacy, inadequate IEC materials, and stigma. Strengthening peer-led and school-based awareness, counsellor capacity and availability, confidential AFHC infrastructure, and programme monitoring may improve service uptake and quality.

Keywords; adolescents; substance use; RKSK; counselling; Adolescent Friendly Health Clinic; Madhya Pradesh; implementation evaluation.

INTRODUCTION

Adolescence is a critical developmental period characterized by substantial physical, psychological, emotional, and social change. It is also a period in which experimentation and exposure to risk behaviours may increase. Substance use during adolescence can adversely affect health, educational attainment, psychosocial development, and later-life outcomes.

The study background identifies tobacco, alcohol, cannabis, inhalants and other psychoactive substances as relevant forms of adolescent substance use and emphasizes the role of peer influence, family circumstances, stress, social environment and limited awareness in shaping risk.

In India, the Government of India launched the Rashtriya Kishor Swasthya Karyakram (RKSK) in 2014 under the National Health Mission as a comprehensive adolescent health programme. Substance misuse is one of its six strategic priority areas. Adolescent Friendly Health Clinics (AFHCs) provide confidential, accessible and adolescent-sensitive services, including counselling, health education, mental health support and substance-misuse counselling.

The effectiveness of such services depends on more than formal programme availability. Trained counsellors, privacy and confidentiality, adolescent-friendly communication, IEC materials, peer participation and regular monitoring are important implementation elements. The dissertation identified gaps in awareness, utilization, counsellor availability, privacy, IEC availability and monitoring as important concerns in vulnerable settings.

Shahdol, Rewa and Sidhi were selected for the present study because they represent settings with different levels of health infrastructure, geographical accessibility and socio-economic vulnerability. The study therefore sought to generate district-focused evidence on how adolescents perceive and experience RKSK counselling services.

The general objective was to evaluate the implementation of RKSK adolescent substance-use counselling services in Shahdol, Rewa and Sidhi. Specific objectives were to assess awareness, evaluate AFHC utilization, examine availability and quality of counselling, identify implementation barriers, and compare implementation across the selected districts. However, detailed district-wise statistical segregation was limited by the nature of the available dataset.

METHODS

Study design and setting

A descriptive cross-sectional study with a quantitative approach was conducted in three selected high-burden districts of Madhya Pradesh: Shahdol, Rewa and Sidhi. The districts were purposively selected because of their socio-economic vulnerability, tribal population, rural healthcare challenges and adolescent health concerns.

Study population

The study population comprised adolescents aged 10–19 years who were beneficiaries of, aware of, exposed to, or residing in communities associated with RKSK services in the selected districts.

Eligibility criteria

Eligible participants were adolescents aged 10–19 years, residing in the selected districts for at least one year, willing to participate voluntarily, and either aware of or exposed to RKSK services. Adolescents outside the age range, unwilling participants, seriously ill individuals unable to respond, and respondents with incomplete questionnaires were excluded.

Sampling and sample size

A multistage purposive sampling approach was described in the dissertation. The three districts were purposively selected; selected AFHCs, schools and communities were identified for data collection; and eligible adolescents were recruited using purposive and convenience sampling. The final sample comprised 100 respondents, distributed across Shahdol, Rewa and Sidhi.

Data collection instrument

Primary data were collected using a structured multiple-choice questionnaire. The instrument covered four domains: demographic information; awareness and utilization of RKSK/AFHC services; counselling service quality; and implementation barriers. Questions addressed counsellor availability, privacy and confidentiality, perceived usefulness, comfort in discussing substance-related problems, IEC material availability and perceived programme effectiveness.

Validity and pilot testing

The questionnaire was developed with reference to RKSK programme indicators, counselling service components, previous literature and adolescent health indicators. Content validity was supported through expert consultation and alignment with study objectives. Pilot testing was undertaken to assess clarity, respondent understanding, feasibility and response difficulties, after which necessary modifications were made.

Ethical considerations

Participation was voluntary. Participants were informed about the purpose of the study, confidentiality and use of information, and consent was obtained before data collection. Personal information and responses were kept confidential, and interviews were conducted in a safe and comfortable environment. The dissertation does not provide an institutional ethics committee approval number; therefore, no approval number has been added to this manuscript.

Statistical analysis

Responses were coded, classified and tabulated. Analysis was primarily descriptive, using frequencies and percentages. The dissertation also describes comparative interpretation across the three districts; however, inferential statistics and detailed district-wise statistical segregation were not reported in the available dataset.

