NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

RKSK

Rashtriya Kishor
Swasthya Karyakram
राष्ट्रीय किशोर स्वास्थ्य कार्यक्रम

operational framework

translating strategy into programmes

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Adolescent Health Division
Ministry of Health and Family Welfare
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Contents

Abbreviations

7Cs	:	Seven Critical Components
AEP	:	Adolescent Education Programme
AFC	:	Adolescent Friendly Club
AFHC	:	Adolescent Friendly Health Clinics
AH	:	Adolescent Health
AHD	:	Adolescent Health Day
AIDS	:	Acquired Immune Deficiency Syndrome
ANC	:	Ante Natal Care
ANM	:	Auxiliary Nurse Midwives
ASHA	:	Accredited Social Health Activists
AWW	:	Anganwadi Workers
BCC	:	Behaviour Change Communication
BMI	:	Body Mass Index
BPL	:	Below Poverty Line
BPMU	:	Block Programme Management Unit
BSY	:	Balika Samriddhi Yojana
CAH	:	Committee for Adolescent Health
CHC	:	Community Health Centre
DCAH	:	District Committee for Adolescent Health
DH	:	District Hospital
DHFW	:	District Health and Family Welfare
DLHS	:	District Level Health Survey
DPMU	:	District Programme Management Unit
FP	:	Family Planning
GBV	:	Gender Based Violence
GoI	:	Government of India
HIV	:	Human Immuno-Deficiency Virus
HMIS	:	Health Management Information System
HRD	:	Human Resource Development
ICDS	:	Integrated Child Development Services
IDA	:	Iron Deficiency Anaemia

IEC	:	Information, Education, Communication
IFA	:	Iron Folic Acid
IPC	:	Inter Personal Communication
KSY	:	Kishori Swasthya Yojana
LHV	:	Lady Health Visitor
M&E	:	Monitoring and Evaluation
MCTS	:	Mother and Child Tracking System
MDGs	:	Millennium Development Goals
MDM	:	Mid Day Meal
MH	:	Maternal Health
MHS	:	Menstrual Hygiene Scheme
MIS	:	Management Information System
MMU	:	Mobile Medical Unit
MoHFW	:	Ministry of Health and Family Welfare
NACP	:	National Aids Control Programme
NAHS	:	National Adolescent Health Survey
NCD	:	Non-Communicable Diseases
NFHS	:	National Family Health Survey
NGO	:	Non Governmental Organisation
NHM	:	National Health Mission
NMHP	:	National Mental Health Programme
NPYAD	:	National Programme for Youth and Adolescent Development
NSS	:	National Service Scheme
NRHM	:	National Rural Health Mission
NTCP	:	National Tobacco Control Programme
NUHM	:	National Urban Health Mission
NYKS	:	Nehru Yuva Kendra Sangathan
PE	:	Peer Educator
PHC	:	Primary Health Centre
PIP	:	Programme Implementation Plan
PPP	:	Public Private Partnership
RBSK	:	Rashtriya Bal Swasthya Karyakram
RKSK	:	Rashtriya Kishor Swasthaya Karyakram
RMNCH+A	:	Reproductive Maternal Neonatal Child Health + Adolescent

RTI	:	Reproductive Tract Infection
SACS	:	State AIDS Control Society
SC/ST	:	Scheduled Castes/Scheduled Tribes
SCAH	:	State Committee for Adolescent Health
SIHFW	:	State Institute of Health and Family Welfare
SOP	:	Standard Operating Procedure
SPMU	:	State Programme Management Unit
SRH	:	Sexual and Reproductive Health
STI	:	Sexually Transmitted Infection
ULB	:	Urban Local Body
UPHC	:	Urban Primary Healthcare Centre
VHND	:	Village Health Nutrition Day
VHNSC	:	Village Health Nutrition and Sanitation Committee
WCD	:	Women & Child Development
WIFS	:	Weekly Iron and Folic Acid Supplementation Programme
WIHS	:	Women's Interagency HIV Study

1 Introduction

Key Features of the National Adolescent Health Strategy[1]

Adolescents: an opportunity and a challenge

1.01 Adolescents (10–19 years) constitute about one-fifth of India's population and young people (10–24 years) about one-third of the population. This represents a huge opportunity that can transform the social and economic fortunes of the country. The large and increasing relative share and absolute numbers of adolescent and youth population in India make it necessary that the nation ensures they become a vibrant, constructive force that can contribute to sustainable and inclusive growth. The skills, knowledge, attitudes and behaviour of today's young people are essential to whether, and how well, the demographic dividend is successfully leveraged.

1.02 In order to enable adolescents fulfil their potential, substantial investments must be made in education, health, development and other areas. Investments in adolescents will have an immediate, direct and positive impact on India's health goals and on the achievement of the Millennium Development Goals (MDGs), especially goals 1, 2, 3, 4, 5 and 6[2]; at the same time, it will enhance economic productivity, effective social functioning and overall population development. However, a considerable number of adolescents face challenges to their healthy development due to a variety of factors, including structural poverty, social discrimination, negative social norms, inadequate education, and early marriage and child-bearing, especially in the marginalised and under-served sections of the population. In order to respond effectively to the needs of adolescent health and development, it is imperative to situate adolescence in a life-span perspective within dynamic sociological, cultural and economic realities.

MoHFW's response: a paradigm shift

1.03 Taking cognisance of the need to respond to health and development requirements of adolescents in a holistic manner, the Ministry of Health and Family Welfare (MoHFW) has developed a comprehensive strategy, based on the principles of participation, rights, inclusion, gender equity and strategic partnerships. The strategy envisions that ***all adolescents in India are able to realise their full potential by making informed and responsible decisions related to their health and well-being***. The implementation of this vision requires a concerted effort by all stakeholder ministries and institutions, including health, education, women and child development, and labour as well as the adolescents' own families and communities.

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[1] This section is a repetition of the Executive Summary of the "National Adolescent Health Strategy", MoHFW, GoI.

[2] MDGs: 1. Eradicate extreme poverty and hunger; 2. Achieve universal primary education; 3. Promote gender equality and empower women; 4. Reduce child mortality; 5. Improve maternal health; 6. Combat HIV/AIDS, malaria and other diseases.

1.04 The strategy is a paradigm shift, and realigns the existing clinic-based curative approaches to focus on a more holistic model, which includes and focuses on community-based health promotion and preventive care along with a strengthening of preventive, diagnostic and curative services across levels of health facilities. The approach proposed in the strategy is based on a continuum of care for adolescent health and development needs, including the provision of information, commodities and services at the community level, with mapped out referral linkages through the three-tier public health system. Most importantly, it proposes a convergent model of service delivery that will engage adolescents and field service providers (for example, teachers, Accredited Social Health Activists—ASHAs, Auxiliary Nurse Midwives—ANMs, *Anganwadi* Workers—AWWs and *Nehru Yuva Kendra Sangathan*—NYKS—volunteers) actively, to secure and strengthen mechanisms for access and relevance. The strategy moves away from a 'one-size-fits-all' approach to more customised programmes and service delivery specific to needs of adolescents, and aims at instituting an effective, appropriate, acceptable and accessible service package, addressing a range of adolescent health and development needs.

7Cs and six strategic priorities

1.05 To implement this paradigm shift, the strategy identifies seven critical components (7Cs) that need to be ensured across all programme areas. These components are: coverage, content, communities, clinics (health facilities), counselling, communication and convergence. The six strategic priorities (programme) areas that have emerged from a situational analysis of adolescent health and development needs in India are: nutrition, sexual and reproductive health (SRH), non-communicable diseases (NCDs), substance misuse, injuries and violence (including gender-based violence) and mental health. The intervention and approaches delineated in National Adolescent Health strategy work at building protective factors that can help young people develop 'resilience' and operates in four major areas: the individual, family, school and community by providing a comprehensive package of information, commodities and services.

Rashtriya Kishor Swasthya Karyakram (RKSK)

1.06 To deliver these interventions, the Ministry of Health and Family Welfare has launched a new adolescent health programme – Rashtriya Kishor Swasthya Karyakram. The programme envisages strengthening of the health system for effective communication, capacity building and monitoring and evaluation. Further, RKSK underscores the need for several constituencies to converge effectively and harness their collective strength to respond to adolescent health and development needs. The different stakeholders, working on issues related to adolescent health and development, have a lot to gain by building on each other's work both in terms of achieving programme objectives as well as in the improved indicators for adolescent health and development.

Purpose and Structure of This Operational Framework

1.07 This Operational Framework is intended to be a user-friendly tool to assist states in implementation of Rashtriya Kishor Swasthya Karyakram (RKSK) in terms of planning, implementation and monitoring. Specifically the Framework provides:

- Guidance on preparation of the Adolescent Health (AH) related components of state and district NHM PIPs including budgets and reporting on progress/indicators.

- Detailed guidelines including recording and reporting formats for implementation of the Peer Education (PE) initiative, Adolescent Health Day (AHD) and operationalisation and strengthening of Adolescent Friendly Health Clinics (AFHCs).

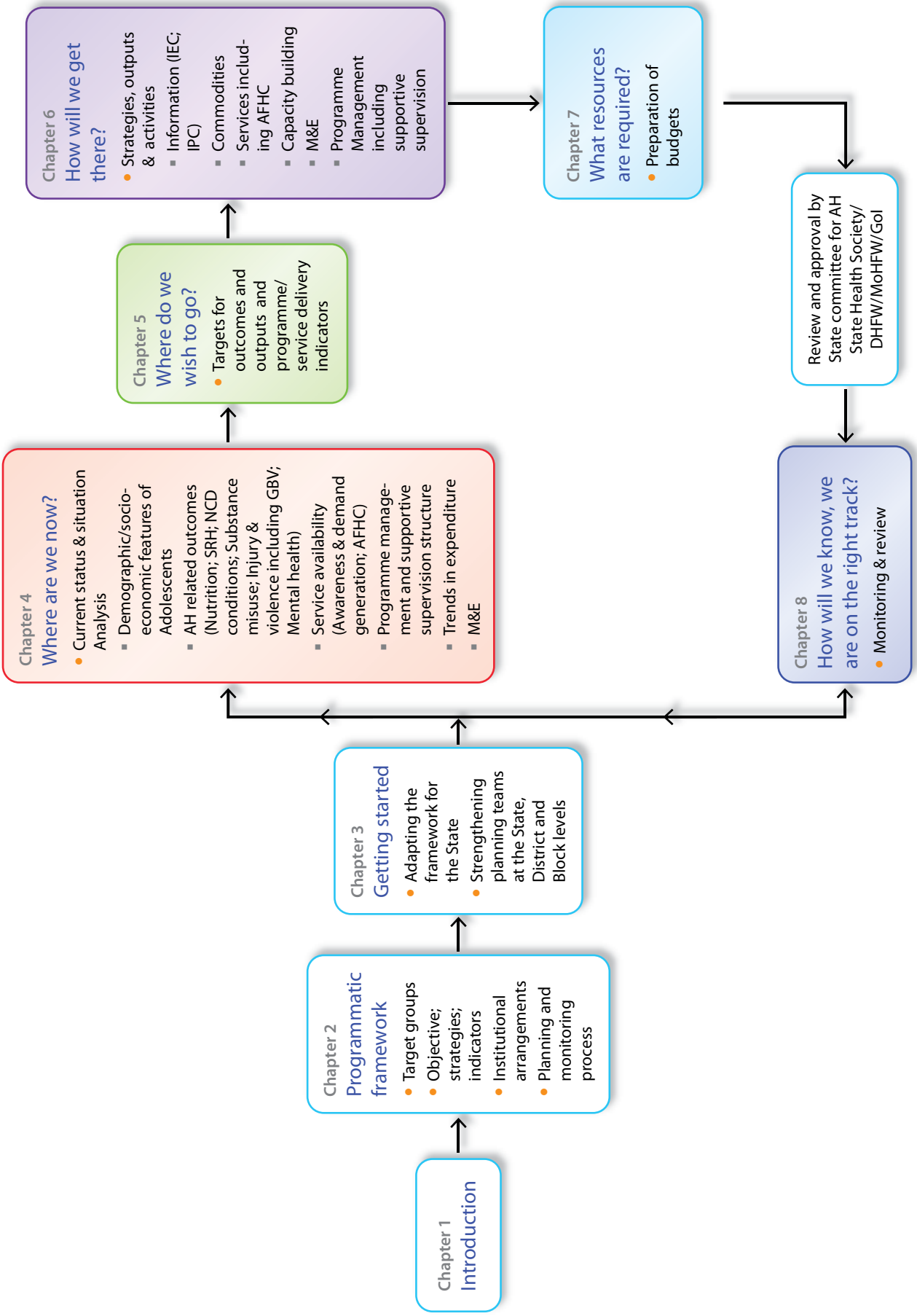
1.08 Target groups (and their roles) for this Operational Framework include:

