NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

सत्यमेव जयते

RKSK
Rashtriya Kishor Swasthya Karyakram
राष्ट्रीय किशोर स्वास्थ्य कार्यक्रम

IMPLEMENTATION GUIDELINES RASHTRIYA KISHOR SWASTHYA KARYAKRAM (RKSK)

Ministry of Health & Family Welfare
Government of India

2018

IMPLEMENTATION GUIDELINES RASHTRIYA KISHOR SWASTHYA KARYAKRAM (RKSK)

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Government of India
Department of Health and Family Welfare
Ministry of Health & Family Welfare

Dated : 18th June, 2018

Foreword

Adolescence is a critical phase defined by rapid growth and transition. Health choices made during this stage can have significant – impacts in future; this makes investments in the health of adolescents imperative. Adolescents are faced with a number of preventable and treatable health issues, including early pregnancy. HIV/AIDS and other sexually transmissible infections, nutritional problems, substance use and abuse, mental health problems and injuries, both intentional and unintentional. Therefore, it is critical to empower them to make informed choices about their health and overall wellbeing.

India is home to 253 million adolescents, comprising more than 20% of the world's 1.2 billion adolescent population. Thus, the urgent need to focus on the health of adolescents has been recognized as a global and national priority. Adolescents are the torchbearers of the future and notable stakeholders in accelerating action towards the Sustainable Development Goals.

The Ministry of Health and Family Welfare under the National Health Mission launched the Rashtriya Kishor Swasthya Karyakram (RKSK), a comprehensive adolescent health programme that seeks to achieve better health outcomes for all adolescents through youth empowerment, community involvement and access to high quality facility based services. It is estimated that with the desired level of implementation of RKSK for adolescents across India, particularly vulnerable groups, our country will be better equipped to adequately meet their health needs.

Any successful intervention for adolescents' demands focus on a continuum of care across levels of the adolescent environment, with support from all relevant stakeholders. It is our endeavour to ensure that all States are well equipped with dedicated RKSK infrastructure to augment the programme's vision, communities are duly engaged though information and counseling opportunities with the support of trained adolescent peer educators (saathiyas), ANMs and ASHAs and Adolescent Friendly Health Clinics are fully operation.

These implementation Guidelines have been evolved to serve as a handbook and a resource for Program Managers for effective planning and implementation of RKSK at the District/State level. I am certain that these guidelines will prove to be useful as a one-stop resource to understand the vision and structure of the programme and plan activities in an effective and timely manner through all levels of implementation.

(Preeti Sudan)

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PREFACE

Adolescents and young people are key to achieving India's demographic dividend. The Rashtriya Kishor Swasthya Karyakram (RKSK) is a unique initiative, which seeks to implement a comprehensive approach to the health and wellbeing of adolescents. The phase of adolescence is defined by several positive and negative influences. Early interventions to curb negative health behaviours coupled with opportunities for productive engagement and equitable access to adolescent friendly health services can be critical in transforming the present and future.

Adolescents in India are vulnerable to a range of health risks including nutritional deficiencies, substance abuse, mental health concerns, NCDs, violence and injury and reproductive and sexual health problems. A number of these issues are preventable through informed health choices. Therefore, adolescent-focused interventions must target both the determinants of health problems as well as their consequences. Empowering adolescents within their ecosystem and providing equitable access to quality healthcare through convergence of various sectors are the cornerstones of RKSK.

Adolescents have thus far remained in the periphery of the health system. RKSK offers an evidence-based approach that transcends the traditional realm of care giving to include inclusive opportunities for adolescents, even in the most hard to reach areas, to develop their capabilities and emerge as champions of health. RKSK is the first of its kind programme in Asia and presents learning prospects for several countries in the region. Therefore, ensuring effective implementation of the programme is critical not only to its own success but also for advancing health outcomes outside India.

This document is designed to serve as a broad guide for Programme Managers at the District and State level, giving them an overview of RKSK, priority areas of actions under this comprehensive approach to addressing adolescent health and avenues to deliver a continuum of care.

I wish all those involved in RKSK great success and I am confident that together we will be able to translate the vision of the programme into practice and transform the lives of millions of adolescents across our country.

(Manoj Jhalani)

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PROLOGUE

In 2014, the Rashtriya Kishor Swasthya Karyakram (RKSK) was launched under the National Health Mission to strengthen India's commitment to adolescent health needs. RKSK is a comprehensive programme that not only provides access to health services but also empowers adolescents to make informed and responsible decisions related to their health. The main principle of RKSK is to build adolescent participation and leadership while addressing critical needs related to nutrition, reproductive health, substance abuse, injuries, mental health concerns and chronic diseases.

RKSK envisages reaching adolescents - male and female, rural and urban, married and unmarried, in and out-of-school adolescents with special focus on marginalized and undeserved groups, through a wide range of preventive as well as promotive activities, especially those related to non-communicable diseases and mental health.

RKSK ropes in key implementers at the first point of service delivery, including trained peer educators, teachers, parents, ASHAs, AWWs, VHNSC and PRI members to undertake community-based interventions. At the same time, RKSK seeks to strengthen facility-based services like Adolescent Friendly Health Clinics (AFHCs) as dedicated spaces for adolescents in the existing health system.

One of the unique aspects of RKSK is its vision to ensure convergence with existing initiatives and programmes of the Ministry of Health and Family Welfare as well as with other Ministries and departments. It is only through multi-sectoral cooperation that the needs of adolescents can be adequately and equitably addressed.

I am confident that the well-conceived implementation guidelines for RKSK will prove to be a stepping-stone towards safeguarding the health of all adolescents in the country now and in future.

I wish success and pledge my unflinching support towards implementation of this important programme.

(Vandana Gurnani)

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Acknowledgement

Rashtriya Kishor Swasthya Karyakram (RKSK) was initiated in India with the aim of reaching our adolescent population to address their health needs. The programme goes beyond traditional understanding of adolescent health, confined to sexual and reproductive health, to include important dimensions like mental health, nutrition, substance misuse, gender based violence and risk factors for non-communicable diseases. RKSK, being a comprehensive and participative programme, not only offers quality treatment and counselling for health conditions but also empowers adolescents to prevent the occurrence of detrimental health conditions. The combination of community-based interventions including school based services and strong facility-based services up to the grass root level are cornerstones of RKSK.

The Operational Guideline for RKSK will be a ready reckoner for programme implementers in the Districts and States to operationalize the programme and translate its vision into reality. The development of this document would not have been possible without the valuable contributions of World Health Organization Regional Office for South-East Asia, World Health Organization Country Office for India, USAID, Public Health Foundation of India and UNFPA.

I will specially like to acknowledge the contribution of Dr. Sushma Dureja, Deputy Commissioner Adolescent Health, MoHFW, Dr. Zoya Ali Rizvi, Assistant Commissioner, Adolescent Health MoHFW, Ms. Risha, Senior Consultant, Mr. Deepak Kumar & Dr. Prairna Koul, Consultants, Adolescent Health, MoHFW, Dr. Kiran Sharma, WHO country Office, Dr. Monika Arora, PHFI, Dr. Jaya UNFPA and Technical Support Unit, USAID in finalizing this document.

(Dr. Ajay Khera)
20/06/18

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ABBREVIATIONS

AEP	Adolescent Education Programme
AFC	Adolescent Friendly Club
AFHC	Adolescent Friendly Health Clinic
AH	Adolescent Health
AHD	Adolescent Health Day
ANM	Auxiliary Nurse Midwife
ARSH	Adolescent Reproductive Sexual Health
ASHA	Accredited Social Health Activist
AWC	Anganwadi Center
AWW	Anganwadi Worker
AYP	Annual Youth Poll
CHC	Community Health Centre
DCAH	District Committee for Adolescent Health
DLHS	District Level Household and facility Survey
GBV	Gender-based Violence
GoI	Government of India
HPD	High Priority District
HMIS	Health Management Information system
ICDS	Integrated Child Development Services
IEC	Information Education Communication
IFA	Iron Folic Acid
MHRD	Ministry of Human and Resource Development
MHS	Menstrual Hygiene Scheme
MO	Medical Officer
MoHFW	Ministry of Health and Family Welfare
MOIC	Medical Officer in charge
MoLE	Ministry of Labor and Employment
MoRD	Ministry of Rural Development
MoYAS	Ministry of Youth Affairs and Sports

MSJE	Ministry of Social Justice and Empowerment
MWCD	Ministry of Women and Child Development
NCD	Non-communicable Disease
NDD	National Deworming Day
NFHS	National Family Health Survey
NGO	Non-Government Organization
NHE	Nutrition and Health Education
NHM	National Health Mission
NMHP	National Mental Health Programme
NPYAD	National Programme for Youth and Adolescent Development
NPCDCS	National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke
NRLM	National Rural Livelihood Mission
NYKS	Nehru Yuva Kendra Sangathan
PE	Peer Educator
PHC	Primary Health Centre
PIP	Programme Implementation Plan
PRI	Panchyati Raj Institutions
RBSK	Rashtriya Bal Swasthya Karyakram
RKSK	Rashtriya Kishor Swasthya Karyakram
RMNCH-A	Reproductive Maternal Neonatal Child health plus Adolescent
RSOC	Rapid Survey on Children
SACS	State AIDS Control Society
SCAH	State-level Committee for Adolescent Health
SCAHD	Steering Committee for Adolescent Health and Development
SDGs	Sustainable Development Goals
SOP	Standard Operating Procedure
SRH	Sexual and Reproductive Health
VHNSC	Village Health, Nutrition and Sanitation Committee
WHO	World Health Organization
WIFS	Weekly Iron Folic Acid Supplementation

A INTRODUCTION AND RATIONALE

Adolescence is a critical phase in the life span, characterized by a tremendous pace in physical and psychological development. Adolescents need the opportunity to develop the capabilities required for leading a prosperous and healthy life and realizing their full potential as social and economic assets of the country.

India is home to the largest number of adolescents - approximately 253 million, which is 21% of India's population

Adolescent: Definition by WHO		
"Adolescence" 10-19 yrs	"Youth" 15-24 yrs	"Young people" 10-24 yrs

The benefits of investing in adolescents are limited not only to their present life stage but transcend entire lifespan and generations to come. Though adolescence is the ideal phase to build healthy behaviors, at the same time adolescents transitioning from childhood to adulthood are predisposed to several preventable and treatable health issues. These health issues have serious long lasting social, economic and- health implications for individuals as well as society if not prevented and adequately supported during the short window of adolescence.

Adolescent health and well-being is also a key driver of a wide range of the Sustainable Development Goals (SDGs)on health, nutrition, education, and gender-equality and food security. As the largest set of beneficiaries, adolescents are important stakeholders and protagonists in the process of sustainable development. Investments in adolescents will have direct and positive impact on India's health goals and at the same time, it will enhance economic productivity, effective social functioning and overall population development.