RESULTS

A total of 100 adolescents participated in the study. Principal findings from the structured questionnaire:

Table 1. Awareness and utilization of RKSK counselling/AFHC services

Indicator	Response	n (%)
Awareness of RKSK counselling	Fully aware	28 (28.0)
	Partially aware	42 (42.0)
	Heard the name only	20 (20.0)
	Not aware at all	10 (10.0)
AFHC visit	Yes, multiple times	18 (18.0)
	Yes, once	26 (26.0)
	Know but never visited	38 (38.0)
	Do not know about AFHC	18 (18.0)

Table 2. Counsellor availability and privacy/confidentiality

Indicator	Response	n (%)
Counsellor availability	Always available	24 (24.0)
	Available sometimes	41 (41.0)
	Rarely available	23 (23.0)
	Not available	12 (12.0)
Privacy/confidentiality	Always maintained	35 (35.0)
	Sometimes maintained	39 (39.0)
	Rarely maintained	18 (18.0)
	Not maintained	8 (8.0)

Table 3. Information sources, perceived usefulness and IEC availability

Indicator	Response	n (%)
Source of information	Peer educator	34 (34.0)
	ASHA/ANM	25 (25.0)
	School teacher	18 (18.0)
	Social media/posters	13 (13.0)
	Friends/family	10 (10.0)
Usefulness of counselling	Very useful	31 (31.0)
	Moderately useful	40 (40.0)
	Slightly useful	19 (19.0)
	Not useful	10 (10.0)

IEC materials	Adequately available	22 (22.0)
	Partially available	44 (44.0)
	Rarely available	21 (21.0)
	Not available	13 (13.0)

Table 4. Comfort, perceived effectiveness and major implementation barriers

Indicator	Response	n (%)
Comfort discussing problems	Very comfortable	29 (29.0)
	Comfortable to some extent	43 (43.0)
	Uncomfortable	19 (19.0)
	Very uncomfortable	9 (9.0)
Perceived effectiveness of RKSK	Highly effective	26 (26.0)
	Moderately effective	45 (45.0)
	Slightly effective	20 (20.0)
	Not effective	9 (9.0)
Major implementation challenge	Lack of awareness	37 (37.0)
	Shortage of counsellors	24 (24.0)
	Social stigma/fear	19 (19.0)
	Lack of privacy	11 (11.0)
	Poor monitoring	9 (9.0)

Key findings

Awareness was incomplete: 42% were partially aware and only 28% were fully aware of RKSK counselling services. AFHC utilization was limited; 38% knew about an AFHC but had never visited, while 18% did not know about AFHCs. Counsellor availability was inconsistent, with 41% reporting that counsellors were available only sometimes and 23% reporting rare availability.

Privacy and confidentiality were not consistently experienced: 39% reported that privacy was maintained only sometimes, while 18% reported that it was rarely maintained. Peer educators were the leading source of information (34%), followed by ASHA/ANM workers (25%). Counselling was perceived positively overall, although 40% rated it as moderately useful rather than very useful.

IEC materials were reported as only partially available by 44% of respondents. Forty-three percent were comfortable to some extent discussing substance-related problems with counsellors, whereas 19% were uncomfortable and 9% very uncomfortable. Overall, 45% considered RKSK moderately effective in preventing adolescent substance use. Lack of awareness was the most frequently reported implementation barrier (37%), followed by counsellor shortages (24%) and social stigma/fear (19%).

DISCUSSION

The study demonstrates a gap between the existence of RKSK counselling services and their effective uptake by adolescents. Although most respondents had at least some awareness of RKSK, complete awareness was limited. This is important because awareness of a programme does not necessarily translate into knowledge of where services are available, what counselling involves, or how confidentiality is protected.

AFHC utilization was also suboptimal. More than one-third of respondents knew about AFHCs but had never visited them. The dissertation identifies stigma, fear of disclosure, concerns about confidentiality, distance and the adolescent-friendliness of services as possible barriers. These findings suggest that demand-side and supply-side interventions need to be addressed together: adolescents need trusted information and referral pathways, while facilities need reliable, confidential and accessible services.

Counsellor availability was another prominent implementation concern. Only 24% reported that counsellors were always available, whereas 41% reported intermittent availability. Continuity is particularly important in behavioural counselling because adolescents may require repeated contact and follow-up. In remote and tribal settings, workforce shortages and geographical barriers can compound this problem.