- State NHM Mission Director
  - Ensure that AH gets the necessary emphasis; provide strategic direction
  - Integration of Adolescent Health component in the state NHM PIP
  - Set-up systems to recruit quality Adolescent Health staff
  - Integrate efforts of development partners towards achieving common Adolescent Health objectives
  - Lead convergence initiatives
  - Oversee preparation of state specific standard operating procedures (SOPs) for Adolescent Health based on the strategy and operating guidelines
  - Monitor progress of Adolescent Health based on the commitments in the PIP
- Adolescent Health Programme Managers/nodal officers at state and district levels
  - Prepare Adolescent Health PIP for state/districts
  - Integration of Adolescent Health component in the state/district NHM PIP
  - Preparation of state specific SOPs for Adolescent Health based on the strategy and operating guidelines
  - Implement Adolescent Health strategies and activities as per the PIP
  - Consolidate monthly adolescent health report
  - Submission of Adolescent Health progress report to MD (NHM) and further to Government of India
  - Regular monitoring and supportive supervision of progress of Adolescent Health programme
- State and district programme managers
  - Oversee preparation of Adolescent Health PIP for state/districts
  - Integration of Adolescent Health component in the state/district NHM PIP
  - Oversee preparation/consolidation of Adolescent Health progress reports
  - Regular monitoring and supportive supervision of progress of Adolescent Health programme
- Members of the team constituted for preparation of NHM PIPs
  - Ensure Adolescent Health PIP planning is in line with the state/district NHM PIP
  - Integration of Adolescent Health component in the state/district NHM PIP

Structure of this Operational Framework

1.09 An overview of the structure of this Operational Framework is provided in Exhibit 1.01. Chapter 2 provides a programmatic framework in terms of target groups, objectives, strategies and indicators (outcome, output and programme/service delivery) followed by an overview of the planning and monitoring process and institutional arrangements. Chapter 3 i.e. 'Getting started' addresses the composition of planning teams at state and district

Exhibit 1.01: Overview of AH Operational Framework



levels and their training. Chapter 4 i.e. 'Where are we now' deals with the current status and situation analysis leading to identification of key issues adversely affecting performance. While Chapter 5 (Where do we wish to go) covers setting of targets for outcomes, outputs and programme/service delivery, Chapter 6 looks at 'How will we get there' in terms of strategies, outputs and corresponding activities. The approach to budget preparation is addressed in Chapter 7. Monitoring and review i.e. 'How will we know if we are on the right track' is covered in Chapter 8.

1.10 Detailed guidelines including recording and reporting formats for implementation of the PE initiative, AHD and operationalisation of AFHCs are provided in Annexures I, II and III respectively.

Other Relevant Guidelines/Documents

1.11 This Operational Framework should be seen together with the following guidelines/documents released by MoHFW, GoI:

- National Adolescent Health Strategy, MoHFW, GoI, December, 2013
- 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
- Operational Guidelines: Rashtriya Bal Swasthya Karyakram (RBSK), February, 2013
- Training Manual for Adolescent Health Counsellors
- Peer Educators Facilitator's Guide and Peer Educator's Handbook
- National Health Mission: Operating Manual for Preparation and monitoring State Programme Implementation Plans, November 2013.

2 Programmatic Framework

2.01 This chapter sets out the target groups, objectives, strategies and indicators followed by an overview of the planning and monitoring process and institutional arrangements.

Target Groups

2.02 The new adolescent health (AH) strategy focuses on age groups 10-14 years and 15-19 years with universal coverage, i.e. males and females; urban and rural; in school and out of school; married and unmarried; and vulnerable and under-served.

Objectives

2.03 The new AH strategy seeks to achieve the following objectives:

Improve nutrition

- Reduce the prevalence of malnutrition among adolescent girls and boys (including overweight/obesity)
- Reduce the prevalence of iron-deficiency anaemia (IDA) among adolescent girls and boys

Enable sexual and reproductive health

- Improve knowledge, attitudes and behaviour, in relation to SRH
- Reduce teenage pregnancies
- Improve birth preparedness, complication readiness and provide early parenting support for adolescent parents

Enhance mental health

- Address mental health concerns of adolescents

Prevent injuries and violence

- Promote favourable attitudes for preventing injuries and violence (including GBV) among adolescents

Prevent substance misuse

- Increase adolescents' awareness of the adverse effects and consequences of substance misuse

Address conditions for NCDs

- Promote behaviour change in adolescents to prevent NCDs such as cancer, diabetes, cardio-vascular diseases and strokes

The strategy is operationalised through six key components i.e. Communication (including Social and Behaviour Change Communication for improved health seeking behaviour); provision of commodities; provision of services; capacity building; monitoring & evaluation and programme management including supportive supervision.

Strategies

2.04 Strategies/interventions to achieve objectives can be broadly grouped as:

A. Community based interventions

- Peer Education (PE)
- Quarterly Adolescent Health Day (AHD)
- Weekly Iron and Folic Acid Supplementation Programme (WIFS)
- Menstrual Hygiene Scheme (MHS)

B. Facility based interventions

- Strengthening of Adolescent Friendly Health Clinics (AFHC)

C. Convergence

- **within Health & Family Welfare** - FP, MH (incl VHND), RBSK, NACP, National Tobacco Control Programme, National Mental Health Programme, NCDs and IEC
- **with other departments/schemes** - WCD (ICDS, KSY, BSY, SABLA), HRD (AEP, MDM), Youth Affairs and Sports (Adolescent Empowerment Scheme, National Service Scheme, NYKS, NPYAD)

D. Social and Behaviour Change Communication with focus on Inter Personal Communication

Each strategy/intervention typically addresses more than one objectives shown in Exhibit 2.01 on the following pages.

Exhibit 2.01: Adolescent Health Programmatic Framework

Target groups →		Adolescent 10-14				Adolescent 15-19				Married Adol		Other Stakeholders			
		In school		Drop-out		In school		Drop-out				PRI	Parents	School teachers	Service providers
		M	F	M	F	M	F	M	F	M	F				
Objectives															
Improve nutrition															
Reduce the prevalence of malnutrition among adolescent girls and boys															
Reduce the prevalence of iron-deficiency anaemia (IDA) among adolescent girls and boys															
Enable sexual and reproductive health															
Improve knowledge, attitudes and behaviour, in relation to SRH															
Reduce teenage pregnancies															
Improve birth preparedness, complication readiness and provide early parenting support for adolescent parents															
Enhance mental health															
Address mental health concerns of adolescents															
Prevent injuries and violence															
Promote favourable attitudes for preventing injuries and violence (including GBV) among adolescents															
Prevent substance misuse															
Increase adolescents' awareness of the adverse effects and consequences of substance misuse															
Address NCDs															
Promote behaviour change in adolescents to prevent NCDs such as hypertension, stroke, cardio-vascular diseases, diabetes and cancer															
Components	**Strategies**														
Information (including SBCC*)															
SBCC, for Nutrition, SRH, Mental Health, GBV, NCD, Substance misuse	**A, B, C**														
Provision for commodities															
IFA and Albendazole	**A** (AHD, AFHC, WIFS), **B** (VHND, RBSK)														

* Social and behaviour change communication

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		Adolescent 10-14				Adolescent 15-19				Married Adol		Other Stakeholders			
Target groups →		In school		Drop-out		In school		Drop-out				PRI	Parents	School teachers	Service providers
		M	F	M	F	M	F	M	F	M	F				
Sanitary Napkins	**A** *(AHD, AFHC, MHS)*														
Supplementary food	**C** *(WCD)*														
Contraceptives	**A** *(AHD, AFHC)*, **B** *(FP)*														
Services															
BMI testing	**A** *(AHD, AFHC)*, **B** *(VHND, RBSK)*, **C** *(WCD)*														
Hb/Anaemia testing	**A** *(AHD, AFHC, WIFS)*, **B** *(MH)*, **C** *(WCD)*														
Clinical service: RTI/STI management	**A** *(AHD, AFHC)*, **B** *(MH)*														
Clinical service: ANC	**A** *(AHD, AFHC)*, **B** *(VHND, MH)*														
Clinical service: Abortion	**B** *(MH)*														
Clinical service: Contraceptive (Spacing)	**A** *(AFHC, AHD)*, **B** *(FP)*														
Clinical Counselling services for: Nutrition, Skin, Pre-marital Counselling, Sexual Problems, Contraceptive, Abortion, RTI/STI, Substance misuse, Learning problems, Stress, Depression, Suicidal Tendency, Violence, Sexual Abuse, Other Mental Health Issues	**A, B, C**														
Training															
PE, Service providers															
Monitoring and Evaluation															
Program Management including supportive supervision															

Strategy Code	Type	Strategies
A	Adolescent Health Division	PE, AHD, AFHC, WIFS, MHS, Adolescent Helpline
B	Other Health Department Convergence	FP, MH (incl VHND), RBSK, NACP, National Tobacco Control Programme, National Mental Health Programme, NCD, IEC division
C	Convergence Other ministries/ programmes	WCD (ICDS, KSY, BSY, SABLA), HRD (AEP, MDM), Youth Affairs and Sports (Adolescent Empowerment Scheme, National Service Scheme, NYKS, NPYAD)

Indicators

2.05 Goal, outcome and output indicators and means of verification have been provided in Exhibit 2.02. For progress against goal and outcome indicators, a number of ministries including health and family welfare, human resource development, women and child development, youth affairs and sports and social justice would need to converge effectively. MoHFW would track progress against the goal and outcome indicators and advocate, where necessary. The responsibility for progress against output indicators primarily rests with MoHFW, key strategies being PE, AHD, WIFS, MHS and AFHCs.