In order to respond to the health and development needs of adolescents in a holistic manner, a multi-component intervention targeting both determinants of health and their consequences is imperative. With this goal, Ministry of Health and Family Welfare (MoHFW) under National Health Mission (NHM) launched a comprehensive programme for adolescents, **'Rashtriya Kishor Swasthya Karyakram'(RKSK)** in 2014 to reach out to the adolescents in India. It has been one of the major steps towards implementing the continuum of care approach in health programmes in the country. RKSK specifically addresses the "+A" adolescent health component of the RMNCH+A strategy.

RKSK includes six strategic priorities namely Sexual and Reproductive Health, Nutrition, Non Communicable Diseases (NCDs), Substance Misuse, Injuries & Violence including Gender Based Violence and Mental health. Recently, in view of the renewed focus on adolescent health at both- global and national level and to capitalize on the momentum set by RKSK, Government of India (GoI) is expanding the programme through newer interventions and rationalizing the existing ones within the framework of RKSK.

The learning of Rashtriya Kishor Swasthya Karyakram(RKSK) implementation also indicate scope for enhanced focus on some critical components namely School Health, multi-sectoral and intradepartmental convergence and harnessing the potential of Non-Governmental Organizations (NGOs).

Currently, the School Health Component under Rashtriya Bal Swasthya Karyakram (RBSK), primarily focuses on early detection and management of childhood diseases, deficiencies, disorders and developmental delays including disabilities. However, it has limited scope of preventive and promotive activities and this needs to be expanded. Besides this, there are number of programmes under National Health Mission which address the adolescent health needs such as, National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS), Mental Health Programme, and Adolescent Education Programme (AEP) under National AIDS Control Programme (implemented through the Ministry of Human Resource Development). Intensified efforts are required to achieve convergence between these programmes with RKSK and effectively utilize the platform of schools.

Also, in order to expedite and effectively implement the community based interventions the available implementation models need further clarity on encouraging partnership with the NGO given their proximity and rapport with the community.

Thus, Rashtriya Kishor Swasthya Karyakram (RKSK) Guidelines have been updated to incorporate:

(a) School Health Component
(b) Defined mechanisms for Inter & Intra departmental convergence and
(c) Guidelines on engaging Non-governmental organizations (NGOs) in the community based interventions

The revised guidelines intend to provide a single comprehensive document to guide policy makers, programme managers and other stakeholders in rolling out the intensified strategies under RKSK across the country. Separate guidelines shall be shared for intensifying school health activities and NGO component.

The following guidelines and documents released by MoHFW, GoI (available on: http://nhm.gov.in/nrhm-components/rmnch-a/adolescent-health-rksk/rksk-guidelines.html) may also be referred to further details on various RKSK Interventions.

- National Adolescent Health Strategy, MoHFW, GoI, December, 2013
- RKSK: Operational framework. Translating strategy into policies, January 2014
- Operational Framework: Weekly Iron and Folic Acid Supplementation Programme for Adolescents
- Operational Guidelines: Promotion of Menstrual Hygiene among Adolescent Girls (10-19 Years) in Rural Areas
- Medical Officers Training manual
- ANM Training manual
- Training Manual for Adolescent Health Counsellors
- Training manual for Peer Educators
- Operational Guidelines: Rashtriya Bal Swasthya Karyakram (RBSK), February, 2013 (http://nhm.gov.in/nrhm-components/rmnch-a/child-health-immunization/rashtriya-bal-swasthya-karyakram-rbsk/2013-12-19-08-30-24.html)

B VISION & OBJECTIVES OF RKSK

Vision

All adolescents in India are able to realize their full potential by making informed and responsible decisions related to their health and well-being.

Objectives

(i) Increase the availability and access to information about adolescent health
(ii) Increase accessibility and utilization of quality adolescents counselling and health services
(iii) Forge multi-sectoral and intra departmental partnerships to create safe and supportive environment for adolescents
(iv) Institute special strategies to target adolescents residing in geographic pockets which make them vulnerable to health and nutrition risks, such as tribal, conflict, migrant and out of school adolescents

The specific objectives of the programme are:

Improve nutrition	Enable sexual and reproductive health	Enhance mental health	Prevent injuries and violence	Prevent substance misuse	Address non-communicable diseases
Reduce prevalence of malnutrition and iron deficiency anemia	Improve knowledge, attitude and behavior in relation to SRH including Menstrual Hygiene Reduce teenage pregnancies Improve birth preparedness and complication readiness Provide early parenting support for adolescent parents	Improved knowledge and skills on mental health issues of adolescents among the health care providers	Promote favourable behavior and attitudes for preventing injuries and violence (including Gender-based Violence-GBV) among adolescents	Increase adolescents' awareness of the adverse effects and consequences of substance misuse	Promote behaviour change in adolescents to prevent NCDs such as hypertension, stroke, cardio-vascular diseases and diabetes

C TARGET POPULATION

The target population includes all adolescents in the age groupof 10-19 years of age. This covers both early (10-14 years) and late (15-19 years) adolescents.

These include both males and females, urban and rural; in school and out of school; married and unmarried adolescents.

There is special focus on adolescents of vulnerable and marginalized population groups including urban slums, tribal areas, migrants, child labor, adolescents with physical/mental disability, orphans, street children, and juvenile home.

D KEY IMPLEMENTATION APPROACHES

The approach is a paradigm shift from clinical to preventive and promotive aspects and realigns the clinic-based curative approaches to focus on a more holistic model, which emphasizes on community and school-based health promotion and preventive care. The approach is based on a continuum of care for adolescent health and development needs, and includes provision of information, commodities and services at the community level, with mapped out referral linkages through the three-tier public health system.

Family Based Approach	School Based Approach	Community Based Approach
• Adolescent Friendly Health Clinics providing counselling and clinical services • Adolescent Health Resource Centre at District Hospital	• Strengthening of school health activities • Screening of Adolescents for 4 Ds (RBSK) • Weekly Iron Folic Acid Supplementation (WIFS) Programme • Deworming during National Deworming Day (NDD) • Provision of sanitary napkins • Peer Educator Intervention (Saathiya)	• Weekly Iron Folic Acid Supplementation (WIFS) Programme • Deworming during National Deworming Day (NDD) • Provision of sanitary napkins • Peer Educator Intervention (Saathiya)- for out of school/vulnerable adolescent groups • Quarterly Adolescent Health Day (AHD) • Adolescent Friendly Clubs (AFCs)

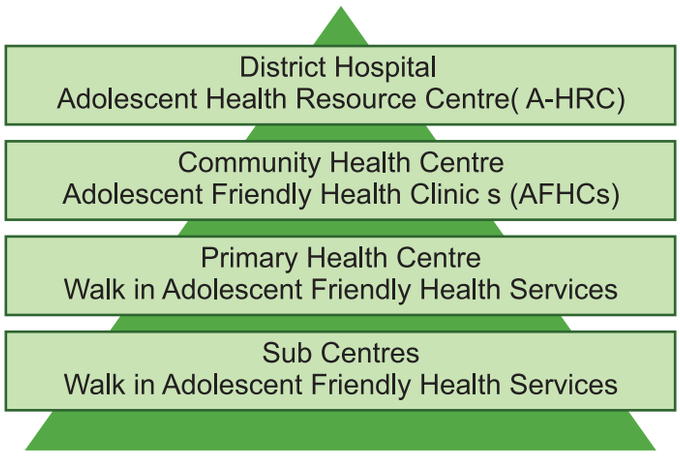
I. Facility Based Approach: This approach was initiated in 2006 under RCH II in the form of Adolescent Reproductive Sexual Health (ARSH) Clinic to provide counselling on sexual & reproductive health issues.

Now under RKSK, AFHC entails a whole gamut of clinical and counselling services on diverse adolescent health issues ranging from Sexual and Reproductive Health (SRH) to Nutrition, Substance abuse, Injuries and Violence (including Gender based violence, NCDs and Mental Health issues at various levels of health care facilities.

The key 'friendly' component of AFHC mandates facility-based clinical and counselling services for adolescents, which are:

- **Equitable—** services are provided to all adolescents who need them.
- **Accessible—** ready accessibility to AFHCs by adolescents i.e. AFHC should be established where adolescents can go without hesitation for example: it should not be placed near labour rooms, Integrated counselling and treatment centres, Sexual and Reproductive Transmitted Infections (STI/RTI) centre etc.
- **Acceptable—** health providers meet the expectation of adolescents who use the services.
- **Appropriate—** the required care is provided and any unnecessary and harmful practices are avoided.
- **Effective—** healthcare produces positive change in the status of the adolescents; services are efficient and have high quality. The right health services are provided in the right way, and make a positive contribution to their health.
- **Comprehensive—** care provision covers promotive, preventive and curative aspects.

Structure of facility based approach



The focus is on strengthening the Adolescent Friendly Health Clinics (AFHCs) at the level of District Hospital and Community Health Centres with a physical makeover to ensure privacy &confidentiality, training of existing staff, introduction of a trained counsellor and provision of necessary commodities and equipments. District level Adolescent Health Counsellor (if in position) or other counsellors at the district may be trained to provide integrated counselling services including adolescent health.

Adolescent Friendly Health Clinics (AFHCs) at District level will be designated as Adolescent Health Resource Centre (A-HRC). These centres apart from providing the full complement of services envisioned for AFHC will also act as resource centre for capacity building of health care providers and repository for. Information, Education and Communication materials on Adolescent Health such as posters, banners, pamphlets, audio-video materials.

Activities at the Adolescent Health Resource Centre (A-HRC)

- Orientation visits of the MOs, ANMs and Counsellors to A-HRCs will be a part of Adolescent Friendly Health Services (AFHS) training curriculum to give hands on experience.
- Quarterly meeting of all the Adolescent Health Counsellors of the District to be conducted at the AHRCs for experience sharing and guidance on AH Issues.
- Mock session or practice with the real time clients will be organized for Counsellors having difficulties in dealing with adolescents on issues like Mental Health, Gender based Violence etc.
- Peer Educators (Saathiyas) will make a visit of the AHRC in order to have acquaintance with the services being provided at the AHRCs.
- Once in every two months, one theme out of the six thematic areas of RKSK will be selected and counselling and clinical services will be provided to the clients during designated hours. This will be widely publicized through various IEC modes and during outreach session of the AH Counsellors.
- Medical Officer in charge of the AHRC will develop linkages with the RBSK team for referral of in school and out of school adolescents.
- AHRC will also act as a repository for IEC material on adolescent health like posters, banner, pamphlets and audio visual material.

Primary Health Centres will continue to provide services while health care providers at sub-centres will be sensitised to adolescent health issues. It is important to recognise that AFHCs is a part of a wider package of AH services. Adolescent Friendly Health Clinics will have strong linkages with Peer Education Programme. Adolescent Health Day and Adolescent Friendly Clubs will work as a platform for referral of clients to the Adolescent Friendly Health Clinics.

Block Adolescent Health Coordinators will play a crucial role in operationalization of Adolescent Friendly Health Clinics (AFHCs). The designation of Adolescent Health Counsellors, wherever existing at the block level, will be renamed as Block Adolescent Health Coordinators having dual responsibility of counselling and coordinating other community and school based activities.