Privacy and confidentiality showed moderate performance. While 35% reported that privacy was always maintained, 26% reported that it was rarely or not maintained. For a sensitive issue such as substance use, inadequate privacy can reduce disclosure and discourage future service use. Improving physical counselling space and strengthening counsellor skills in adolescent-sensitive and non-judgmental communication are therefore important.

Peer educators emerged as the most frequently reported information source. This finding supports the potential value of peer-led communication within RKSK, particularly where adolescents may be more comfortable discussing sensitive issues with peers. At the same time, the relatively lower contribution of school teachers and digital communication suggests opportunities to strengthen school-based and adolescent-targeted communication.

The overall perception of counselling and RKSK was moderately positive rather than strongly positive. Forty percent rated counselling as moderately useful and 45% rated RKSK as moderately effective. This pattern suggests that the programme has an important foundation but that

implementation quality may be limiting its perceived impact.

The study should be interpreted cautiously in relation to district comparisons. Although Shahdol, Rewa and Sidhi were selected to permit comparative assessment, the available analysis did not provide sufficiently detailed district-wise statistical segregation or inferential testing. Statements that Shahdol and Sidhi may face greater challenges than Rewa should therefore be treated as contextual interpretation rather than statistically demonstrated differences.

PUBLIC HEALTH IMPLICATIONS

The findings have implications for adolescent health programme planning in Madhya Pradesh. Priority areas include strengthening adolescent-friendly counselling infrastructure; ensuring regular availability of trained counsellors; improving confidentiality and privacy; expanding peer educator and school-based communication; ensuring adequate IEC materials; and establishing routine monitoring of counselling sessions, adolescent participation, follow-up and referrals.

RECOMMENDATIONS

- Strengthen awareness generation through community campaigns, school health activities, adolescent outreach, social media and culturally appropriate communication, with specific attention to rural and tribal communities.
- Ensure regular, adolescent-friendly AFHC services, including private counselling rooms and convenient service timings.
- Recruit and retain qualified counsellors and provide regular capacity-building in adolescent psychology, substance-use counselling, empathy-based communication, confidentiality and mental health support.
- Expand and strengthen peer educator networks through regular training, supportive supervision and monitoring.
- Ensure continuous availability of adolescent-friendly IEC materials in appropriate formats and local languages.
- Address stigma through sensitization of parents, teachers, community leaders and youth groups and through non-judgmental counselling practices.
- Integrate schools more strongly into RKSK through life-skills education, early identification, awareness activities and referral mechanisms.
- Strengthen community participation through ASHAs, ANMs, Anganwadi workers, youth groups and local organizations.

- Establish routine monitoring indicators covering counsellor availability, counselling sessions, adolescent participation, IEC distribution and follow-up.
- Conduct larger mixed-method and longitudinal studies to assess district-level differences, counselling quality and longer-term outcomes.

STRENGTHS AND LIMITATIONS

The study provides focused evidence on adolescent perceptions of RKSK counselling services in three high-burden districts and examines several implementation domains within a single framework. However, the sample was limited to 100 respondents, the study covered only three districts, and purposive/convenience sampling limits generalizability. The cross-sectional design does not permit assessment of long-term behavioural outcomes. Substance-use and counselling-related responses may also be affected by social desirability or reluctance to disclose sensitive information. The quantitative design provides limited insight into cultural, family and psychosocial experiences. Finally, detailed district-wise statistical segregation and inferential analysis were not available in the dissertation dataset.

CONCLUSION

RKSK provides an important platform for adolescent substance-use prevention and counselling in Madhya Pradesh, but the present study indicates that implementation remains incomplete. Awareness is often partial, AFHC utilization is limited, counsellor availability is inconsistent, privacy is not uniformly experienced, and IEC materials are not consistently available.

Peer educators are an important communication channel, while lack of awareness, counsellor shortages and stigma are the leading reported barriers. Strengthening adolescent-friendly infrastructure, human resources, peer and school-based communication, confidentiality and routine monitoring could improve the reach and quality of RKSK counselling services in high-burden districts.

DECLARATIONS

Ethics approval and consent

The study was conducted in accordance with ethical principles for research involving human participants. Participation was voluntary, and informed consent was obtained from participants & guardians prior to data collection. Confidentiality and privacy were maintained throughout the study.

Funding

The author received no specific funding for this study..

Conflict of interest

The author declares no competing interests.