Exhibit 2.02: Goal, Outcome and Output Indicators

Goal	Goal indicators	Means of verification
Improved adolescent health and well-being	1. Reduction in malnutrition and IDA among adolescents 2. Decline in age specific fertility rate among adolescent girls (15-19 yrs) 3. Reduction in proportion of maternal death contributed by 15-19 years age group 4. Decline in HIV prevalence among adolescents 5. Decline in experience of violence among adolescents 6. Decline in prevalence of serious Mental Health Problems among adolescents 7. Decline in substance misuse among adolescents 8. Decline in incidence of NCDs among adolescents 9. Improvement in healthy life styles among adolescents (Diet, exercise etc.)	Ongoing rapid assessments of nutritional and health outcomes among adolescents Periodic surveys (AHS, DLHS, SRS, BSS, NFHS)

Objectives	Outcome indicators	Output indicators	Means of verification
		Improve nutrition	
1. Reduce the prevalence of malnutrition among adolescent girls and boys	**1.1** Percentage of adolescents who are thin (BMI <18.5 kg/m^2) **1.2** Percentage of adolescents who are overweight/obese (BMI >25.0 kg/m^2)	**1.3** Percentage of adolescents with correct knowledge on balanced diet and nutritional deficiencies **1.4** Percentage of care-givers such as ANMs, ASHAs, AWWs, teachers, peer educators and parents, having correct knowledge on balanced diet and nutritional deficiencies	Ongoing rapid assessments of nutritional and health outcomes among adolescents Periodic surveys (AHS, DLHS, NFHS) measuring knowledge, attitudes and practices
2. Reduce the prevalence of iron-deficiency anaemia (IDA) among adolescent girls and boys	**2.1** Percentage of adolescents with any anaemia (<12.0 g/dl) **2.2** Percentage of adolescents with severe anaemia (<7.0 g/dl)	**2.3** Percentage of care givers such as ANMs, ASHAs, AWWs, teachers, peer educators, ASHA and parents having correct knowledge on iron rich foods **2.4** Percentage of adolescents having correct knowledge on iron-rich foods **2.5** Percentage of adolescents given 4-5 IFA tablets per month	Ongoing rapid assessments of nutritional and health outcomes among adolescents Periodic surveys (AHS, DLHS, NFHS) measuring knowledge, attitudes and practices WIFS MIS

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Objectives	Outcome indicators	Output indicators	Means of verification
		Enable sexual and reproductive health	
3. Improve knowledge, attitudes and behaviour, in relation to SRH	**3.1** Percentage of married adolescents reporting unmet need for contraceptives (separately for spacing, limiting and total) **3.2** Contraceptive prevalence rate among married adolescents **3.3** Percentage of adolescents who used condom during first sexual intercourse **3.4** Percentage of adolescents aged 15-19 who had sexual debut before age 18	**3.5** Percentage of adolescents correctly reporting that a woman can get pregnant at first sex if not used any contraception **3.6** Percentage of adolescents aged 15–19 with knowledge of at least one modern method of contraception **3.7** Percentage of adolescents with comprehensive knowledge about HIV/AIDS[3] **3.8** Percentage of adolescents aware of at least one symptom of RTI/STI **3.9** Percentage of care-givers such as AWWs, teachers, peer educators, ASHAs and parents, who have correct knowledge of adolescent SRH management **3.10** Percentage of adolescents accessing adolescent clinics for RTI/STI, abortion and puberty related problems **3.11** Percentage of adolescent girls aware of benefits of menstrual hygiene **3.12** Percentage of adolescent girls using disposable sanitary napkins or washed and sun-dried cloth	Ongoing rapid assessments of nutritional and health outcomes among adolescents Periodic surveys (AHS, DLHS, NFHS) measuring knowledge, attitudes and practices AFHC MIS
4. Reduce teenage pregnancies	**4.1** Percentage of adolescents married in age group 15–19 **4.2** Percentage of married adolescents aged 15-19 who have begun childbearing (either had a live births or pregnant with first child) **4.3** Median Age at first Marriage **4.4** Age-specific fertility rates (15-19 years) **4.5** Percentage of married adolescents aged 15-19 years using any modern method of contraception	**4.6** Percentage of adolescents indicating positive attitude about delaying first conception after marriage **4.7** Percentage of married adolescent couples having comprehensive knowledge on risks of early pregnancy **4.8** Percentage of parents/community leaders having correct knowledge of legal age at marriage and disadvantages of early child bearing **4.9** Percentage of married adolescent couples accessing adolescent clinics for contraceptives or counselling on family planning services	Sample Registration System yearly statistical report Periodic surveys (AHS, DLHS, NFHS) measuring knowledge, attitudes and practices Ongoing rapid assessments of nutritional and health outcomes among adolescents AFHC MIS

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[3] Respondents who recall of at least three mode of transmission, at least two methods of prevention and reject major misconceptions about HIV/AIDS.

Objectives	Outcome indicators	Output indicators	Means of verification
5. Improve birth preparedness, complication readiness and provide early parenting support for adolescent parents	**5.1** Percentage of pregnant adolescents who received antenatal care within the first trimester of pregnancy **5.2** Percentage of pregnant adolescents who received at least three antenatal care checkups **5.3** Percentage of adolescent mothers who delivered in a health facility during last one year **5.4** Percentage of adolescent mothers who received assistance during delivery from health personnel during last one year	**5.5** Percentage of adolescents reporting correct knowledge of care during pregnancy **5.6** Percentage of service providers (such as, ASHAs, ANMs, AWWs etc.) reporting correct knowledge of care during pregnancy **5.7** Percentage of adolescents accessing adolescent clinics for counselling on pregnancy care	Periodic surveys (AHS, DLHS, NFHS) measuring knowledge, attitudes and practices Ongoing rapid assessments of nutritional and health outcomes among adolescents HMIS/MCTS AFHC MIS
Enhance mental health			
6. Address mental health concerns of adolescents	**6.1** Percentage of adolescents (10-14 and 15-19 years) who reported felling of sad/ hopeless/depressed almost every day at least for two weeks during last one year **6.2** The proportion of adolescents aged 10-14, 15-19 years who reported that during the past 12 months they felt so sad or hopeless almost every day for two weeks or more in a row, that they stopped doing their usual activities	**6.3** Percentage of adolescents, who have correct knowledge of early warning signals of common mental health problems **6.4** Percentage of teachers, parents and ANMs who have correct knowledge on early warning signals of common mental health problems **6.5** Percentage of adolescents accessing adolescent clinics for counselling on mental health	Ongoing rapid assessments of nutritional and health outcomes among adolescents AFHC MIS
Prevent injuries and violence			
7. Promote favourable attitudes for preventing injuries and violence (including GBV) among adolescents	**7.1** Percentage of married adolescents who have experienced physical violence from their spouses in past 12 months **7.2** Percentage of married adolescents who have experienced emotional violence from their spouses in past 12 months	**7.6** Percentage of adolescent girls who agree that a husband is justified in hitting or beating his wife for at least one specified reason[4] **7.7** Percentage of peer educators and care givers (such as partners, husbands, mothers-in-law, teachers and service providers) reporting correct understanding of GBV	Periodic surveys (AHS, DLHS, NFHS) measuring knowledge, attitudes and practices Ongoing rapid assessments of nutritional and health outcomes among adolescents

Contd...

[4] Going out without telling him, neglects husband or children, argues with him, refuses to have sexual intercourse, doesn't cook properly, suspects that she is unfaithful or shows disrespect to in-laws.

Objectives	Outcome indicators	Output indicators	Means of verification
	7.3 Percentage of married adolescents who have experienced sexual violence from their spouses in past 12 months **7.4** Percentage of married adolescents who have experienced physical, emotional or sexual violence from their spouses in past 12 months **7.5** The proportion of adolescents aged 10-19 years, who suffered from major injuries (accident, fall or any other which restricted their locomotor function), during the past 12 months		
	Prevent substance misuse		
8. Increase adolescents' awareness of the adverse effects and consequences of substance misuse	**8.1** Percentage of adolescents who drink alcohol at least once a week **8.2** Percentage of adolescents who are daily tobacco users (smoking) **8.3** Proportion of adolescents aged 13-15 years who have smoked one or more cigarettes in the past 30 days **8.4** Percentage of adolescents who are daily smokeless tobacco users	**8.5** Percentage of adolescents who believe smoking causes serious illnesses **8.6** Percentage of adolescents who believe smokeless tobacco causes serious illnesses **8.7** Percentage of peer educators and care givers (such as partners, husbands, mothers-in-law, teachers and service providers) reporting correct understanding of adverse effects and consequences of substance misuse	Periodic surveys (AHS, DLHS, NFHS) measuring knowledge, attitudes and practices Ongoing rapid assessments of nutritional and health outcomes among adolescents
	Address NCDs		
9. Promote behaviour change in adolescents to prevent NCDs such as hypertension, stroke, cardio-vascular diseases and diabetes	**9.1** Prevalence of obesity in adolescents[5] **9.2** Prevalence of insufficiently active adolescents[6] **9.3** Prevalence of current tobacco use (smoking and smokeless) among adolescents **9.4** Percentage of adolescents with diagnosed diabetes **9.5** Percentage of adolescents with diagnosed hypertension	**9.6** Percentage of adolescents, who have correct knowledge of early warning signals of NCD (diabetes and hypertension) **9.7** Percentage of adolescents with correct knowledge of healthy lifestyle	Periodic surveys (AHS, DLHS, NFHS) measuring knowledge, attitudes and practices Ongoing rapid assessments of nutritional and health outcomes among adolescents

[5] Defined as two standard deviations BMI for age and sex overweight according to WHO growth reference.
[6] Defined as less than 60 minutes per day in the last seven days.