Their roles and responsibilities are indicated in the table below:

Role of Block Adolescent Health Coordinators

Counselling and Outreach Activities: Inform, educate and counsel clients on Adolescent Health issues and refer clients to health facilities, or other service delivery points such as Integrated Counselling Testing Centre (ICTC), de-addiction centre, Non Communicable Diseases clinics etc. Besides this, outreach services by counsellors will be carried out at schools, colleges, youth clubs and in community at least twice a week to sensitize the adolescents, caregivers and influencers on various adolescent health issues and apprise them of various available adolescent friendly health services.

Programme Management: Block Adolescent Health Coordinators will support implementation of block level activities for Rashtriya Kishor Swasthya Karyakram (RKSK) –Selection of Saathiyas, plan and coordinate trainings of MOs/ ANMs/ Saathiyas and teachers, facilitating the implementation of School Health Activities, coordinating the convergence activities, data collection and reporting for Rashtriya Kishor Swasthya Karyakram (RKSK)

ii. School Based Approach: As large numbers of adolescents are in school, under AYUSHMAN BHARAT intensified activities for school based health promotion and prevention will be carried out in close collaboration with the Department of School Education & Literacy, Ministry of Human Resource Development (MoHRD). This will offer comprehensive and evidence-based health promotion interventions, in addition to offering age-appropriate health education, health screening, preventive services, documentation of health-related data and better skills for emergency care.

Five components under intensification of preventive and promotive school health activities:

Intensified School Health Promotion Activities

Age appropriate incremental activity based promotion of healthy behavior towards prevention of various diseases delivered through school teachers/Health Ambassadors trained in each school

Health Screening

The screening of children will continue for 30 identified health conditions for early detection, free treatment and management through dedicated RBSK mobile health teams

Provision of Services

- IFA tablet and Tablet Albendazole administration by teachers through IFA Supplementation and NDD programme respectively
- Provision of sanitary napkins
- Age appropriate vaccination

Electronic Health Records

Electronic health record for each child.

Upgrading skills of emergency care

Training on basic first aid will be provided to teachers

Two teachers, preferably one male and one female, in every school designated as “Health and Wellness Ambassadors” will be trained to transact health promotion and disease prevention information in the form of interesting activities for one hour every week. These health promotion messages will also have bearing on improving health practices in the country as students will act as Health and Wellness Messengers in the society. Every Tuesday may be dedicated as Health and Wellness Day in the schools. Two Peer Educators (Saathiya), one boy and one girl, will support the Health and Wellness Ambassadors in carrying out health promotion activities.

It is recommended that proactive and self-motivated teachers with good communication skills, and ability to connect with students should be selected. The teachers from science, physical education background may be given preference. The age of teachers selected as Health and Wellness Ambassadors should be preferably below 45 years. States may consider giving special recognition at the time of promotions as an incentive for their contribution in promoting health in their respective schools.

A cascade model of training will be followed. The National Level training will be conducted jointly by trainers from Ministries of Health & Education. The National Level Master Trainers will train, four State level trainers (State Council of Educational Research and Training (SCERT), Department of Health/State Institute of Health and Family Welfare) at National level. These State trainers will then train three trainers per district at the State level. The three district level trainers will be from the District Institute of Education and Training (DIET) and those from the Department of Health may be Medical Officer and Counsellor. They will train three trainers per block, at the district level, who can be Block Medical Officer, RBSK doctor and Block Resource Centre (BRC) Coordinators. The block level trainers will train two teachers per school (Health and Wellness Ambassadors) at block level. All these trainings will be for five days' duration with 30 participants per batch. The block trainers will also conduct a two-day orientation, for all the school principals of their respective block.

Existing teacher capacity building mechanisms may be considered for trainings. Moreover, infrastructure of DIET may be appropriately utilized for the same.

The trained teachers/ Health and Wellness Ambassadors will conduct weekly sessions and complete the modules in the academic year as per the proposed schedule. The sessions have to be preferably included in the time table and regular curriculum of the classroom teaching. It is also proposed to have Tuesday of every week as the Health and Wellness Day. Age appropriate material is being adapted from various programmes such as Life Skills, AEP, Peer educator module, ASHA modules for conducting activities in the schools. The current sessions will build on the existing process to make it more comprehensive with respect to health.

The screening and management of important health conditions will be carried out by Rashtriya Bal Swasthya Karyakram (RBSK) mobile teams placed in every block of the country. These teams will also act as resource in the block for capacity building of Health Ambassadors.

> Over 54% of adolescent girls and 29% of adolescent boys are anaemic (NFHS-4)

Weekly Iron and Folic Acid Supplementation (WIFS) and biannual Deworming will be carried out through School Health Programme to meet the challenge of high prevalence and severity of anaemia amongst adolescent girls and boys. All the school going adolescent boys & girls in standard 6th to 12th, enrolled in Government, Government aided municipal schools and out of school adolescent girls will be provided supervised weekly iron & folic acid supplement.

Strategy for Prevention of Anaemia in Adolescents:

- Administration of Weekly Iron and Folic Acid Supplementation (WIFS). Each IFA tablet containing 100mg elemental iron and 500µg folic acid for 52 weeks in a year.
- Screening of target groups for moderate/severe anaemia and referring these cases to an appropriate health facility.
- Biannual de-worming (Albendazole 400mg), six months apart, for control of worm infestation.
- Information and counselling for improving dietary intake and for taking actions for prevention of intestinal worm infestation.

The WIFS strategy involves a "fixed day" approach for IFA administration. It is recommended that Monday be the day on which all schools and Anganwadi Centres distribute weekly IFA tablets, with one additional designated day for missed out beneficiaries. To ensure high compliance supervised consumption of the IFA tablets is recommended. The programme also encourages and provides for the consumption of IFA tablets by the teachers and frontline workers such as AWW and ASHA enhance the value of IFA among adolescents and community members. In order to screen adolescents for moderate/severe anaemia, AWW and teachers will be trained to identify adolescents with moderate/severe anaemia. States may include Haemoglobin testing for school children at least annually through the School Health Programme.

iii. Community based Approach:

a) The adolescents in the community will be covered through **Peer Education (PE) Programme.** The selected Peer Educators called ***Saathiya*** will ensure that adolescents benefit from regular and sustained peer education covering all six themes of RKSK.

Who can be a Saathiya

A person

- In the age group of 15-19 years
- With social and demographic characteristics similar to the community the Saathiya will work in
- Who can volunteer time
- Has good communication skills
- Has leadership qualities
- Is motivated

It is envisaged that this approach would further facilitate coverage of out of school adolescents. There are 112 districts in the country with more that 50% adolescents out of school (Annex 1). The states may consider these districts to reach out of school adolescents through RKSK.

Under the PE programme, two peer educators (one boy and one girl) shall be selected per village/1000 population/ASHA habitation to reach out to out of school adolescents. Saathiya selection shall be facilitated by ASHA in consultation with Village Health Sanitation and Nutrition Committee. ASHA is entitled to get Rs.100 for facilitating selection of a Saathiya, given once in two years.

Each *Saathiya* shall form a group of 15-20boysor girls from their community and conduct weekly one to two hour participatory sessions using PE kits. *Saathiya* will maintain a diary, including a brief overview of each session and the number of participants. At the end of each month, peer educators will prepare a brief composite report of the number of sessions and average attendance rates. A non-monetary monthly incentive of Rs.50 has been proposed for Saathiyas.

Saathiya will facilitate in organization of the quarterly Adolescent Health Days (AHD) and participate in the Adolescent Friendly Club (AFC) meetings also. The Saathiya will coordinate with the Peer Educators *(Sakhi-Saheli)* from the Sabla programme in districts where the programmes overlap to optimize reach.

ASHA will act as the village level Saathiya coordinator and take the lead in ensuring that the peer education activities are carried out smoothly at the village level. ANMs and Male Health Workers will moderate the monthly AFC sessions and Medical Officer In-charge and BlockAdolescent Health Coordinatorswill provide oversight.

b) The Quarterly **Adolescent Health Day (AHD)** is one of the interventions under RKSK to improve coverage with preventive and promotive interventions for adolescents and to increase awareness among adolescents, parents, families and stakeholders about issues and needs related to adolescent health. AHDs will be conducted at the village level at Anganwadi Centres or any other public place where adolescents and all stakeholders have easy accessibility. Block adolescent health coordinators will be the focal person to coordinate for AHD, ensuring availability of commodities and services and will ensure that publicity is done before hand. ASHAs will engage with parents and families of adolescents to increase awareness about the unique needs of adolescents. There is a provision of incentive of Rs. 200 per ASHA for AHD to support in mobilization of adolescents and other stakeholders.

c) Apart from above, **Adolescent Friendly Club (AFC)** meetings will be organized once a month at sub-centre level under the overall guidance of ANM. These typically cover 5 villages/5000 population composed of 10-20 Saathiya each. During meetings, Saathiya from different villages will meet and clarify issues which they have encountered during their weekly sessions with the help of ANM. There is a provision of Rs.500 for organising monthly AFC meetings.

d) Under the **WIFS programme,** out-of-school adolescent girls in the age group of 10-19 years (married and unmarried) will be reached through ICDS system. State Health and Family Welfare Department will undertake the procurement and supply IFA and Albendazole tablets. The District Project officer (DPO) and Block Project Officer (CDPO) of ICDS will implement WIFS in coordination with District Chief Health /Medical Officers/ CMO and Block Medical/Health Officer. The following key activities will be undertaken:

- AWW with the help of ASHA will mobilize adolescent girls at the AWC on a fixed day in the week. On that day one IFA tablet will be provided to each girl by AWW and she will ensure supervised ingestion of IFA tablet by adolescent girls.
- AWW will screen adolescent girls for presence of moderate/severe anaemia by examining the nail bed and tongue pallor.
- Biannual deworming will be done through administering Albendazole for control of worm infestation.
- Monthly Nutrition and Health Education session.

e) **Menstrual Hygiene Scheme (MHS)** is implemented to ensure that adolescent girls have adequate knowledge and information about maintaining good menstrual hygiene. Under the scheme, there is a provision of decentralized procurement of sanitary napkin at the State level with NHM support or state budget. ASHAs will be providing these napkins to adolescent girls in schools and within communities at a subsidized rate of Rs. 6/- (Rupees Six) for a pack of six napkins and are entitled to get Re.1 for every pack sold and one free pack of sanitary napkins per month for themselves.

ASHA will conduct monthly meetings with adolescent girls at the Anganwadi Centre or Panchayat Bhawan or any other safe place, to create awareness on health and hygiene including menstrual hygiene along with safe disposal of used sanitary napkins. At the community level, deep pit burial or burning are two options which could be considered after due environmental clearances are obtained. States could leverage funding for such equipment through the Total Sanitation Campaign (TSC) or *Sarva Shiksha Abhiyan*(SSA).