REFERENCES

- [1] Barua A, Watson K, Plesons M, Chandra-Mouli V, Sharma K. Adolescent health programming in India: a rapid review. *Reprod Health*. 2020;17(1):87.
- [2] Jain N, Bhatnagar T, Sahoo KC, et al. Progress and challenges in implementing adolescent and school health programmes currently implemented in India. *BMJ Open*. 2022;12(5):e047435.
- [3] Shah T, Mavalankar D, Singh A. Situational analysis of Rashtriya Kishor Swasthya Karyakram implementation in Gujarat. *J Family Med Prim Care*. 2022;11(2):450-458.
- [4] Ministry of Health and Family Welfare, Government of India. Rashtriya Kishor Swasthya Karyakram (RKSK) Strategy Handbook. New Delhi: MoHFW; 2014.
- [5] Ministry of Health and Family Welfare, Government of India. RKSK Implementation Guide on Adolescent Friendly Health Clinics. New Delhi: MoHFW; 2015.
- [6] Ministry of Health and Family Welfare, Government of India. National Adolescent Health Programme: Rashtriya Kishor Swasthya Karyakram. New Delhi: MoHFW; 2014.
- [7] Chandra-Mouli V, Lane C, Wong S. What does not work in adolescent sexual and reproductive health: a review of evidence on interventions commonly accepted as best practices. *Glob Health Sci Pract*. 2015;3(3):333-340.
- [8] Patton GC, Sawyer SM, Santelli JS, et al. Our future: a Lancet commission on adolescent health and wellbeing. *Lancet*. 2016;387(10036):2423-2478.
- [9] World Health Organization. Global status report on alcohol and health 2018. Geneva: WHO; 2018.
- [10] World Health Organization. Adolescent mental health and substance use prevention framework. Geneva: WHO; 2021.
- [11] National Institute of Mental Health and Neuro Sciences. Magnitude of Substance Use in India. Bengaluru: NIMHANS; 2019.
- [12] United Nations Office on Drugs and Crime. World Drug Report 2022. Vienna: United Nations; 2022.
- [13] UNICEF India. Adolescent Development and Participation in India: Situation Analysis Report. New Delhi: UNICEF; 2021.

- [14] United Nations Population Fund. Counselling for Adolescents: Learning Manual for RKSK Counsellors. New Delhi: UNFPA India; 2020.
- [15] National Health Systems Resource Centre. Adolescent Health Care Training Manual for Community Health Officers. New Delhi: NHSRC; 2021.
- [16] Viner RM, Ozer EM, Denny S, et al. Adolescence and the social determinants of health. *Lancet*. 2012;379(9826):1641-1652.
- [17] Picoito J, Santos C, Loureiro I, Aguiar P, Nunes C. Gender-specific substance use patterns and associations with family, school and peer factors in adolescents. *Child Adolesc Psychiatry Ment Health*. 2019;13:4.
- [18] Richter M, Kunst AE, Kannas L, et al. Socioeconomic inequalities in adolescent smoking across countries. *Eur J Public Health*. 2015;25(3):457-463.
- [19] Godley SH, Smith JE, Meyers RJ, Godley MD. The adolescent community reinforcement approach for adolescent cannabis users. Rockville, MD: SAMHSA; 2001.
- [20] Campos-Melady M, Smith JE, Meyers RJ, Godley SH, Godley MD. Effect of therapist adherence and competence in adolescent substance use counselling outcomes. *Psychol Addict Behav*. 2017;31(1):112-123.
- [21] Webb CA, DeRubeis RJ, Barber JP. Therapist adherence and competence in relation to treatment outcomes: a meta-analytic review. *J Consult Clin Psychol*. 2010;78(2):200-211.
- [22] Sahadevan S, et al. Effect of adolescent health policies on health outcomes in developing countries. *Youth*. 2023;3(4):43-58.
- [23] Ministry of Health and Family Welfare, Government of India. Peer Education Programme under Rashtriya Kishor Swasthya Karyakram: Operational Guidelines. New Delhi: MoHFW; 2020.
- [24] Daniel S. Peer Education Programme under Rashtriya Kishor Swasthya Karyakram: Implementation Experiences and Lessons. New Delhi: National Centre for Good Governance; 2021.
- [25] Patton G, Coffey C, Cappa C, et al. Health of the world's adolescents: a synthesis of internationally comparable data. *Lancet*. 2012;379(9826):1665-1675.