2.06 For day to day management of the programme, implementation progress of each strategy could be tracked by way of programme/ service delivery indicators (Exhibit 2.03):

Exhibit 2.03: Programme/Service Delivery Indicators

Strategies	Service delivery indicators	Means of verification
Peer Education Programme (PE)	• Percentage and number of Peer Educators enrolled against planned • Percentage and numbers of peer educators trained (out of to total number of PEs) • Percentage and number of adolescents reached through village based Peer Educators • Percentage and number of sessions held by peer educators against planned • Number of adolescents referred by PE to AFHC	• Peer Educator MIS reports • State PIP • AFHC MIS • Training reports
Adolescent Friendly Health Clinics (AFHC)	• Percentage and number of AFHC operationalised against planned (at PHC, CHC, DH/Medical College) • Client load at Adolescent Friendly Health Clinics per month (no.) • Client referred from community to AFHC per month (no.) • Percentage of adolescents accessing adolescent clinics for puberty-related problems, RTIs/STIs, mental health concerns, abortion care, nutrition • Percentage and number of AH counsellors recruited against planned • Total no. of clients counselled • Percentage and number of trained Counsellors in place against planned • Proportion of trained counsellors to total number of adolescents • Percentage and number of MO trained in AFHS (Male/ female) against planned • Percentage and number of ANMs/LHVs trained on AFHS against planned	• AFHC MIS • State PIP • Training reports
Adolescent Health Day (AHD)	• Number and percentage of AHD planned and held • Total number of adolescents visiting AHD • Total number of adolescents referred to AFHCs during AHD • Total number and percentage of AHDs providing contraceptives • Total number of parents attending AHD • Percentage of parents who were sensitized through IPC/ Orientation/ discussion during AHD (out of total no. of parents who attended the AHD)	• AHD MIS • State PIP
Weekly Iron Folic Supplementation (WIFS)	• Percentage of care-givers (AWWs, teachers) who have been trained on implementation of the Weekly Iron and Folic Acid Supplementation (WIFS) • Coverage of WIFS: percentage of adolescents given 4 or 5 IFA tablets in the reporting month • Coverage of Albendazole: Percentage of adolescents given Albendazole tablets in the last six months • Percentage of distribution points for WIFS reporting IFA stock-out	• WIFS MIS • Training reports
Menstrual Hygiene Scheme (MHS)	• Number of adolescent girls provided free sanitary packs • Number of sanitary packs distributed to adolescents	• MHS MIS

Overview of the Planning and Monitoring Process

2.07 The planning, implementation and monitoring of the AH strategy would need to feed into/be a component of the State/district National Health Mission (NHM) Program Implementation Plans (PIPs). Key features of the latter relevant to AH include:

- In terms of budget implications AH would be reflected in *NRHM plus RMNCH+A (including immunization) Flexipool*[7].
- Each state should prepare a three year perspective plan/PIP for the period 2014-15 to 2016-17. The three year plan would have a results framework broken down by year in terms of key indicators i.e. goals, outcomes, outputs and process. On an annual basis, States are to update the PIP by way of providing:
  - Progress in the last year/lessons learnt and changes proposed;
  - Detailed action plan including activities, agencies/persons responsible and timeline, by quarter;
  - Quarterly targets for outcomes and outputs (to be based on the web based HMIS); and
  - Detailed quarterly budgets linked to physical outputs.
- The perspective plan for 2014-2017 will also have the detailed quarterly targets, work plan and budget for the first year, 2014-15.
- The AH component of State PIPs would be an aggregate of AH components of district/city health action plans. DP supported activities (as a part of RMNCH+A Intensification and Harmonization of efforts in High Priority Districts) would be reflected in district/state PIPs.

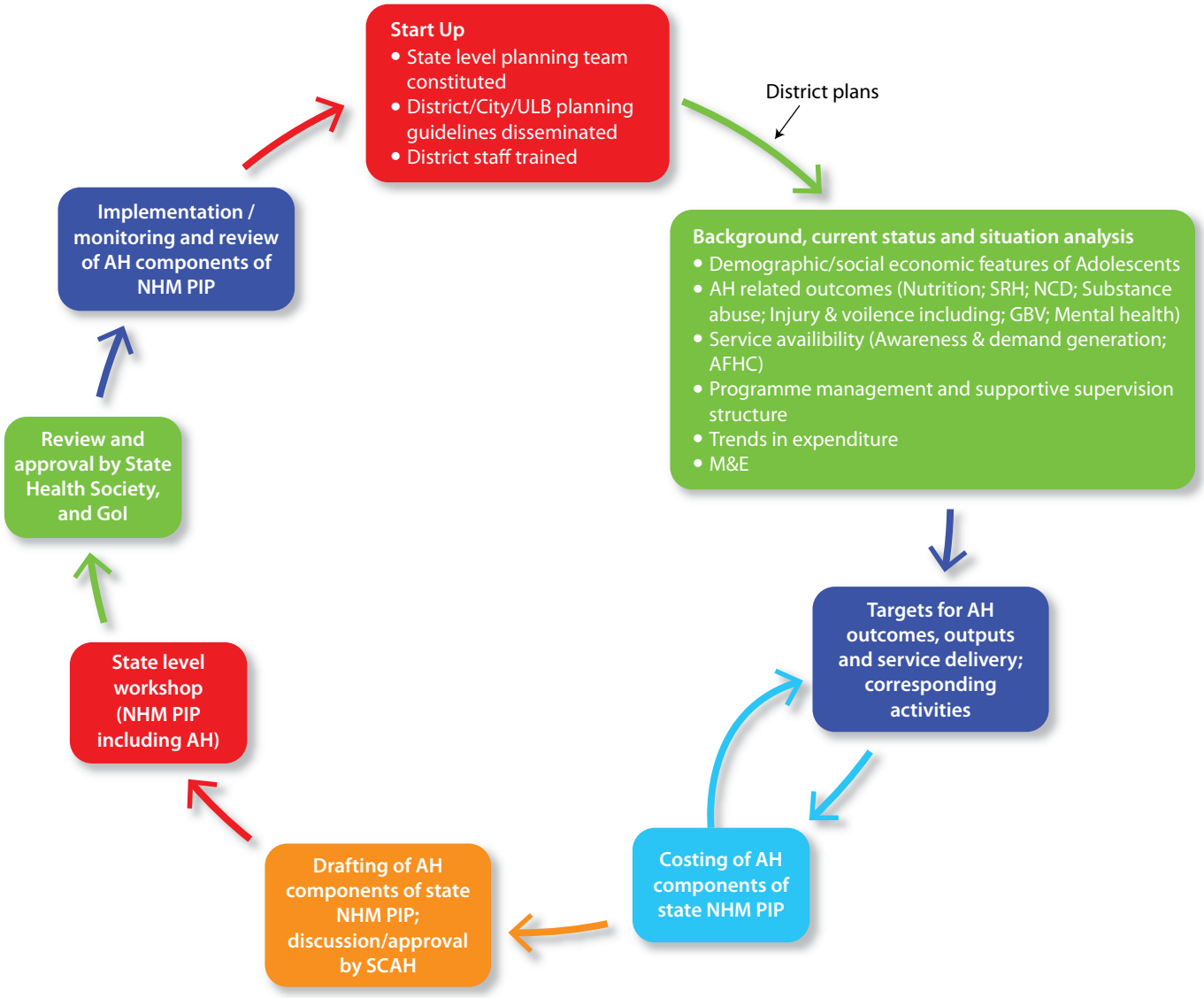
2.08 An overview of the planning and monitoring process for AH component of state NHM PIPs is schematically shown in Exhibit 2.04[8]. The starting point is the constitution of the state, district and city planning teams (state may also include universities, professional associations and NGOs in the planning team), allocation of flexible and other funds to districts and state level/other agencies (SIHFW, IEC bureau, M&E, logistics, urban local bodies, etc.) and training of their respective planning teams. It should be ensured that AH is represented in the planning teams at both state and district levels and if possible a sub financial allocation should be made for AH.

2.09 As shown in Exhibit 2.04, key stages include preparation of AH components of district/city plans; a state level situation analysis followed by setting of targets for AH related outcomes, outputs and service delivery. The subsequent costing of the corresponding activities would be iterative in order to ensure that the AH components are within the sub-envelope. The AH related members of the team should draft the AH components of the NHM PIP in line with the NHM PIP preparation guidelines; key features should be discussed and agreed with the State Committee for Adolescent Health (SCAH). Once the state NHM PIP including the AH related components have been drafted, a state level workshop should be conducted. It should be ensured that members of the SCAH also participate in the workshop. With feedback incorporated, and appropriate modifications made into the PIP, states should then present it to the respective State Health Society and subsequently, MoHFW, GoI. Implementation of the approved PIP should lead to improvement in outcomes and hence favorably impact the current situation (analysis). This would then be the starting point for the planning process in the subsequent year.

[7] The erstwhile, RCH, Mission Flexi-pool and Immunization components of PIPs.

[8] This is in line with the process followed for the NHM PIP.

Exhibit 2.04: Overview of State AH Planning, Implementation and Monitoring Process



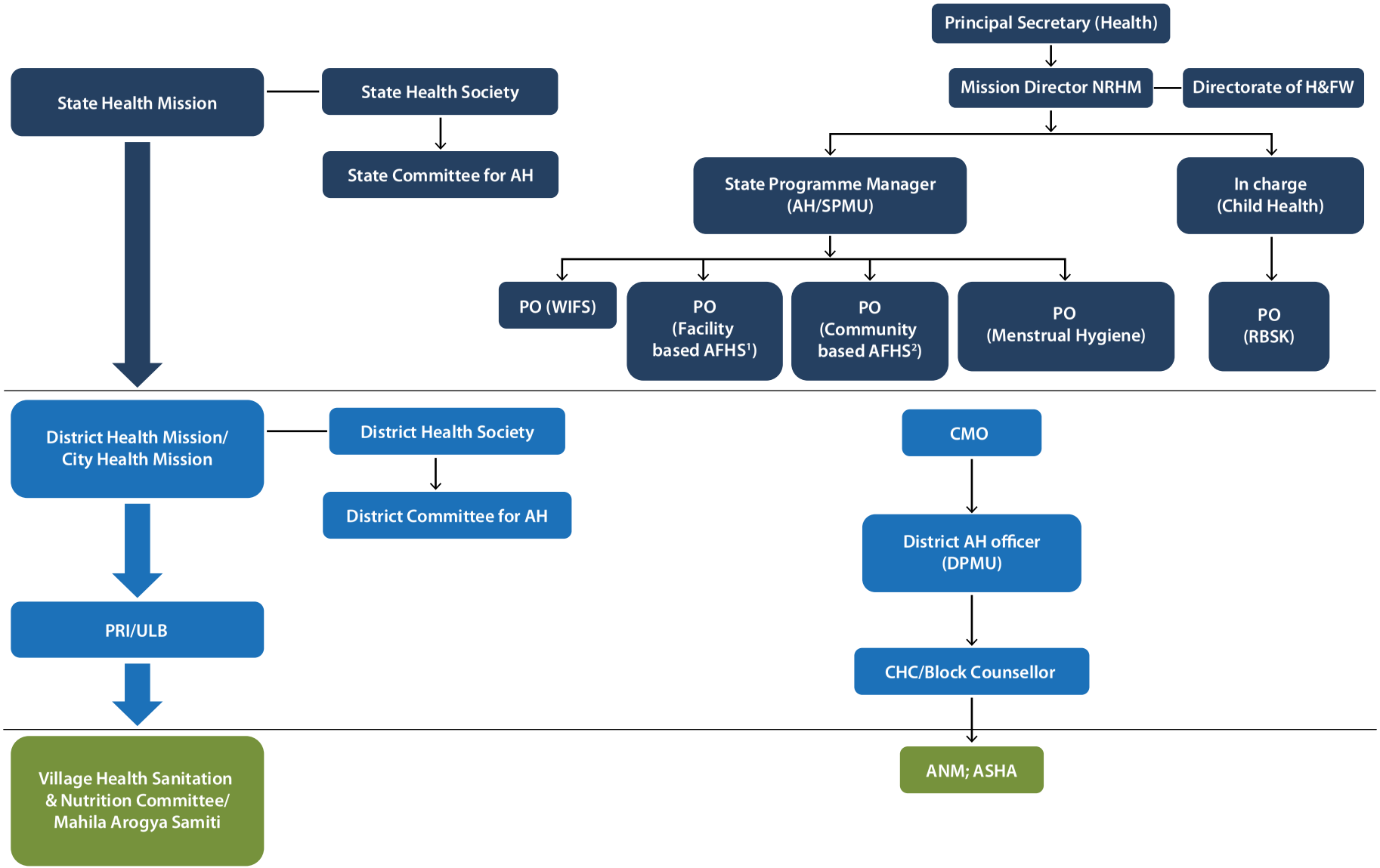
2.10 On a quarterly basis, each state will prepare a variance analysis report against the plan/targets/expenditure for the reporting quarter no later than the end of the month following the quarter. A copy of the above quarterly variance analysis reports are to be sent to MoHFW. The AH team at the state/district levels should analyse variances and ensure that necessary corrective action is identified and implemented.