Implementation strategies for community based approaches: The States will have to consider which agency will be best placed to implement the PE programme based on an assessment of capacity and resource requirements. In this context, there are two key options.

a) Direct implementation by the Department of Health and Family Welfare: In this model, all the components of the community based approach will be implemented by the government through the available resources. Saathiya selection will be facilitated by ASHA in consultation with Village Health Sanitation and Nutrition Committee. ASHA would act as the village level PE coordinator and take the lead in ensuring that the PE related activities are carried out at the village level and the ANMs/MHWs moderate the monthly AFC sessions. Quarterly AHDs will be carried out with the help of Block adolescent health coordinators with PHC MOIC providing oversight.

b) Implementation outsourced to Non-Government Organizations (NGOs) In States, where well-established field-level NGOs are in place, implementation by NGOs could be considered. The NGO is likely to bring in the necessary commitment to implement, monitor and mentor community based PE programme. States selecting NGO for implementation should put in place following suggestive processes to further enable the sustainability and effectiveness of PE programme:

NGO Implementation Model Madhya Pradesh

Madhya Pradesh has implemented the NGO led model successfully since 2016.The state implemented RKSK in 11 districts of the state. 11 NGOs have been selected for 11 RKSK districts through competitive bidding process. The NGOs are given the complete responsibility of the following:

- Providing counsellors for AFHCs
- Selection and training of Saathiyas
- Providing mentoring support and monitoring of Saathiya Programme
- NGOs have appointed 2-3 training mentors who visit 15-20 villages in a month to provide handholding support to the Saathiyas.

- Advertisement in two leading newspapers – one in English and the other in the regional language.
- NGOs fulfilling the following criteria may be considered:
  - NGO should be registered under the Societies Registration Act/Indian Trust Act/ Indian Religious and Charitable Act/Companies Act or the State counterparts of such acts for more than three years.
  - NGOs applying for projects in a State other than that of its registration should have experience of working in the State for at least three years in the last 7 years.

- NGOs should have appropriate infrastructure, strong community outreach networks, stable governance structures, transparent financial systems and flexible administrative norms.
- NGOs with professional or managerial skills and with substantial expertise in managing outreach health service delivery programmes.
- NGOs with professional competencies in training health workers.
- NGOs with good grassroots linkages that have a strong commitment to the marginalized and underserved.
- The NGO should be financially stable.
- An NGO blacklisted or placed under funding restriction by any Ministry or Department of the Government of India (GoI), State Government or CAPART would not be eligible for applying.

- Names of the selected NGOs would also be displayed on the website of the State/ District Health Department.
- Field appraisal of the short-listed organization would be done by a team constituted for the purpose.
- On completion of the satisfactory appraisal the partnerships will be formalized through a Memorandum of Understanding (MoU). The State/District Health Society would enter into a MoU with the NGO, which would detail the key roles and responsibilities of either partner.
- The NGO should be given the complete responsibility of implementing the Peer Education Programme including selection and training of Saathiyas as well as field level monitoring and mentoring support.
- Once the MoU has been signed the State/District Health Society releases the grant to the NGO as under:
  - **1st release:** 15% of the total grant
  - **2nd release:** 40% of the total grant based on the UCs received
  - **3rd release:** 40% of the total grant based on UCs submitted and favorable evaluation report.
  - **4th release:** 5% of the total grant – the final grant is released on receiving the completed UCs and audited Statement of accounts along with project completion report.

- The cost of implementation will be the same as that of the system driven model, but in the NGO model, a 10% administrative cost will be given to the selected organization.
- The performance of the NGO would be monitored on the basis of agreed indicators, which would be clearly mentioned in the MoU signed between the NGO and the State/ District health society. These indicators should be relevant and specific to the work undertaken by the NGO.
- In the quarterly meetings of the District Committee for Adolescent Health (DCAH) the NGO will report on progress as well as constraints faced in the field. These meetings will serve as a forum for discussing any problems faced by the NGOs in the project implementation, the inputs and support required from the government machinery etc.
- The State would commission external evaluations as and when required to review and enable further improvement in the program

E SOCIAL MOBILIZATION AND BEHAVIOR CHANGE COMMUNICATION

Social mobilization is a process that mobilizes community, stakeholders and other gatekeepers to facilitate social and behavior change. This involves adopting behavior change communication strategy at various level and advocacy with the policy and decision makers. There is a need to have 360° Communication Strategy with adequate utilization of mass & mid media and due emphasis on inter personal communication. Both traditional and modern methods need to be well utilized.

MoHFW has developed various IEC materials and advocacy tool kit so as to involve political leaders and policy makers. A special intergenerational dialogue and parenting skill guide is being developed to bridge the gap between adolescents and parents.

Adolescent Helpline

Many States have set up Helpline for adolescents to provide health related information to the adolescents, their caregivers and service providers. A National Helpline is being established to provide comprehensive health related information and counselling services to adolescents across the nation in English, Hindi and selected local languages. States may consider setting up their own helplines, if the requirement is not fulfilled due to language issues by the National helpline. There are also examples of states like Assam &Maharashtra who have integrated the adolescent helpline with existing 104 services. The queries related to adolescents are diverted to a trained counsellor to provide the required response. States can also consider this model.

Understanding the growing number of mobile based app users, 'Saathiya Salah' App has been developed. This application provides information through both audio and written formats. For those adolescents who have queries, the application provides a link to the toll free number which connects the adolescent to a counsellor trained in addressing these queries. This is of immense help in answering the common queries of adolescents without visiting a health facility.

F CAPACITY BUILDING

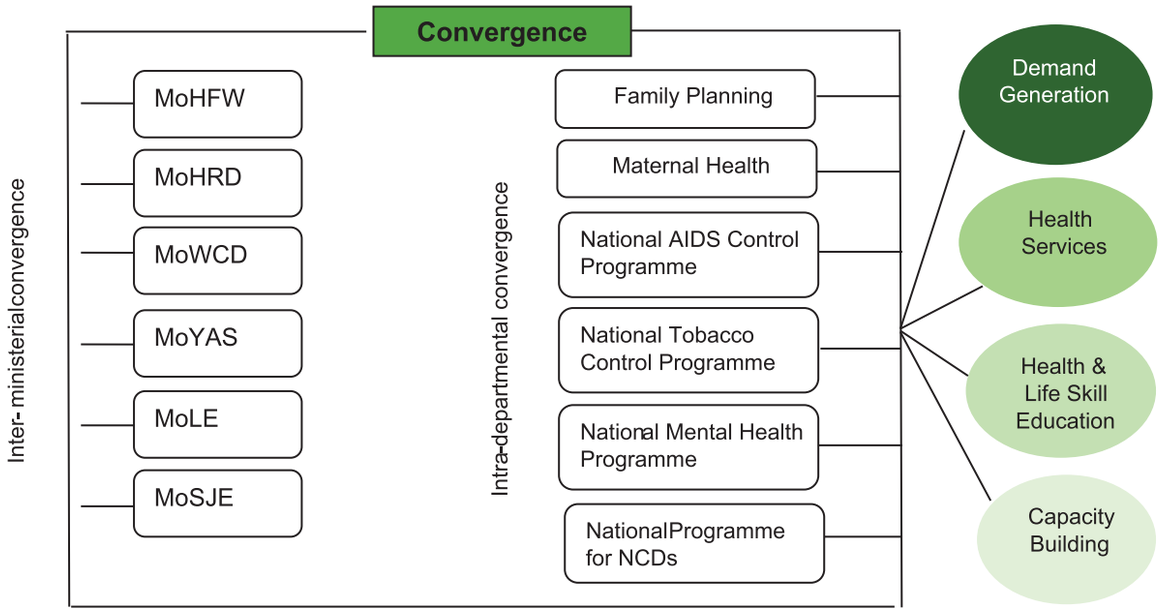
For the implementation of a programme, trained service providers are one of the foremost and important requirements. RKSK being a new programme with many components, the capacity building of functionaries at each level is envisaged in the programme. There are different kinds of training under RKSK:

S.No	Type of Training	Trainers	Trainees	Level	Duration
Training for Adolescent Health Services					
1	**Adolescent Friendly Health Services**				
a.	Medical officers	National Level Trainers	Medical Officers/ Program Officers nominated by State	National	4 Days
		State Master Trainers trained at National level	Medical Officers/ Program Officers nominated by District	State	
		District Level Trainers trained at the State level	Medical officers posted at the AFHCs	District	
b.	ANMs/LHVs	National Level Trainers	SIHFW faculty/ANM Tutor/MOs nominated by the State	National	5 Days
		State Master Trainers trained at National level	ANMs/LHVs nominated by the District	State	5 Days
		District Level Trainers trained at the State level	ANM posted at the AFHCs	District	4 Days
c.	Block Coordinators/ Counsellors	National Level Trainers	Medical Officers/ Program Officers nominated by State	National	5 Days
		State Master Trainers trained at National level	Medical Officers/ Program Officers nominated by District	State	5 Days
		District Level Trainers trained at the State level	Counsellors posted at the AFHCs	District	6 Days
Peer Educator (Saathiya) Programme Training					
2.	Block Coordinators/ Counsellors	National level trainers	Medical Officers/ Program Officers nominated by State	National	5 Days
		District Master Trainers trained at the National Level	ANMs nominated by District	Block	5 Days
		ANMs trained at the block level	Peer Educators and ASHAs	Sub-Block	6 Days
Training for School Health Activities					
3.	Training of Health Ambassadors	National Level Trainers	Participants from SCERT, DIET, BRC and Health Department	National	5 Days
		District Level Trainers trained at the National Level	Teachers (two each from the schools implementing School Health Activities)	District	5 Days
4.	Orientation of School Principals	District Level Trainers trained at the National Level	Principals from the schools implementing School Health Activities	District	2 Days

Training modules along with the resource book and facilitator's guide available on the website of NHM (nhm.gov.in)

G CONVERGENCE

The programme requires intra-departmental and inter-ministerial convergence and partnerships with civil society/ institutions/ private sector. Addressing the main six thematic areas through convergence across ministries would help bring about holistic adolescent healthcare in the country.



Strategic partnerships with other related ministries, departments and key stakeholders will strengthen existing linkages and create new opportunities for partnerships and prevent duplication. This will maximize efforts, resource utilization, impact and help establish comprehensive review mechanisms. The key strategies for convergence include cross-training of service providers, inclusion of the adolescent health module in the training curriculum, and the use of existing platforms for generating demand and service provision.

The interdepartmental coordination should be spearheaded by the respective department heads at the State level and Nodal Officers at the district level who must take a lead to ensure successful coordination. This can be achieved through monthly/quarterly meetings of all stakeholders for discussion on progress and issues.

The adolescents are reached through various government programmes through different programmes and schemes. It is important that these programmes complement each other to optimize the outcomes for the adolescents' wellbeing.' The potential role that the different Ministries can play is highlighted in the table below:

GoI Ministry	Programmes	Ground-level Linkages
Health and Family Welfare	• Family Planning	• **Family planning:** Provision of contraceptives and pregnancy testing kits to adolescents; capacity building of health functionaries regarding varied contraceptive needs of adolescents; incentivization of ASHAs for delaying first pregnancy in married adolescents.
	• Maternal Health	• **Maternal health:** Tracking of adolescent pregnancy for birth preparedness and complications prevention; capacity building of health functionaries to manage adolescent pregnancy and its complications.
	• National AIDS Control Programme	• **National AIDS Control Programme:** Linkages with ICTC for counselling, testing and treatment of HIV/AIDS.
	• National Tobacco Control Programme	• **National Tobacco Control Programme(NTCP):** Trigger behavior change to control tobacco use among adolescents through peer educators, role models and school-based activities of NTCP
	• National Mental Health Programme	• **National Mental Health Programme:** Well-defined linkages with the District Mental Health Programme and the psychiatric wings of Medical colleges for referral care.
	• National Programme for Prevention and Control of cancer, diabetes, Cardiovascular disease and stroke (NPCDCS)	• **National Programme for Prevention and Control of cancer, diabetes, Cardiovascular disease and stroke(NPCDCS):** Linkages with NCD clinics at CHC and DH levels; inclusion of health promotion on NCD Prevention in training modules of MOs, ANMs, staff nurses, counsellors, teachers and peer educators
Women and Child Development	• ICDS • Kishori Shakti Yojana (KSY) • Balika Samriddhi Yojana (BSY) • Rajiv Gandhi Scheme for Empowerment of Adolescent Girls *(Sabla)*	• AWC to be the hub of activities for out of school girls (*Sabla* and Kishori Shakti Yojna to serve as platforms). • Implementation of WIFS for out of school adolescent girls to be done through AWCs • AWWs to be trained in health promotion for adolescent health programme areas, viz., nutrition and healthy lifestyles, SRH in order to inform and mobilize/influence adolescents, care givers and the community through regular contact. • AWWs to undertake screening for BMI and palmar pallor (pale palms) and refer adolescent girls, as and when required, to the health service providers/ facilities • AWWs and ASHAs to hold sessions on nutrition and SRH, including menstrual hygiene during dedicated quarterly AHDs in the villages (in *Sabla* district to coincide with *Kishori Diwas*) Kishori Diwas can complement the Adolescent Health Day activities at the community level • Linkages with BSY for community awareness on legal age at marriage • AWWs to ensure supplementary nutrition and early registration of pregnant adolescent girls

GoI Ministry	Programmes	Ground-level Linkages
Human Resource Development	• Adolescent Education Programme (AEP) • Midday Meal Scheme under the SSA • Rashtriya Madhyamik Shiksha Abhiyan (RMSA) • Sakshar Bharat	• AEP to complement the intensified school health activities under RKSK • Using the platform of schools to increase awareness about facility-based health services for adolescents at Adolescent Friendly Health Clinics. • Generating awareness about the importance of secondary education for girls on AHDs and peer-based Adolescent Clubs/*Samoohs*
Youth Affairs and Sports	• Adolescent Empowerment Scheme • National Programme for Youth and Adolescent Development (NPYAD) • National Service Scheme • Nehru Yuva Kendra Sangathan (NYKS) Programmes	• Adolescents, who have under gone the 45-day training on 'life skills education' can form a cadre of peer-educators • Telephonic counselling under the National Programme for Youth and Adolescent Development (NPYAD)can be utilized to provide counselling services to adolescents • Trained District Youth Coordinators and Project Coordinators can be trained on adolescent health and development • Nehru Yuva Kendra Sangathan (NYKS)has linkages with local NGOs, the capacity of which can be built through training provided by skilled personnel from the Health Department

Convergence made possible

Intra Departmental Convergence

The **Weekly Iron and Folic Acid Supplementation (WIFS)** is a good example that convergence is possible within a government setting. The convergence between Departments of Health and Education has made it possible to take this initiative to scale and reach school children across the country. The IFA is given to the children in schools through nodal teachers trained by the health department for this purpose.

Udaan

In School, at Scale, Adolescence Education Program is a **public-private partnership program between the State Development of Education, Government of Jharkhand, the Jharkhand State Aids Control Society (JSACS) and Centre for Catalyzing Change.** Launched in 2006, *UDAAN* aims to promote adolescent development and establish a cadre of healthy and empowered youth. *UDAAN* strengthens the Adolescence Education Program (AEP) in all senior secondary schools in the state of Jharkhand. Centre for Catalyzing Change provides technical assistance to integrate life skills-based adolescent education in the state secondary education system by strengthening teacher training, developing teaching curriculum and developing and operationalizing a monitoring system for the Jharkhand state government.

UDAAN is recognized by national and state government (including National Aids Control Organization) as an at scale partnership program for replication in other states. The program, one of the largest interventions of its kind in north India, over the past years has reached out to over 500,000 adolescents through the UDAAN curricula in classes IX and XI in almost 1500 government secondary/senior secondary schools including Kasturba Gandhi Balika Vidyalayas (KGBVs) and around 20,000 students in classes 6, 7 and 8.

Similarly, now C3 is attempting to converge Sabla implemented by Women and Child Department and RKSK's community component in West Singhbum, Jharkhand through the EACH initiative **(Equal Access for Change, Harnessing Opportunities).**

H INSTITUTIONAL ARRANGEMENTS

Under RKSK, committees at each level have been constituted to guide and steer policy and program for Adolescent Health and Development.

At the National level, The MoHFW will be the nodal ministry for implementation of RKSK. The National Level Steering Committee for Adolescent Health and Development will be chaired by the Secretary, Health and co-chaired by Secretary MHRD and Secretary MWCD. Members of the committee will also include representatives from Ministry of Human Resource Development, Ministry of Women and Child Development, Ministry of Youth Affairs and Sports (MoYAS), Ministry of Drinking Water and Sanitation, Ministry of Tribal Affairs, National Rural Livelihood Mission, a few States, and other stakeholders as appropriate. A similar structure will be established at State and District level.

At the National Level, Adolescent Health Division of MoHFW will be responsible for the overall coordination, planning, implementation and monitoring of the strategic plan.A 'Technical Support Unit' has been established to provide overall technical guidance to the Adolescent Health Division and States/UTs for the effective implementation and robust monitoring of RKSK activities.

District Committee for Adolescent Health (DCAH)	Village Health, Nutrition and Sanitation Committees (VHNSC)
• Chaired by the District Magistrate and will meet quarterly • Chief Medical Officer to be the Secretary of the DCAH • DCAH will have representation from all the concerned departments and play an important part in overseeing convergence and resolving bottlenecks.	• Recommended to include a school teacher (preferably lady teacher) and peer educator • Sensitization and capacity building of Gram Panchayats/VHSNCs • VHSNCs have an important role in ensuring accountability of frontline workers

National Level: Steering Committee for Adolescent Health and Development (SCAHD)	State Committee for Adolescent Health (SCAH)
• Chaired by the Secretary, Health and co-chaired by Secretary MHRD and Secretary MWCD • **Representatives from:** o MoHFW o MHRD o MWCD o MoYAS o MDWS • Ministry of Tribal Affairs • NRLM – National Rural Livelihood Mission • Some states and other stakeholders • Guide and steer policy and programme for Adolescent Health and Development. • Meet biannually	• Chaired by the Chief Secretary/Principal Secretary Health • MD, NHM to be the Secretary of SCAH • **Representatives from:** o SACS o Department of Education o Social Welfare (Integrated Child Development Services -ICDS, SABLA) Youth Affairs o Tribal Welfare o Drinking Water and Sanitation o Rural development and Pachayati Raj o Development partners, NGOs, civil societies, medical colleges and public health experts. • Meet biannually • The SCAH will ensure regular meetings of DCAH • Convergence efforts at the state level

I Roles and Responsibilities

In order to ensure a smooth and seamless rollout of programme, the following steps need to be taken by the State:

- o Set up a RKSK Unit at the State level with a dedicated full time Joint/ Deputy Director, who is made in-charge of RKSK
- o At the district level, a nodal officer may be identified for Adolescent Health (AH) to coordinate all RKSK activities and ensure convergence.
- o Block level Adolescent Health Coordinator/counsellor in AFHC will be designated as Block Nodal Officer for RKSK and will be responsible for all RKSK related activities in the Block.

State Mission Director - (NHM)

- o Ensures that adolescent health gets the necessary emphasis; provides strategic directions
- o Inclusion of adolescent health components in the state NHM-Programme Implementation Plan (PIP) with emphasis on newer elements.
- o Sets-up systems to recruit quality adolescent health staff

- o Integrates efforts of development partners towards achieving common adolescent health objectives
- o Leads convergence initiatives
- o Oversees preparation of State-specific Standards Operating Procedures (SOPs) for adolescent health based on the strategy and operational guidelines
- o Explores alternatives for implementation of Peer Education Programme through CBOs/ Academic Institutions.
- o Monitors progress of adolescent health based on the commitments in the PIP.
- o Ensures that allocated funds are timely disbursed to districts
- o Ensures regular monitoring &reporting mechanism are established

Programme Managers- Adolescent Health at State and District levels

- o Act as a focal point person for all adolescent health programme in the State/District
- o Responsible for implementation of RKSK at State /District
- o Advocate the importance of adolescent health at State / District
- o Coordination with all stakeholders for implementation of programme
- o Prepare Adolescent Health PIP for state/districts
- o Publicity of adolescent Health Issues at different platforms using IEC, mass media, mid media etc.
- o Consolidate and submit Adolescent Health progress report on quarterly basis to Mission Director (NHM) and further to Government of India
- o Engage in regular monitoring and supportive supervision of progress of Adolescent Health programme

Technical Support by Development Partners:

States / District Programme management units will have the overall responsibility of implementation of RKSK however they should also appropriately utilize the technical expertise of the development partners working in the area of Adolescent Health to foster the implementation of RKSK.

The Development Partners can be engaged in the following areas.

1. **Planning:** Facilitating the states to develop plans/ strategies to deliver the package of services/ envisioned under RKSK.
2. **Implementation:** Guidance and field level mentorship for various RKSK interventions.
3. **Capacity building:** Support in training of service providers and orientation of SPMUs/DPMUs on RKSK.
4. **Monitoring:** Supporting the SPMUs/DPMUs to develop and institutionalize a system to monitor the implementation regularly.
5. **Review:** Supporting formulation of a process of regular periodic reviews and feedback.
6. **Documentation:** Consolidation of learning's, documenting case studies; innovative approaches related to Peer Education Programme, establishing inter-sectoral linkages/convergence models etc.