Institutional Arrangements

2.11 Suggested institutional arrangements for AH and linkages with existing NHM arrangements are shown schematically in Exhibit 2.05. Key features are:

- State Committee for Adolescent Health: A state-level Committee for Adolescent Health (SCAH), as a sub group of the state health society will be formed to oversee convergence efforts at the state level and resolve implementation issues. The Committee will meet biannually. CAH may be convened and chaired by the Principal Secretary Health, with representation from State AIDS Control Society (SACS) and the departments of

Exhibit 2.05: Indicative Institutional Arrangements



Note:

1. Adolescent Friendly Health Clinics
2. Peer Education and AHD

Education, Social Welfare (ICDS, SABLA and NYKS), Tribal Welfare, and Water and Sanitation, Rural Development and Panchayati Raj, Home Affairs, and other stake holders such as development partners, NGOs, civil societies, medical colleges (including psychiatrists and psychologists) and public health experts. The state WIFS Advisory Committee will be subsumed in CAH.

- District Committee for Adolescent Health (DCAH): The scope of the existing district WIFS Advisory Committee will be expanded to encompass all adolescent health-related issues. The Committee will be chaired by the District Magistrate and will meet quarterly, to oversee convergence efforts, programme implementation and resolve bottlenecks. The Committee will have representation from all stakeholder groups as in SCAH and will play an important part in planning convergent activities reflected in the annual work plan.
- Village Health, Nutrition and Sanitation Committee: The membership of this committee could be expanded by including a school teacher, preferably a lady teacher, and peer educator. The work plan of VHNSC could also include health promotion activities for adolescents, for example, adolescent health *melas*. Often, the 'gatekeepers' of the community block access of adolescents to services; these committees, therefore, can play a pivotal role in providing safe spaces for adolescents to seek services. Untied funds can also be utilised for conducting specific activities for adolescents.
- States are expected to augment AH management capacity commensurate to the work load and allocated budget. States should consider a full time State Nodal Officer for AH supported by program officers for WIFS; Facility based Adolescent Friendly Health Services (clinics and counsellor), Community Based AFHS (peer educator & AHD), Menstrual Hygiene and RBSK (the latter as a part of Child Health). At the district a full time program officer for AH should be considered; while the AFHC counsellor at the CHC could take on the role of Block Nodal Officer for AH.

3 Getting Started

3.01 Pre planning activities for preparation of the state NUHM PIP include formation of the state, district and city level planning teams, allocation of funds to districts, Urban Local Bodies (ULBs) and other "spending centres", dissemination of district/city planning guidelines and training of district planning teams. This chapter addresses the above aspects in the context of AH.

State and District Level Planning Teams

3.02 The State Programme Management Unit (SPMU) together with the urban cell is primarily responsible for coordinating the preparation of the state NHM PIP and its final drafting. A state level PIP preparation team would be constituted with representatives from RMNCH+A technical divisions, Urban health, disease control programmes and non-communicable diseases, finance and M&E. As part of the planning team, state may also include universities, NGOs and professional associates working in the field of AH. It should be ensured that the full time State Nodal Officer for AH and program officers for WIFS/National Iron Plus Initiative, Facility based AFHS, Community based AFHS, Menstrual Hygiene and RBSK (the latter as a part of Child Health) are members of the planning team and would be responsible for preparation of the AH related components of the NHM PIP. Further, efforts should be made to involve representatives from SACS, state departments of Education (AEP, NYKS), Woman & Child (ICDS, KSY, BSY, Sabla) and Youth Affairs/Social Welfare (NYKS).

3.03 Similarly the District Programme Management Units (DPMUs) would have the primary responsibility for development of District NHM and city NUHM plans; in the case of metros, large ULBS, wherein the responsibility for NUHM is primarily with the concerned city, the CPMU would take the lead in preparation of the City NUHM Plan. As at the state level, it should be ensured that the District program officer for AH is responsible for the AH related components of the District NHM plan and a representative from other departments are involved in the planning process.

Allocation of Resources by State

3.04 Allocation of resources/financial envelope to districts/cities would be primarily made for RMNCH+A. However, to the extent feasible, efforts should be made to obtain a broad indication of the available envelope for AH for the 3 year period: 2014-15 to 2016-17.

Guidelines to Districts

3.05 Key steps include:

- Make necessary modifications to this Operational Framework, taking into account state specific conditions.
- Ensure that the guidelines sent to districts as a part of the NHM planning process reflect the key components of this Operational Framework including the detailed budget formats.
- Provide necessary support to districts in preparing the AH component of district NHM PIPs.
- For rollout of the PE, AHD and AFHC strategies, necessary guidance has been provided in Annexures I, II and III respectively. These should be addressed separately from the overall NHM PIP planning process. In the case of WIFS, Menstrual Hygiene and RBSK the existing guidelines would be applicable.

4 Where Are We Now (Situation Analysis)?

4.01 This chapter sets out an indicative approach to an assessment of the current status and situation analysis in the context of AH.

Data Collection

4.02 The starting point is to collect state and district level data (current and trends) vis-a- vis the national average in terms of[9]:

Target group (Coverage)

- Adolescents in the age groups 10 to 14 years and 15-19 years broken down by males and females; urban and rural; in school and out of school; married and unmarried; and vulnerable and under-served subgroups/SC/ST/ BPL. Sources of data include Census, State Education and Urban departments and possibly special studies, if any carried out.

Adolescent health status

- AH outcomes: For each sub target group above, assess status in terms of nutrition; sexual and reproductive health; injuries and violence (including GBV); substance misuse; and conditions for NCDs. Apart from a qualitative assessment, collect data to the extent possible in terms of indicators listed in Exhibit 2.02. Almost certainly all the necessary data would not be available. Make a provision in the budget for carrying out a base-line assessment to start with, in districts prioritized for the first year. A detailed guideline on the indicators and definitions will be provided by Ministry of Health and Family Welfare, Government of India.
- Programme related: Assess coverage and performance of ongoing programmes (AFHCs, WIFS, MHS as well as family planning, maternal health, IEC activities and SACS), both qualitatively and in terms of programme/ service delivery indicators listed in Exhibit 2.03, as well as past trends in expenditure against budget. Ideally this assessment, wherever applicable should again be broken down by sub-target group and by district. Try and identify gaps/root cause of poor performance as well as key success factors. In case of AFHCs, WIFS and MHS use the criteria given in the respective guidelines.

[9] This is in addition to data to be collected for preparation of NHM PIPs as a whole.

- Human Resource: Assess details of AH related HR (dedicated counsellors as well as health staff who have under gone AH related training) as well as counsellors under the purview of FP and SACS. This should be in terms of location of posting as well as training undergone. Based on the number of existing dedicated AH counsellors and ICTC counsellors, state should be able to quantify the number of counsellors which will be needed to operationalise all AFHCs at CHC, DH and medical college levels.
- AH program management: Details of dedicated AH staff at state and district levels and supportive supervision arrangements
- NGO and Self Help Group (SHG) capacity (district wise) particularly in terms of suitability for e.g. managing the PE initiative
- DP (donor assisted) AH programmes in the state (objectives, outputs, key activities, funds, etc.)
- Health systems (in the context of AH): Current status and key issues in terms of:
  - HMIS/MCTS in terms of AH related indicators/AH disaggregated data
  - IEC/BCC (emphasis to AH)
  - Procurement and logistics
  - ASHA/community processes: any AH related incentives

Convergence

- Assess status of programmes carried out by other departments e.g. Education (AEP), Woman & Child (ICDS, KSY, BSY, Sabla, Saksham) and Youth Affairs/Social Welfare (NYKS) in terms of coverage and possible areas of synergy. A menu of such areas is listed in Annexure IV.
- Specifically for each programme, assess extent of overlap with the AH programmatic framework particularly in terms of objectives, target groups, information (IEC/IPC), commodities and services (refer earlier Exhibit 2.01); specifically:
  - Assess extent of coverage, effectiveness and quality
  - Identify possible areas of convergence
  - Assess amenability/possible bottlenecks to convergence
  - Present findings to the DCAH/SCAH and obtain necessary approvals

4.03 Both quantitative and qualitative sources of data would need to be tapped. The former would include Census, SRS, AHS/DLHS, NFHS, HMIS, MCTS, etc. Qualitative sources include discussions with a wide range of stakeholders including NGOs, experts, etc.

4.04 The above data collection would typically be carried out by both the state and district planning teams, since certain types of data is likely to be available only at the district level.

Data Analysis

4.05 Typically data collection and analysis takes place simultaneously and quite often the latter would lead to requirement of additional data. Nevertheless for the sake of convenience, data analysis has been shown as a sequential activity.

4.06 It would be useful to present data in the form of tables/graphs etc. as this would facilitate analysis. Key indicators have been provided earlier in Exhibit 2.02 and 2.03. The State should supplement/add to these.

4.07 For each item, systematically consolidate district wise data. Reconcile these figures with state level data wherever this is available or judgmentally. This reconciliation is necessary in order to ensure sanctity of the reported figures. Apart from providing the consolidated state level figures, analyze variations across districts and appropriately group districts/cities.

4.08 Try and identify common core issues to be addressed across districts and issues, which are category, or district specific. This should lead to a set of common interventions across all districts and some category/district specific interventions.

4.09 The above analysis of district/city plans should lead to identification of issues to be primarily addressed by the State and those that need to be addressed at the district/sub-district levels. Preparation of training materials, training of district level trainers, strengthening HMIS and procurement systems are all examples of the former; whereas improved supervision and in service training of ASHAs and ANMs would be under the purview of districts. In districts with localized issues, develop a district specific scheme.

Outcome

4.10 The above assessment of current status and situation analysis should lead to:

- Prioritization over the next three years in terms of strategies and districts/cities. States should consider prioritising districts which already have well functioning facilities/active SABLA programme so that tangible results can be shown in a relatively short period of time.
- Identification of key issues and gaps affecting delivery and utilization of AH related services in terms of the 7Cs i.e. coverage, content, communities, clinics, counselling, communication and convergence as well as cross cutting aspects such as programme management/supportive supervision and procurement and logistics.
- Decisions on strategic partnerships e.g. NGO implementation of PE, convergence within health and with other departments.

5 Where Do We Wish to Go?

5.01 This chapter sets out some suggestions for setting targets for objectives and strategies in terms of outcome and output/service delivery indicators respectively.

Choice of Indicators

5.02 A list of outcome and output and programme/service delivery indicators has been provided earlier in Exhibits 2.02 and 2.03 respectively. States should review the choice of indicators and are free to add to these. Targets should be set at both state and district levels for each of these indicators.

Basis for Setting Targets

5.03 In order to ensure that the targets are realistic, states may wish to consider the following:

- Past trends in performance; projecting these trends to establish targets would probably be very conservative.
- Likely impact of strategies/activities which could lead to accelerated improvement; in order to estimate the likely impact, try and obtain data from experiences elsewhere.
- Where possible carry out 'back of the envelope' cross-checks. For example, a projected increase in percentage of adolescents covered by PEs could be tallied with number of PEs to be made functional (identified, trained and supported) multiplied by say 15 adolescents.
- Poor performing districts may wish to target outcomes achieved by average/best districts in the state. The best districts in the state could set themselves targets in line with performance of better districts in other states. District wise targets should then be consolidated for the state as a whole and compared with the better/best performing states in the country, before a final determination of the target is made.
- Setting targets should be linked to resource allocation and hence, this would be an iterative process.

6 How Will We Get There?

6.01 As discussed in Chapter 2, the strategies/interventions to reach objectives could be grouped as:

- Directly under the purview of AH Division: community based (PE, AHD, WIFS, MHS) and facility based (AFHC and counsellors) and communication including Adolescent Helpline.
- Convergence within Health department: FP, MH (including VHND), RBSK, NACP, National Tobacco Control Programme, national Mental Health Programme, NCD, IEC division.
- Convergence with other departments/programmes: WCD (ICDS, KSY, BSY, SABLA), HRD (AEP, MDM), Youth Affairs and Sports (Adolescent Empowerment Scheme, National Service Scheme, NYKS, NPYAD).

This chapter commences with suggestions for operationalisation of the above strategies as well as for training and communication. In the case of WIFS and MHS, the existing guidelines are applicable.

Peer Education

6.02 The PE programme aims to ensure that adolescents or young people between the ages of 10-19 years benefit from regular and sustained peer education covering nutrition, sexual and reproductive health, conditions for NCDs, substance misuse, injuries and violence (including GBV) and mental health. This is eventually expected to improve life skills, knowledge and aptitude of adolescents.

6.03 Key features of the PE operational framework in rural areas include:

- In every village, it is expected that at least four peer educators i.e. Two male and two female peer educators will be selected per village/1000 population/ASHA habitation. To ensure coverage of adolescents in both schools and out of school, two peer educators (i.e., one male and one female) will be selected to work with young people in school, and similarly, two peer educators will be selected to work with young people out of school. States/districts can vary this norm depending upon the number of adolescents in school/out of school (drop outs).
- Each male and female peer educator will be expected to:
  - Form a group of 15-20 boys and girls respectively from their community and conduct weekly one to two hour participatory sessions using PE kits, which include books detailing a curriculum for PE sessions and games.
  - Participate in Adolescent Health Day to inform and educate young people and involve parents.
  - Refer young people to: 1) AFHCs and/or Adolescent Helpline; and 2) the Adolescent Health Day for health check-ups.
  - PEs will constitute Adolescent Health Club at sub-centre level, under the overall guidance of ANM. These clubs will meet monthly to discuss issues of PEs and get support from ANM.

- Peer Educators are expected to maintain a diary, including a brief overview of each session and the number of participants. At the end of each month, Peer Educators are to develop a brief composite report of the number of sessions and average attendance rates.

The PE programme in urban areas will operate in a similar manner as rural areas.

6.04 Annexure I provides operating guidelines for implementing Peer Education (PE) at the village and urban slum levels. The guidelines cover a) programme planning and preparation, including implementation modalities; b) recruitment and retention of peer educators; c) training; d) facilitating PE sessions; e) supportive supervision and management; and finally, f) monitoring and review.

Adolescent Health Day

6.05 AHD, one of the strategies to achieve the objectives of the adolescent health program seeks to:

- Improve coverage with preventive and promotive interventions for adolescents.
- Increase awareness among adolescents, parents and families and stakeholders about the determinants of adolescent health such as nutrition, SRH, mental health, injuries and violence (including GBV), substance misuse and NCDs.
- Improve awareness of other AH related services, in particular Adolescent Friendly Health Clinics (AFHCs)/ helplines.

6.06 The AHD should be organized in every village once every quarter on a convenient day (preferably on a Sunday) following the VHND; in Sabla districts, this day should coincide with the existing Kishori Diwas. AWCs or community spaces may be used as venues for organizing the AHD. During an AHD, services should be offered to all the adolescent target groups (male/female; 10-14 and 15-19 age; school going, drop out; and married adolescents). Efforts should also be made to reach out to other stakeholders including parents, school teachers and PRI members to sensitize them on adolescent health needs.

Detailed operating guidelines for implementation of the AHD are provided in Annexure II.

Adolescent Friendly Health Clinics (AFHCs)

6.07 Both the Peer Education Programme and the AHD should lead to referrals to AHFCs which would seek to provide a combination of commodities, IEC and curative services at PHC, CHC and DH levels plus outreach and referral services:

Commodities

- Weekly Iron & Folic Acid Supplementation & Albendezole
- Sanitary napkins
- Contraceptives
- Medicines

Information (IEC & IPC)

- Counselling on nutrition, menstrual disorders, personal hygiene, menstrual hygiene, use of sanitary napkins, use of contraceptives, sexual concerns, depression, sexual abuse, gender violence, substance misuse and promoting healthy behavior to prevent non communicable diseases
- Posters/booklets/pamphlets, wall writing and visuals

Curative Services

- Treatment of severe malnutrition
- Treatment of common RTI/STI problems
- Treatment of menstrual disorders
- Treatment for sexual concerns of males and female
- Mental health service/management of depression
- Treatment of non communicable diseases and other common ailments
- Management of injuries related to accidents and violence
- Management of sexual abuse among girls
- Management of substance misuse
- Treatment of non-communicable diseases like hypertension, stroke, cardio-vascular diseases and diabetes

Counsellors should be recruited at AFHCs operationalized at CHC, SDH and DH level based as mentioned in Section 4.02.

Refer Annexure III for guidelines for operationalisation of AFHCs.

Adolescent Helpline

6.08 Many states are in the process of setting up a 104 Helpline for health related information for the public at large and service providers as well as grievance redressal. States should consider expanding the scope of 104 to address the needs of adolescents.

Convergence within Health Department

6.09 As shown in Annexure IV, there are a number of potential areas of synergy within the health department. These include VHND, MMU and RBSK. In addition, FP, MH and SACS would also offer services to adolescents. For example, the scope of the monthly VHND could be expanded to create awareness of AH needs, roles of Peer Educators and the availability of services at AFHCs; similarly FP and AH could, as a minimum start collecting disaggregated data to capture services to adolescents (various sub groups).

6.10 MoHFW would review key relevant guidelines through a AH "lens" and issue revised guidelines.

Convergence with Other Departments/Programmes

6.11 Possible areas of convergence with other departments in particular Education, WCD, Youth Affairs and Sports/Social Welfare have also been listed in Annexure IV. In order to take this forward:

- A meeting of SCAH should be held wherein the key features of the new AH strategy and potential areas of convergence/overlap presented and discussed. For example, the AHD could be held on the same day as the Kishori Samooh and Peer Education could be initiated through schools with teachers providing necessary support. The outcome of the meeting should be an in principle agreement on areas of convergence and broad modalities.
- Subsequently, for each area of convergence a detailed memorandum of understanding (MOU) should be drawn up; the MOU should, inter alia, articulate the relative roles of each department, the implementation modalities, estimate of costs and cost sharing arrangements.
- Once the memorandum of understanding has been signed, the costs should be budgeted for in the district and state NHM PIPs.
- Subsequent to approval, joint guidelines/standard operating procedures should be prepared and released and implementation could commence.

Training

Preparation of training plan

6.12 The State Nodal Officer AH should prepare a comprehensive district wise training plan across all components of AH. Key steps are:

- The starting point would be to pull together target groups, training needs and training materials[10] across all components of AH (PE, AFHC, AHD, MHS, WIFS) as well as agreed convergence strategies.
- Revisit training materials and if necessary prepare training programmes to fill gaps e.g. the ASHA may need to be sensitised regarding the PE programme; mainstream AH in other training programmes planned for the same target group.
- Estimate training load by target group in the prioritised districts for roll out of the AH strategy. Operationalisation of AFHCs, PE and AHD, MHS and WIFS, in particular should be synchronised i.e. the State should be in a position to commit to districts where the AH strategy in its entirety is fully operationalised (rather than spreading its resources thinly across the state).
- Consult SIHFW/Training section in DHFW to assess other training programmes planned for the same target group. Subsequently prepare a realistic training calendar ensuring that the identified staff would be released for training.

[10] Four training programmes have been developed by MoHFW for Counsellors (6 days), Peer Educators (6 days), MO (3 days) and ANM (4 days).

Training implementation

6.13 Training of Peer Educators should be handled through the existing system for training of ASHAs. In the case of large training loads State may consider outsourcing training to an appropriate training agency. Care should be taken to ensure that the contract with the training agency stipulates relative roles of DHFW and the agency and mechanisms for ensuring quality of training.

6.14 The Nodal Officer, AH at state and district levels should monitor performance against the plan and take necessary corrective action as and when necessary. For training of counsellors, it is suggested to involve medical colleges and universities with expertise in psychology and counselling. The pool of master trainers identified in these institutes should also act as the support system for counsellors through telephonic consultations and bimonthly meetings.

Training Duration

Training	TOT- State/District/Block level	Training of providers
Medical Officer	4 days	4 days
ANM	5 days	5 days
Counsellors	5 days	6 days
Peer Educator	5 days (Through ASHA mechanism)	6 days

Communication

6.15 Communication is a key cross-cutting component of the AH strategy. In order to operationalise the communication frame work provided in the National AH strategy document, states should:

- Carry out a base-line assessment of awareness levels, behavioral practices and underlying factors as well as media habits (including mobile phones/social media) amongst the target groups, service providers and key influencing agents in the districts planned for Year 1. There would be variations across districts and even within a district. Indicators listed in Chapter 2 should be considered.
- Identify key behaviors to be changed.
- Set targets for improvement in awareness levels and changes in behavior by district and target group.
- Develop a media plan which would largely be a combination of mid media, social media/mobile phones and IPC; this would need to address the needs of target groups, service providers and key influencing agents as well as sensitisation of service providers. Ensure that the media plan has provision for concurrent monitoring of impact.
- Prepare budgets and obtain necessary approvals.