J Reporting

A monthly reporting format has been prepared to collect regular information from the states:

Monthly Reporting Format for RKSK – State/ District level				
a.	**Coverage under Weekly Iron and Folic Acid Supplementation Program (WIFS)**	**Boys**	**Girls**	**Total**
	Number of adolescents to be covered under WIFS (in school)			
	Number of adolescent girls to be covered under WIFS (out of school)			
	Number of adolescents (6th -12th class) provided 4 IFA tablets in schools			
	Number of adolescents (6th -12th class) provided Albendazole in schools**			
	Number of out of school adolescent girls provided 4 IFA tablets at AWC			
	Number of out of school adolescent girls provided Albendazole at AWC**			
b.	**Coverage under Menstrual Hygiene Scheme**			
	Total number of adolescent girls to be covered under MHS			
	Number of adolescent girls provided sanitary napkins packs			
	Number of sanitary packs distributed to adolescent girls			
c.	**Adolescent Friendly Health Clinics (AFHCs)**			
	Number of Adolescents (10-19 years) registered in Adolescent Friendly Health Clinic (AFHC)			
	Number of Adolescents (10-19 years) received clinical services in Adolescent Friendly Health Clinic (AFHC)			
	Number of Adolescents (10-19 years) received counselling services in Adolescent Friendly Health Clinic (AFHC)			
d.	**Peer Education Programme**	**Boys**	**Girls**	**Total**
	No. of PEs to be Selected			
	No. of Peer Educators selected			
	No. of Peer Educators trained			

	No. of Adolescent Health Day (AHD) planned*			
	No. of Adolescent Health Day (AHD) held*			
	No. of Adolescent Friendly Club (AFC) meetings planned			
	No. of Adolescent Friendly Club (AFC) meetings held			
e.	**School Health Programme** No. of schools implementing School Health Programme			
	No. of Schools conducting School Health Promotion Activities			
	No. of adolescents reached	**Boys**	**Girls**	**Total**
f.	**Convergence**	**State****	**District***	
	No. of convergence meetings held during the month.			

* Data will be collected Quarterly

** Data will be collected biannually.

Data collection formats for different levels of each component have also been given in Annex 2:

K Budget

Adolescent Health budget is a part of NHM budget and it includes adolescent health services, human resources, trainings, programme management, ASHA incentives, community orientation workshops, IEC/BCC activities, procurement and new school initiatives.

Financial Guidelines

Estimated Budget for a District with 2 million population for one year

A. Facility Based Services			
S. N.	**Budget head**	**Budget**	**Remarks**
		(Rs. In lakhs)	
	Establishment and operational cost for Adolescent Friendly Health Clinics	6.0	Establishment (one time cost up to Rs 50,000 per AFHC) and Operating Cost of 10 AFHCs:
subtotal		6.0	

B. School Based Services			
S. N.	**Budget head**	**Estimated Budget per District (Rs. in Lakh) For 1000 Schools**	**Remarks**
1.	Training of master trainers at district by SCERT (A 9.12.6.1)	1.0	(Rs. 800 per person X 2 persons X 5 days)
2.	Training of Principal+ two nodal teachers per school (A.9.12.6.2)	17.0	(Rs. 150 per teacher X 2 teachersX5 days X no. of schools in a district) + (Rs. 150 for training of principal X 2 days X no. of schools)
3.	Training Kits for teachers which includes manuals for imparting health education (A 5.3.1)	15.0	(Rs. 500 per kit b X 3 kits X no. of schools in a district)
4.	Printing of school kits which includes activity kit and activity aids, audiovisuals, films, posters, postcards, fact sheets, pamphlets (A 5.3.2)	15.0	(Rs. 1500 per school X no. of schools in a district)
5.	IEC Activities including printing cost of IEC materials, monitoring forms etc. (B 10.7.4.9)	2.0	Rs. 2 lakh per district
6.	Provision of IT equipment (Calling Tab for continuous communication with health department and as resource material)/incentive	20.0	Rs. 1000 per Health and Wellness Ambassador per school (2 Health and Wellness Ambassadors * Rs. 1000)
subtotal		**70.0**	

C. Community Based Services			
S. N.	**Budget head**	**Budget (Rs. In lakhs)**	**Remarks**
1.	Incentives to Peer Educators	33.6	Non-monetary incentive to PEs
2.	Organizing Quarterly Adolescent Health Days at village level and monthly Adolescent Friendly Club meetings at the Sub Centers.	156.8	Organizing quarterly AHDs and monthly AFC meetings
3.	Incentives to ASHAs for selection of PE s and for organizing AHDs	16.8	Incentives to ASHAs for selection of PEs and for organizing quarterly AHDs
4.	Focused activities with at risk adolescents	10.0	Project mode activities for vulnerable adolescent groups
subtotal		**217.2**	

D. Miscellaneous			
S. N.	**Budget head**	**Budget (Rs. In lakhs)**	**Remarks**
1.	Human Resource	25.8	Salary for State, District and Block (coordinator) level consultants
2.	Trainings under RKSK	163.0	Training of MOs, ANMs, AH coordinator/counsellors and PEs
3.	Printing of manuals, PE kit, Formats, IEC and Others	80.0	Review meetings and printing under RKSK
4.	Procurement of Blue IFA and Tab. Albendazole.	80.0	Procurement under WIFS to be budgeted under the head Procurement of Drugs and Supplies in NHM PIP :6.2.4.1 & 6.2.4.2
5.	Procurement of Sanitary Napkins	80.0	Procurement under Menstrual Hygiene Scheme to be budgeted under the head Procurement of Drugs and Supplies in NHM PIP :6.2.4.3.
subtotal		**375.7**	
Grand Total		**620.9**	

ANNEXURE

Key Programme/Service Delivery Indicators to be monitored by Programme Managers

Strategies	Service delivery indicators	Means of verification
Peer Education Programme (PE)	• Percentage of Peer Educators enrolled against planned • Percentage of peer educators trained (out of total number of PEs (Sathiyas) enrolled) • Percentage of sessions held by peer educators against planned	• Peer Educator MIS reports • State PIP • Training reports
Adolescent Friendly Health Clinics(AFHC)	• Percentage of AFHC operationalized against planned (at CHC,DH/Medical College) • Average monthly Client load at Adolescent Friendly Health Clinic(at CHC,DH/Medical College) • Percentage of adolescents counseled against total clients registered in AFHCs • Percentage of adolescents received clinical services against total clients registered in AFHCs • Percentage of AH counsellors recruited against approval in the PIP. • Percentage of AH Counsellors trained against recruited • Percentage of AFHCs havingCounsellors in place • Percentage of MO trained in AFHSagainst planned • Percentage of AFHCs having trained MO in place • Percentage of ANMs/LHVs trained on AFHS against planned • Percentage of AFHCs having trained ANM in place	• AFHCMIS • State PIP • Training reports
Adolescent Health Day (AHD)	• Percentage of AHDs held against planned. • Average attendance ofadolescents in AHDs • Percentage of adolescents referred to AFHCs during AHD	• AHD MIS • State PIP
Weekly Iron Folic Supplementation (WIFS)	• Percentage of AWWs trained on implementation of the Weekly Iron and Folic Acid Supplementation(WIFS)programme against planned. • Percentage of teacherstrained on implementation of the Weekly Iron and Folic Acid Supplementation(WIFS) programme against planned • Percentage monthly Coverage of WIFS ▪ In school ▪ out of school (Adolescent Girls) • Percentage of beneficiaries given Albendazole tablets in the last six months • Percentage of schools reporting IFA stock-out • Percentage of AWCs reporting IFA stock-out	• WIFS MIS • Training reports

Strategies	Service delivery indicators	Means of verification
Menstrual Hygiene Scheme(MHS)	• Total number of adolescent girls to be covered under MHS • Percentage of adolescent girls provided sanitary packs	• MHS MIS
Convergence	• Convergence committees formed at State and District level • Percentage of bi-annual SCAH meetings held against planned • Percentage of quarterly DCAH meetings held against planned • Number of Combined events of Health & WCD (Adolescent Health Day/Kishori Mela)	• Meeting reports • Event reports

Annexure 1

District wise proportion of adolescent aged 15-19 years who are out of School/colleges based on Census-2011 information

Total (15-19 years)				
Name of the State	**No of districts with out-of-school adolescents are >50%**	**Name of district with out-of-school adolescents are >50%**	**Proportion (in %) of out of school adolescent**	**Whether RKSK district Yes or NO**
JAMMU & KASHMIR	0			
HIMACHAL PRADESH	0			
PUNJAB	0			
CHANDIGARH	0			
UTTARAKHAND	0			
HARYANA	1	Mewat	63.9	Yes
NCT OF DELHI	0			
RAJASTHAN	14	Bikaner	52.1	No
		Jaisalmer	64.9	Yes
		Barmer	61.2	Yes
		Jalor	64.9	Yes
		Sirohi	59.7	No
		Pali	52.4	No
		Bhilwara	56.6	No
		Rajsamand	53.2	Yes
		Dungarpur	51.1	Yes
		Banswara	52.9	Yes
		Chittaurgarh	55.6	No
		Jhalawar	53.0	No
		Udaipur	53.2	Yes
		Pratapgarh	56.7	No
UTTAR PRADESH	13	Moradabad	53.6	No
		Rampur	59.3	Yes
		Budaun	62.0	Yes
		Bareilly	56.4	Yes
		Pilibhit	51.3	Yes
		Shahjahanpur	53.6	Yes
		Kheri	51.9	Yes
		Sitapur	50.8	Yes
		Hardoi	50.5	Yes
		Bahraich	59.2	Yes
		Shrawasti	61.2	Yes
		Balrampur	63.1	Yes
		Siddharthnagar	54.1	Yes

Name of the State	No of districts with out-of-school adolescents are >50%	Name of district with out-of-school adolescents are >50%	Proportion (in %) of out of school adolescent	Whether RKSK district Yes or NO
BIHAR	8	Sheohar	52.8	Yes
		Sitamarhi	54.7	Yes
		Araria	54.0	Yes
		Kishanganj	60.6	Yes
		Purnia	57.0	Yes
		Katihar	55.5	Yes
		Saharsa	50.1	Yes
		Darbhanga	50.2	No
SIKKIM	0			
ARUNACHAL PRADESH	0			
NAGALAND	1	Mon	51.3	Yes
MANIPUR	0			
MIZORAM	0			
TRIPURA	0			
MEGHALAYA	1	Jaintia Hills	54.7	Yes
ASSAM	10	Dhubri	59.2	Yes
		Goalpara	50.9	No
		Morigaon	54.3	No
		Nagaon	54.2	Yes
		Sonitpur	51.6	No
		Tinsukia	51.1	No
		Cachar	52.8	No
		Karimganj	59.2	Yes
		Hailakandi	57.2	Yes
		Darrang	50.8	No
WEST BENGAL	5	Maldah	50.2	Yes
		Murshidabad	51.4	Yes
		Birbhum	53.6	Yes
		Haora	51.0	No
		South Twenty Four Parganas	53.8	Yes
JHARKHAND	5	Godda	50.9	No
		Sahibganj	52.7	No
		Pakur	60.3	No
		Jamtara	54.9	No
		PashchimiSinghbhum	54.6	Yes