The State nodal officer for AH should take the lead for the above. States should consider outsourcing the base-line assessment and preparation of the media plan.

Strengthening Role of Parents

6.16 Parents have a key role in supporting adolescents. State needs to identify strategies to work with existing parent-teacher associations/similar platforms to sensitise parents on adolescent health. In addition, during Adolescent Health Day the Counsellor or the trained MO/ ANM should hold group sessions with parents to provide:

- Information on topics related to adolescent health as mentioned in Annexure II. In addition feedback should be collected on the area specific adolescent and parenting problems, and efforts should be made to help parents get information on resolving these issues.
- Skills: Efforts should be made to help parents develop/enhance skills on communicating with adolescents, such as talking with adolescents about sex, listening to adolescents' concerns, or talking without shouting.
- Support: Parents should be educated and sensitised on the resources available for assisting them in managing adolescent issues.

7 What Resources Are Required?

7.01 This chapter sets out suggestions for budget preparation in terms of the adolescent health strategies and the level of detailing required including formats.

Adolescent Health as Part of NHM Budget

7.02 As mentioned in Chapter 2, the NHM budget would have separate financial envelopes for PART I: NRHM plus RMNCH+A (including immunization) Flexipool[11]; PART II: NUHM Flexipool; PART III: Flexipool for Disease Control Programmes and PART IV: Flexipool for non-communicable diseases including injury and trauma; most of the adolescent health activities can be budgeted under various sections of Part I of NHM budget. The adolescent health budget includes adolescent health services, human resource, training, programme management, ASHA incentives, PRI (orientation workshops), IEC/BCC activities, PPP/NGOs (including intersectoral convergence), procurement and new initiatives (e.g. adolescent helpline).

Basis for Budget Preparation

7.03 The starting point for budget preparation is to cost each strategy/activity identified in Chapter 6. Please note:

- As far as possible, estimate the quantity of work to be carried out in each quarter for 2014/15 and for the whole remaining two years 2015/16 and 2016/17.
- For each activity, estimate the rate or unit cost.
- Where a quantity and rate cannot be estimated, states can estimate a lump sum amount. But this should be the exception.
- The state adolescent health strategy and the budget should be aligned.

7.04 Use the adolescent health budget formats provided in Annexure V. The formats are self explanatory. For convenience, efforts have been made to retain the existing budget heads and codes as per the NMH PIP formats. The adolescent health budget can be easily incorporated into the state PIP.

[11] The erstwhile, RCH, Mission Flexi-pool and Immunization components of PIPs.

Process of Iteration

7.05 Budget preparation is a process of iteration; once a first cut of the adolescent health budget has been prepared, this would need to be extensively discussed within the Adolescent Health Division, State Planning Team and the State NHM Director in order to:

- Re-visit and agree priorities. Please note that the allocation of funds should be in-line with the situation analysis. For example, if a district has a reasonable numbers of functional adolescent clinics, then with minimal efforts, AFHCs could be operationalised.
- Identify other sources of funds.
- Scale down targets for outputs and service delivery.

7.06 Typically the budget would need to be reworked several times before consistency between the situation analyses, targeted outcomes, strategies, work plan and allocation of funds is achieved.

8 How Do We Know We Are on the Right Track?

(Programme Monitoring & Review)

8.01 States should establish a system of supportive supervision to improve programme monitoring by way of monthly reviews at state, district and block levels and pre determined schedule of field visits to AFHCs, AHDs and Peer Education sessions.

8.02 In addition, on a quarterly basis, states would be expected to report holistically in terms of:

- Achievement against key outcomes/outputs
- Physical achievement vis-à-vis the activities specified in the State PIP; and corresponding expenditure against each activity
- Variance analysis: If the targeted outcomes/outputs have not been met, the reasons for the shortfall, corrective action planned/taken and, if necessary a modification in the targets

The quarterly report (outcomes, physical progress with financial expenditure) should show achievement in percentage terms against the activities specified in the state PIP. Format for physical progress is provided in Annexure VI. The report together with the variance analysis indicating corrective action, as well as a brief description of key achievements should be sent to MoHFW in the month following the reporting quarter.

Annexure I

Operating Guidelines for Peer Education

Contents

1 Introduction

1.1 The National Adolescent Health (AH) Strategy places much needed emphasis on preventive and promotive care for young people between the ages of 10 to 19 years. A key component of this strategy is engendering peer education at the community level. This is based on the fundamental premise that young people are much more likely to be receptive to information communicated by their peers, and would also be more likely to change their behavior if peers they trusted advocate change.

1.2 In this context, this document highlights the key processes for implementing Peer Education (PE) at the village and urban slum levels. It begins with a brief introduction to PE and the PE model including its overall aim, operational framework and key factors for success. This is followed by separate sections detailing—a) programme planning and preparation, including implementation modalities; b) recruitment and retention of peer educators; c) training; d) facilitating PE sessions; e) supportive supervision and management; f) monitoring and review and finally, g) key steps for rolling out the peer education programme.

1.3 This Guideline will support programme managers at the state, district and block level to rollout the PE program in districts and villages. It also includes monitoring formats to support implementation.

Exhibit 1.01: Structure of Operating Guidelines for Peer Education

What is Peer Education (PE)?

1.4 Globally, PE is a widely used approach for promoting health and wellbeing amongst young people. It is defined as a process through which a selected and trained individual or peer educator leads organized activities to provide information, education, and/or resources to their peers. A 'peer educator' is typically someone who belongs to the same social group, sharing one or more social or demographic characteristics such as age or education.

1.5 In general, the role of a peer educator can be varied—from 'information sharing' through distribution of appropriate materials, to 'peer education' which involves sessions aimed at supporting young people to build on their knowledge, aptitude and skills and finally, to providing counselling or intensive psychological support through trained counsellors.

1.6 The following Exhibit 1.02 shows how information sharing, peer education and counselling differ. This operating guideline focuses on peer education, which forms a key component of a larger strategy that involves IEC/IPC through Adolescent Health Days and delivering counselling through trained counsellors at the Adolescent Helpline and Adolescent Friendly Health Clinics (AFHCs).

Exhibit 1.02: Types of interventions[i]

	Information sharing	Peer Education	Peer Counselling
Objectives	Awareness Information Attitude change	Awareness Information Attitude change Skills building First referral point for counselling	Information Attitude change Self esteem Psychological support
Coverage	High	Medium	Low
Intensity	Low	Medium/High	High
Target audience	Community Parents Large groups of adolescents	Small groups of adolescents, and in some cases individuals	Individuals, and in some cases small groups
Types of interventions	Adolescent Health Day	Peer educators conducting repeated sessions with the same group of adolescents based on a defined curriculum	Adolescent Helpline AFHCs at CHCs and/or District Hospitals

Overview of NHM-AH Peer Education (PE) Programme

1.7 As defined in the National AH strategy, the PE programme aims to ensure that adolescents or young people between the ages of 10-19 years benefit from regular and sustained peer education covering nutrition, sexual and reproductive health, conditions for NCDs, substance misuse, injuries and violence (including GBV) and mental health. This is eventually expected to improve life skills, knowledge and aptitude of adolescents.

PE Operational Framework (Rural)

1.8 To operationalise PE in rural areas, it is expected that four peer educators i.e. **two male and two female peer educators** will be selected in each village/1000 population. To ensure coverage of adolescents in both schools and out of school, two peer educators (i.e., one male and one female) will be selected to work with young people in school, and similarly, two peer educators will be selected to work with young people out of school. States/ districts can vary this norm depending upon the number of adolescents in school/out of school (drop outs).

1.9 Each Peer Educator is expected to:

- Form a group of 15-20 boys and girls (separate group of boys and girls) respectively from their community and conduct a two hour sessions per week–using PE kits, which include books detailing a curriculum for PE sessions and games (there are a total of eight modules and 15 sessions)
- Participate in and organise adolescents for the Adolescent Health Day (AHD)
- Refer young people to:
  - Adolescent Health Clinics, and/or Adolescent Helpline and
  - Inform and mobilize adolescents to participate in Adolescent Health Day
- Report on activities.

1.10 To provide a supportive environment for Peer Educators:

- *Form one or two (one male and one female)* ***Adolescent Friendly Club (AFC)*** at the sub-health center level (which typically covers five villages/5000 population) composed of 10 to 20 Peer Educators each. The AFC is expected to meet once every month to:
  - discuss their individual sessions and any issues or questions they have;
  - plan upcoming sessions and AHD
  - organise activities such as drawing competition, skits, qizzes and debates for Peer Educators and adolescents
- The AFC meeting should be moderated by ANM with the aim of supporting and further developing the skills of Peer Educators. The monthly AFC meetings could be held at the sub health centers or any other designated place convenient for the Peer Educators to travel.
- As a moderators for the AFC the ANM will provide regular feedback to peer educators on what's working well and what could be improved. This will be based on discussing/assessing one PE session per month for every peer educator.

1.11 Finally to enable monitoring, PEs are expected to maintain a diary, including a brief overview of each session and the number of participants. At the end of each month, peer educators are to develop a brief composite report of the number of sessions and average attendance rates.

PE Operational Framework (Urban)

1.12 The PE programme in urban areas will operate in a similar manner as in rural areas. For every Urban Primary Healthcare Center (UPHC), four peer educators will be selected and trained. One male and one

female peer educator will form and conduct weekly PE sessions with a group of 15-20 boys and girls in school respectively and similarly, one male and one female peer educator will conduct weekly sessions with groups of 15-20 out of school boys and girls respectively. States can vary the number of PEs, depending upon the response from the community.

1.13 The supportive environment and reporting arrangements for Peer Educators would be similar to that in rural areas.

Key Factors of Success

1.14 The development and implementation of PE programme in each state should take into consideration the following factors of success[ii]:

- Appropriate selection, quality training and intensive supportive supervision is necessary to ensure the programme's effectiveness. Without this, Peer Educators would find it difficult to move beyond simply sharing information towards building skills for behavior change.
- Creating community support for PE at the onset is necessary for creating an enabling environment for peer educators and for the overall sustainability of the programme. To this end, Field level workers like ASHA and platforms like VHSCs will create a support mechanism to inform, educate and involve different type of stakeholders—parents, in-laws where appropriate and community leaders—in the implementation of PE programme.
- Peer educators should share similar social and demographic characteristics (e.g. age, sex, schooling, etc.) as their peer group, as that this is much more likely to enable communication and ensure the success of PE programme.
- Incentives are necessary to minimize turnover of Peer Educators. Volunteer Peer Educators have limited time and in this context, non-financial incentives would go a long way towards ensuring the continued participation and assuring parents. Direct financial incentives are not recommended.
- Motivation and retention of Peer Educators will also be significantly enabled by ensuring that they share in the decision-making process and are given autonomy to further develop the PE programme.
- PE sessions should be tailored to address the needs of adolescent groups or participants. This involves two key aspects:
  - While there is a standardised curriculum for conducting weekly PE sessions, flexibility should be built to adapt or bring forward topics for discussions so that the needs of participants are met in a culturally sensitive manner (for e.g. discussion on the importance of ante and post-natal care should be prioritised if there are pregnant and/or married adolescent girls in a group).
  - PE sessions should take into consideration participants preferences, i.e. they should be held at times and places most suitable for participants.