Name of the State	No of districts with out-of-school adolescents are >50%	Name of district with out-of-school adolescents are >50%	Proportion (in %) of out of school adolescent	Whether RKSK district Yes or NO
ODISHA	24	Bargarh	63.8	No
		Jharsuguda	57.2	No
		Sambalpur	60.1	No
		Debagarh	60.5	No
		Kendujhar	62.2	No
		Mayurbhanj	58.3	No
		Baleshwar	50.9	No
		Bhadrak	50.3	No
		Dhenkanal	57.6	Yes
		Anugul	58.7	No
		Nayagarh	59.4	No
		Puri	50.8	No
		Ganjam	61.6	No
		Gajapati	59.9	No
		Kandhamal	58.1	No
		Baudh	64.5	No
		Subarnapur	60.0	No
		Balangir	61.2	Yes
		Nuapada	62.1	No
		Kalahandi	61.8	No
		Rayagada	68.4	No
		Nabarangapur	75.2	No
		Koraput	70.2	No
		Malkangiri	74.0	No
CHHATTISGARH	4	Bastar	55.3	No
		Narayanpur	57.3	No
		Dakshin Bastar Dantewada	66.9	Yes
		Bijapur	67.7	Yes
MADHYA PRADESH	10	Sheopur	50.9	No
		Mandsaur	53.3	No
		Ratlam	53.5	No
		Shajapur	51.3	No
		Khargone (West Nimar)	55.7	No
		Barwani	62.4	Yes
		Jhabua	64.6	Yes
		Alirajpur	67.6	Yes
		Khandwa (East Nimar)	56.8	No
		Burhanpur	59.5	No

Name of the State	No of districts with out-of-school adolescents are >50%	Name of district with out-of-school adolescents are >50%	Proportion (in %) of out of school adolescent	Whether RKSK district Yes or NO
GUJARAT	10	Kachchh	61.0	Yes
		BanasKantha	60.3	No
		Patan	52.7	No
		Surendranagar	57.3	No
		Jamnagar	57.9	No
		Porbandar	55.0	No
		Amreli	51.1	No
		Bhavnagar	58.1	No
		Dohad	51.8	Yes
		The Dangs	54.3	Yes
DAMAN & DIU	1	Daman	67.7	Yes
DADRA & NAGAR HAVELI	1	Dadra & Nagar Haveli	50.4	Yes
MAHARASHTRA	0			
ANDHRA PRADESH	0			
KARNATAKA	4	Raichur	54.4	Yes
		Koppal	51.1	Yes
		Bellary	54.0	Yes
		Yadgir	61.7	Yes
GOA	0			
LAKSHADWEEP	0			
KERALA	0			
TAMIL NADU	0			
PUDUCHERRY	0			
ANDAMAN & NICOBAR ISLANDS	0			
Total no. of Districts	**112**			**54**

Annexure 2 Reporting formats
Formats for Adolescent Friendly Health Clinics

AFHCs: State/District/Facility Level reporting format												
Name of the State/District/Facility:					Name of the Nodal Person:							
Reporting period and year:					Contact No.:							
A. Budget for RKSK Programme *(to be filled by district & State level)*	Amount (in lakhs)						Comments/Observations					
Allocated Budget for RKSK in the last financial year(in lakhs)												
Expenditure during the last F.Y. (in lakhs)												
Allocated Budget for RKSK (in lakhs) in the current financial year												
Expenditure during the current F.Y up to the reporting period (in lakhs)												
B. Establishment of Adolescent Friendly H ealth Clinics (AFHCs) *(to be filled by district & State level)*	Target AFHCs for the current FY as per RoP				No. of clinics established during the reporting quarter				No. of clinics established in the current financial year till date			
Medical College												
DH												
SDH												
CHCs												
PHCs												
UHC												
PPP												
Total	0				0				0			
C. Training Status of staffs on AFHS	Training target for the current FY as per RoP				No. Trained during the reporting quarter				No. Trained in the current financial year till date			
No. of Medical Officers (male) trained on AFHS												
No. of Medical Officers (female) trained on AFHS												
No. of ANMs/LHVs trained on AFHS												
No. of MPW (male) trained on AFHS												
No. of Counsellors trained on AFHS												
Indicators	Service Provisions											
	Male						Female					
	Unmarried		Married		Total		Unmarried		Married		Total	
	10-14	15-19	10-14	15-19	10-14	15-19	10-14	15-19	10-14	15-19	10-14	15-19
Total no. of Clients registered in AFHCs during reporting period												
Clinical Services provided to the Clients out of total no. of registered clients during the reporting period												
Total no. of Clients who received clinical services out of total no. of registered clients in AFHCs during the reporting period												
Menstrual Problems												
RTI/STI Management												
Skin Problems												
ANC												

IFA Tablets												
Contraceptives												
1. Condoms												
2. OCP												
3. ECP												
4. IUD												
Immunization												
Others												
Counselling Services provided to the clients out of total no. of registered clients during the reporting period												
Total no. of Clients who received counselling services in AFHCs out of total no. of registered clients during the reporting period												
Nutrition												
Skin												
Pre-marital Counselling												
Sexual Problems												
Contraceptive												
Abortion												
RTI/STI												
Substance abuse												
Learning problems												
Stress												
Depression												
Suicidal Tendency												
Violence												
Sexual Abuse												
Other Mental Health Issues												
Others												
Referral (to other health facilities) out of total no. of registered clients during the reporting period												
Total no. of Clients referred (from AFHCs) to other facilities out of total no. of registered clients during the reporting period												
ICTC												
Suraksha/RTI/STI Clinic												
Skin OPD												
Ob/Gyn Department												
MTP												
Psychiatrist												
Others												

Client participation & mode of out-reach activities during the reporting period	Out-reach Activities			
	In-school		Out-school	
	Male	Female	Male	Female
Total no. of clients participated in the out-reach sessions during the reporting period				

Mode of Out-reach activities	No. of out-reach activities conducted during the reporting period	Topics discussed	Activities Conducted
Direct in schools			
Direct in colleges			
VHNDs			
School Health Team			
Mobile Medical Unit			
Teen Clubs			
Youth clubs/Gymnasium			
SHGs			
Vocational Training Centres			
Youth Festivals			
Health Mela			
Others			
Has the state established Adolescent Health Helpline? (1: Yes, 2: No) 'If yes,details of the helplines and number of adolescent male/female provided services			

Note: District and the facilities will report on monthly basis using the same format.

Formats for Peer Educator Component
State/District/Block Quarterly Peer Education Progress Reporting Form

	Indicators	Planned	Actual	Variance
Name of District:		Reporting Quarter:		
	Coverage			
1	Number of blocks covered by PE programme			
2	Number of villages covered by PE programme			
3	Number of ANMs or NGO staff(female) in place			
4	Number of MHWs or NGO staff (male) in place			
5	Number of ASHAs in place			
	PE Enrollment			
6	Number of Peer Educators enrolled in this quarter			
7	Number of Peer Educators enrolled in this FY till Date			
8	Number of Peer Educators enrolled in since roll out of PE programme			
	Training			
9	Number of ANMs and MHWs or NGO staff trained in this quarter			
10	Number of Health staff (MOs, ANMs, ASHAs) that received sensitization /AH training in this quarter			
11	Number of peer educators trained in this quarter			
12	Number of peer educators trained in this FY till Date			
13	**Number of peer educators that have received a PE kit (out of total number of PEs enrolled)**			

Formats for Peer Educator Component
State/District/Block Quarterly Peer Education Progress Reporting Form

	Indicators	Planned	Actual	Variance
	Peer Groups			
14	Number of out of school male adolescents reached through peer educators in this quarter			
15	Number of out of school female adolescents reached through peer educators in this quarter			
16	Number of in-school male adolescents reached through peer educators in this Quarter			
17	Number of in-school female adolescents reached through peer educators in this Quarter			
18	Total number of adolescent through village based peer educators in this Quarter			
	Peer Education Sessions with Adolescent Group			
19	Number of sessions held by peer educators in this Quarter			
20	Number of sessions held by peer educators in this FY till date			
21	Average attendance per PE session in this quarter			
	Referral			
22	Number of female adolescents referred by PE to AFHC in this quarter			
23	Number of male adolescents referred by PE to AFHC in this quarter			
	Adolescent Friendly Club (AFC)			
24	**Number of AFC held in this quarter**			

Note: Same format will be used for reporting of progress under PE programme at District & Block level . Reporting will be done on Monthly basis.

Peer Educator Monthly Reporting Form

Month/Year:_____

Name of Peer Educator:_____

Phone:_____

Parent name and address:_____

_____

Village name:_____

Block:_____

District:_____

Adolescent Friendly Club monthly meeting attended (yes/no):_____

Number of adolescents enrolled:_____

Number of Peer Education Sessions conducted this month:

_____

Average attendance in each session:_____

Please specify dates and times of Peer Education sessions	Number of adolescents that attended peer education session
1	
2	
3	
4	

Number of adolescents referred to AFHC:

Please list any other activities conducted e.g. Adolescent Health Day dates and times:

B. CoverageFormat for Basic Data Collection during AHD

A. Basic Information	
Date of AHD:	Name of the village:
Venue:	Block: District:
Name of the service providers who attended the AHD:	
Name of the health provider who attended the AHD	
…… (MO In charge)	
…… (ANM)	
…… (Block Adolescent Health Coordinator/Counsellor)	
……	
Other Organizers	
…… (ASHA)	
…… (AWW)	
…… (PE Male)	
…… (PE Female)	
AHD attended by: (Parents/teachers/PRIs/NGOs/others	

B. Coverage

1. Total Village Population: ……..

2. Total Adolescent population in the village and attendance in the AHD: ……

3.Total number of parents who attended the AHD:

Total Population		Attendance at AHD
Girls (Unmarried)		
Boys (Unmarried)		
Married Adolescents (Women)		
Married Adolescents (Men)		
Total Number of adolescents		

C. Services		Unmarried				Married				Parents	Other Stakeholders	Total
		Female		Male		Female		Male				
		10-14 yrs	15-19 yrs	10-14 yrs	15-19 yrs	10-14 yrs	15-19 yrs	10-14 yrs	15-19 yrs	1		
1.BMI Screening												
2. Anemia testing												
3.Number of adolescent provided IFA tablets												
4. No. of adolescent Provided Albendazole tablets												
5. No. of adolescents provided contraceptives												
a	Condom											
b	OCP											
c	ECP											
6. Number of adolescent provided sanitary napkins												
7.IPC/Orientation/Discussion:												
a	Nutrition											
b	SRH											
c	Mental Health											
d	GBV											
e	NCD											
f	Substance misuse											
9.Total number of adolescents referred:												
a	To AFHC for clinical services											
b	To AFHC for counselling services											
c	To other health facilities											

Stakeholders includes parents,,school teachers, PRI etc

D. Remarks (include performance, challenges etc.)			
Signature			
MO		ANM	
Counsellor		ASHA	
AWW		PRIrepresentative	
PE(Female)		PE(Male)	

Formats for Weekly Iron and Folic Acid Supplementation (WIFS)

Format2–Class Monthly Register								
Class:		Name of School:				Reporting Month and Year:		
Total No. of Girls in Class:		Total No. of Boys in Class:				Total No. of students:		
S.no.	Name of the Student	F/M	Weekly IFA consumption					Consumption of Albendazole *(February/August)*
			Week 1	Week 2	Week 3	Week 4	Week 5	
			Date:	Date:	Date:	Date:	Date:	Date:
Class Teacher Consuming IFA:								

	I. Students consuming at least 4 IFA tablets in this month	II. Students consuming Albedazole Tablets *(February/August)*	III. Students with moderate and severe anemia (based on physical checkup)		IV. Adverse Effects	
			Identified	Referred	No. of students who experienced adverse effects	No. of students referred to health facilities due to adverse effects
Girls						
Boys						
Total						

Signature of Class Teacher.....

FORMAT3–MONTHLY SCHOOL REPORT

Name of School:	Village/Town/City:	Block:	District:
Type of School: Govt./Govt. Aided/Residential Schools/Others, specify/.....	Name of the Nodal Teachers/Principal:		
Reporting Month and Year:	Classes in School:(pls tick) $6^{th}/7^{th}/8^{th}/9^{th}/10^{th}/11^{th}/12^{th}$		

I. IFA Consumption	Girls	Boys	Total
Total no. of Students in 6^{th} to 12^{th} Classes	a)	b)	(a+b)
No. of Student in 6^{th} to 12^{th} Classes consuming at least 4 IFA tablets in this month	c)	d)	(c+d)
Coverage%	*c/ax100=*	*d/bx100=*	*(c+d)/(a+b)x100=*
Total number of teachers and other staff consuming at least4 IFA tablets in this month			

II. Albendazole Tablet Consumption *(February/August)*	Girls	Boys	Total
No. of Students in 6^{th} to 12^{th} Classes Consuming Albendazole tablets	m)	n)	(m+n)
Coverage%	*(m)/(a)x100=*	*(n)/(b)x100=*	*(m+n)/(a+b))x100=*

III. Students with moderate/severe anemia (Based on physical check-up only)		Girls	Boys	Total
	Identified			
	Referred			

IV. Nutrition and Health Education	
a. Number of Nutrition and Health Education sessions planned in the month	
b. No. of Nutrition and Health Education sessions conducted	

V. Adverse Effects	
No. of students who experienced adverse effects following IFA consumption	
No. of students referred to health facility for management of adverse effects	

VI. Stock Details	Opening Stock	Stock received in the month (if any)	Stock Utilized in the month	Balance Stock with expiry date	Stock needed (if any)
IFA Tablets					
Albendazole Tablets					

Nodal Teacher 1 Nodal Teacher 2 Head Teacher

FORMAT4- MONTHLY BLOCK REPORT FOR ICDS/EDUCATION DEPT.						
Block/Project:			District:		State:	
Reporting Month and Year:			Name of the Block Education Officer/Name of the CDPO:			
					Schools	AWCs
Total No. of schools *(including govt./govt. aided, municipal , residential land others)* with6thto12thclasses/AWCs in the Block/Project						
No. of schools with6thto12thclasses/AWCs submitting reports for the month						
I. IFA Consumption					In School (*for Block Education Officer)*	In AWC *(for CDPO)*
Total no. students in classes 6th-12th/out of school girls covered under WIFS Programme in the block/project					Girls:	
					Boys:	b)
					Totala):	
No. of Girls consuming at least 4 IFA tablets in this month						
No. of Boys consuming at least 4 IFA tablets in this month						
Total No. of adolescents consuming at least 4 IFA tablets in this month					c)	d)
COVERAGE%					*(c)/(a)X100=*	*(d)/(b)X10*
Total No. of staff (teachers/AWW&AWH) consuming at least 4 weekly IFA tablets in this month						*0=*
II. Albendazole Consumption *(In February/August)*					Inschool	I
No. of Girls consuming Albendazole tablets						nAWC
No. of Boys consuming Albendazole tablets						
Total No. of adolescents consuming Albendazole tablets					m)	n)
COVERAGE%					*(m)/(a)x100=*	*(n)/(b)x10*
					G	Boys *0=* Girls
III. Adolescents with moderate/ severe anemia (Based on checkup)				Identified		
				Referred		
IV. Nutrition and Health Education						
Total No. of Nutrition Health Education sessions planned in the reporting month						
Total Nutrition Health Education sessions conducted by in the reporting month						
V. Adverse effects						
No. of adolescents who experience adverse effects following IFA consumption						
No. of adolescents who were referred to health facility for management of adverse effects						
VI. Supply Details	Opening Stock		Stock Received (If any)		Stock Utilize	Balance	Stock need (if any)
IFA tablets						stock	
Albendazole tablets							

date

Signature of CDPO/Block Education Officer
Date:

FORMAT 5–DISTRICT MONTHLY REPORT									
District:	State:			Reporting Month and Year:					
Name of the Nodal Officer:									
Total No. of Blocks in the District:	Total No. of Schools (including Govt./Govt. Aided/Residential Schools in the District:			Total No. of AWCs in the District:					
Total No. of Blocks submitting reports from Education Dept.:									
Total No. of Blocks submitting reports from ICDS Dept:									
I. IFA Consumption	In School			In AWC		Total			
Total no. of adolescents covered under WIFS Programme in the District	Girls: Boys: Total a):			b)		c)			
No. of Girls consuming at least 4 IFA tablets in this month									
No. of Boys consuming at least 4 IFA tablets in this month									
Total of adolescents consuming at least 4 IFA tablets in this month	d)			e)		f)			
COVERAGE%	*(d)/(a)X100=*			*(e)/ (b)X100=*		*(f)/ (c)X100=*			
Total No. of staff (Nodal Teachers/AWWs/AWHs) consuming 4 IFA tablets in this month									
II. Albendazole Consumption *(February/August)*	In school			In AWC		Total			
No. of Girls consuming Albendazole tablets									
No. of Boys consuming Albendazole tablets									
Total No. of adolescents consuming	m)			n)		p)			
COVERAGE%	(m)/(a)x100=			(n)/(b)x100=		(p)/(c)x100=			
III. Adolescents with moderate/severe anemia (Based on physical check up only)		Girls	Boys	Total	Girls	Girls	Boys	Total	
	Identified								
	Referred								
III. Nutrition and Health Education Session									
Total Nutrition Health Education sessions planned by nodal teachers/AWWs in the reporting month									
Total Nutrition Health Education sessions conducted by nodal teachers/AWWs in the reporting month									
IV. Adverse effects									
No. of adolescents who experience adverse effects following IFA consumption									
No. of adolescents who were referred to health facility for management of adverse effects									
V. Supply Details *(TO BE SUBMITTED IN APRIL AND OCTOBER)*									
	Opening Stock	Stock Received (if any)		Stock Utilized (in the last 6 months)		Balance Stock with expiry date			
IFA tablets									
Albendazole tablets									
Signature of District Nodal Officer				Date:					

Format 7(A) –Monthly format for Anganwadi Centre								
Name of AWC/Village:			AWC Code:			Block/Project:		
Name of AWW:			Reporting Month and Year:			District:		
S. No	Name of girl enrolled under WIFS Programme and Father's name	Age	*Pls. tick (√) if the girl has consumed IFA Tablets*					Girls consuming Albendazole tablets (February and August)
			Week 1	Week 2	Week 3	Week 4	Week 5	
			Date:	Date:	Date:	Date:	Date:	Date:
			OPTIONAL. THIS RECORD MAY BE KEPT IN AWC REGISTERS					
Total No. of girls consuming IFA in a week								

	I. IFA Consumption	II. Albendazole Consumption (February and August)	III. No. of girls with moderate/severe anemia (based on physical checkup)	IV. Nutrition and Health Education Sessions	V. Adverse Effects
Total No. of Adolescent Girls(10-19years) registered at the AWC under WIFS Program			Referred:	Total no. of sessions planned:	a. No. of Adolescent girls who experienced adverse effects
No. of Adolescent Girls(10-19 years) registered at the AWC consuming at least 4 IFA tablets in this month			Identified:	Total No. of sessions conducted:	c. No. of adolescents girls referred to health facility for management of side effects:
VI. Supply	Opening balance	Stock Received	Stock Utilized	Closing Balance with expiry date	Stock Required (if any):
IFA Tablets					
AlbendazoleTablets					

Signature Anganwadi Worker

Signature ICDS Supervisor

Format 9-State Monthly Report									
State:					Reporting Month and Year:				
Name of the Nodal Officer :									
Total No. of Districts in the State:									
Total No. of Districts submitting reports for the month (by both education and ICDS Dept):									
I.IFA Consumption			In school			In AWC		Total	
Total no. of adolescents covered under WIFS Programme in the State			Girls: Boys: Total a):			b)		c)	
No. of Girls consuming at least 4 IFA tablets in this month									
No. of Boys consuming at least 4 IFA tablets in this month									
Total No. of adolescents consuming at least 4 IFA tablets in this month			d)			e)		f)	
Total No. of staff (Nodal Teachers/AWWs/AWHs) consuming at least 4 IFA tablets in this month									
COVERAGE%			*(d)/(a)X100=*			*(e)/(b)X100 =*		*(f)/(c) X100=*	
II. Albendazole Consumption (February/August)			In school			In AWC		Total	
No. of Girls consuming Albendazole tablets									
No. of Boys consuming Albendazole tablets									
Total No. of adolescents consuming Albendazole Tablet			m)			n)		p)	
COVERAGE%			*(m)/(a)x100=*			*(n)/(b)x100=*		*(p)/(c)x100=*	
III. Adolescents with moderate/severe anemia (Based on physical check-up			Girls	Boys	Total	Girls		Girls	Boys	Total
		Identified								
		Referred								
IV. Nutrition and Health Education Session									
Total No. of Nutrition Health Education sessions planned in the reporting month									
Total Nutrition Health Education sessions conducted in the reporting month									
VI. Adverse Effects									
No. of adolescents who experience adverse effects following IFA									
No.of adolescents who were referred to health facility for management of adverse effects									
VII. Supply Details *(TO BE SUBMITTED APRIL AND OCTOBER)*									
	Quantity procured		Date of procurement		Expiry date of stock		Stock utilized		Balance stock (with expiry date)
IFA Tablets									
Albendazole									
Signature State Nodal Officer:							Date:		

Formats for Menstrual Hygiene Scheme (MHS)

Report regarding implementation of Menstrual Hygiene Scheme supported by NHM Budget

State:
Name :

1. Procedure adopted for procurement:
2. Name of manufacturer/supplier:
3. No. of packs procured in FY.....
4. No. of sanitary napkins per pack:
5. Unit cost of sanitary napkin:

* through meetings or sale of napkins

Detailed Report for the month of .....

S. No.	Name of district	No. of blocks in the district	No.of blocks covered under the scheme	Total no. of AGs to be covered	No. of AGs covered this month *	No. of Sanitary packs sold to AGs this month	No.of ASHA in the block	No. of packs distributed free to ASHA this month	Funds generated from sale of sanitary napkins this month in Rs. Lakhs	Expenditure in Rs. Lakhs			Funds recouped to the SHS this month in Rs. Lakhs
										Incentive to ASHA for holding AGs meeting this month	Rental Cost for storage of Sanitary this month (if applicable)	Transportation cost of SN	

Developed with support from WHO Country Office for India