1.15 The following sections detail the processes for rolling out the PE programme across districts and villages.

2

Programme Planning and Preparation

2.1 This section provides guidelines for developing an operational plan for the implementation of PE programme in districts and villages. It assumes that states are—1) looking to set up a new PE programme, but these guidelines can be used to strengthen and/or scale up existing programmes; 2) states will implement PE programme in a phased manner; and 3) each year, preparatory activities for PE programme will take approximately 3 months and implementation will be over a 6 month period.

Determine Who will Implement the Programme

2.2 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:

- Direct implementation by the DoHFW.
- *Implementation is outsourced to Non-Government Organisations (NGOs)* who would report on activities and progress to the District Nodal AH Officer.

Direct Implementation Model

2.3 In this model, it is expected that (1) the 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 (2) the ANMs/MHWs moderate the monthly AFC sessions and (3) The PHC MOIC provides oversight.

2.4 The support to Peer Educators would be provided by the support structure for the community process interventions – viz, ASHA, ASHA facilitator and block community mobilizer (role of ASHA and ASHA facilitator is provided in Exhibit 2.02). Support/oversight to ASHA would be provided by the ASHA facilitator who would review the programme during the village visit. As far as possible, the visit should coincide with a PE session. The report prepared by each PE (see later) would be collected by the ASHA and discussed by the ASHA facilitator during the PE session/village meeting. The reports from all facilitators (normative: nine in a block) are given to the CHC/Block counsellor during the monthly meeting of ASHA facilitators conducted by the Block Community Mobilizer.

2.5 Implementation will begin with training for key staff members i.e. MOIC (4 days), ANM/MPW (5 days) and ASHA (on AH Module and her role as PE Coordinator)[1]. This will be followed by creating community and parent support for PE programme, selecting and training peer educators, formation of adolescent groups, supportive supervision for peer educators, and monitoring.

[1] In addition, the ASHA may participate in the 6 day training programme for Peer Educators. Further, NHSRC is in the process of developing a module on Adolescent Health for ASHA.

Exhibit 2.01: Direct Implementation Structure

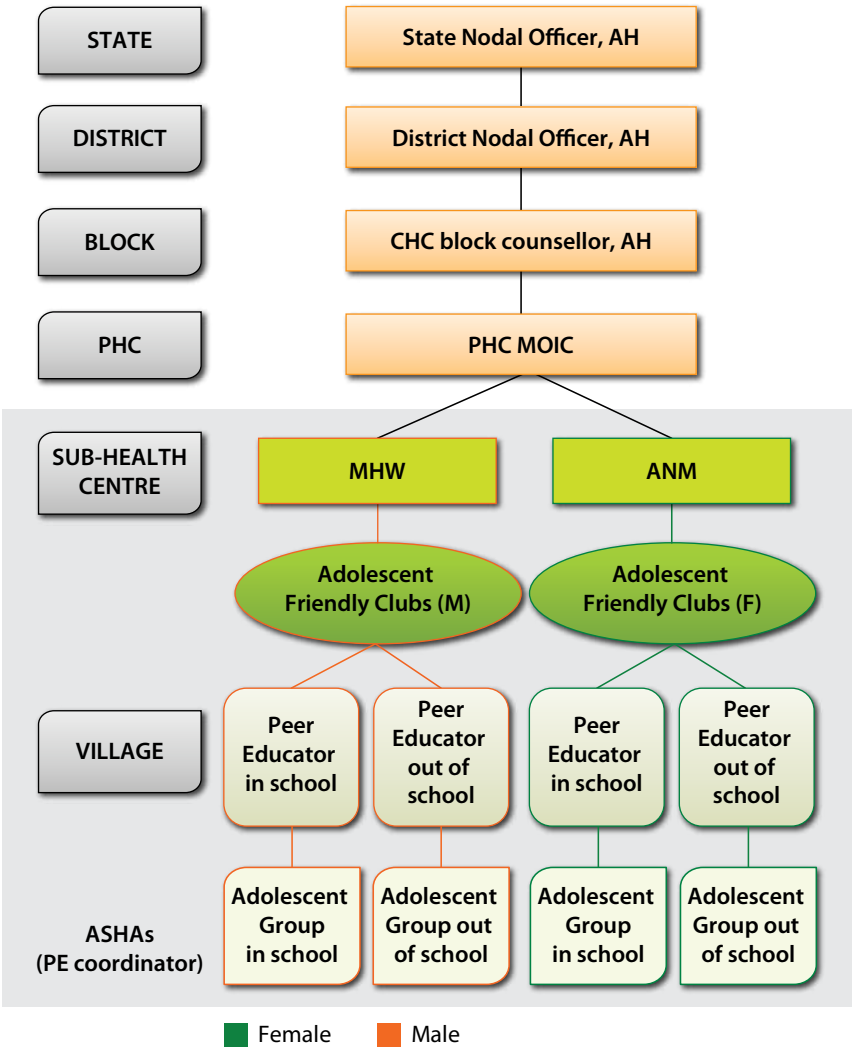


Exhibit 2.02: Indicative Role of ASHA and ASHA Facilitator

ASHA

- Help in identification of potential peer educators and participants in consultation with community leaders and parents.
- Support Peer Educator to form his/her groups
- Act as first level of 'go-to' person for resolving ad hoc issues faced by Peer Educators
- Attend at least one PE session per peer educator per month to resolve matters such as poor attendance, availability of venue, etc.
- Collect and consolidate Peer Educators monthly report

ASHA Facilitator

- Attend at least one PE session during her monthly meeting with ASHAs to understand and resolve any issues raised by ASHAs/Peer Educators
- Provide inputs and help ASHA to resolve any issue faced by ASHA on Peer Educator (e.g. recruitment of Peer Educator, poor attendance during group meetings etc.)
- Collect and consolidate Peer Educator monthly report (collected by ASHAs)

The following Exhibit 2.03 provides an overview of the key activities, and as shown minimum one time commitment for ANM/MHW, ASHA and Peer Educator would be 10, 2.5 and 8 days respectively; while the corresponding time requirement each month would be 2.5, 1 and 4 days respectively.

Exhibit 2.03: Key Activities and Time Commitment in Rural Areas

Activities	Description	PHC MOIC	Time commitment		
			ANM/MHW	ASHA	PE
One Time Activities					
1. Creating community support through sensitization	Meetings with key stakeholders i.e. community leaders (including Panchayat and VHSC members), and parents of adolescents should be conducted to build consensus and identify potential peer educators and participants. Discussions with stakeholders should involve: • the need for adolescent health • advocacy for the relevance and effectiveness of peer education • a description of the PE programme and its benefits for peer educators and adolescent groups. This should be followed by a community event to further create community support, and enable the final selection of peer educators.	N/A	10 days (assuming two days per village)	2 days	N/A
2. Select four peer educators	Peer educators, who must be volunteers, may be selected at the community event mentioned above (i.e. two (one male and one female) peer educators working with young people in school, and two (one male and one female) peer educators working with young people out of school). Ensure that selected peer educators and their parents are made aware of expectations including time commitment, code of conduct and available non-financial incentives.				
3. Form adolescent groups	Each peer educator will be responsible for forming an adolescent group of 15-20 adolescents. This involves compiling a list of potential participants with input from community leaders, AWW and ASHA, and convincing them to join. Should there be any queries from the community or parents, the ASHA can intervene.	N/A	N/A	0.5 days	2 days
4. Train Peer Educators	A six-day training programmer, using PE kits, should be organised for peer educators.	N/A	N/A	N/A	6 days
Total time commitment *(each day is estimated as 8 hours)*			**10 days**	**2.5 days**	**8 days**

Contd...

Activities	Description	PHC MOIC	Time commitment		
			ANM/MHW	ASHA	PE
Ongoing Activities *(Time estimated per month)*					
1. *Conduct PE sessions and maintain session dairy*	Each peer educator will be responsible for: 1) conducting four PE sessions with his or her group each month (based on a prescribed curriculum); and 2) maintaining a diary with details on each session – Each peer group is expected to go through 15 sessions (one session per week). Each peer educator is expected to spend 2.5 hrs per session (i.e. 2 hours for conducting the session, and half an hour for maintaining the diary).	N/A	N/A	N/A	1.5 days/ month
2. *Organize monthly AFC meeting*	ANM and MHW to organize and moderate a monthly Adolescent Friendly Club (AFC) meeting for 20 adolescents (10 female peer educators + 10 female educators). Each AFC meeting should take approximately four hours (including travel time) and be held at a location convenient for peer educators.	N/A	0.5 day/ month	N/A	1 day/ month
3. *Help in organizing AHD (in addition to Kishori Diwas)*	PE will discuss with their group on the objectives and process of AHD; mobilize the group to reach out to all the adolescents in the village to communicate the date, venue and the benefits of attending AHD. Each PE is expected to spend 1.5 days per quarter for this activity.				0.5 day/ month
4. *Admin. Support for Peer Educators*	At least one PE session per peer educator should be covered each month primarily to resolve matters such as poor attendance, availability of venue, etc.	N/A	N/A	1 day/ month	N/A
5. *Reporting PE session progress*	Each peer educator will be expected to submit a monthly report based on a consolidation of weekly activities. This should take approximately 2 to 4 hours each month.	N/A	N/A	N/A	0.5 day/ month
6. *Monitoring-field visits*	PHC MOIC to assess the quality of Peer Education, as a part of existing routine field visits. Approximately two adolescent groups should be covered in a month.	0.5 day/ month	N/A	N/A	N/A
7. *Reporting, analysis and feedback*	This involves: A) Preparing, analyzing and submitting a monthly progress report for block level consolidation; B) Communicating feedback down the line, along with suggestions for course correction. PHC MOIC to spend one day per month, and ASHA and MHW to spend one day per month each.	1 day/ month	1 day/ month	N/A	N/A

Contd...

Activities	Description	PHC MOIC	Time commitment		
			ANM/MHW	ASHA	PE
8. Disburse non-financial incentives	A public awards ceremony (during Adolescent health day–once a quarter) for disbursing non-financial incentives for peer educators. With support from community leaders, this should take one ANM/MHW approximately 2 hour per village per quarter, i.e. 8 hrs per village in a year or 40 hrs per year for 5 villages.	N/A	0.5 days	N/A	N/A
9. Exit interview and transition of peer educators	An exit interview should be conducted i.e. meet with peer educators that decide to leave the programme to determine why they wish to leave and obtain feedback. To ease transition, departing peer educators should be asked to use a scheduled PE session for—1) getting members of their adolescent group to vote for their replacement; and 2) providing support/advise to the newly appointed peer educator.	N/A	0.5 days	N/A	0.5 days
Total time commitment *(each day is estimated as 8 hours)*		**1.5 days/ month**	**2.5 days/ month**	**1 day/ month**	**4 day/ month**

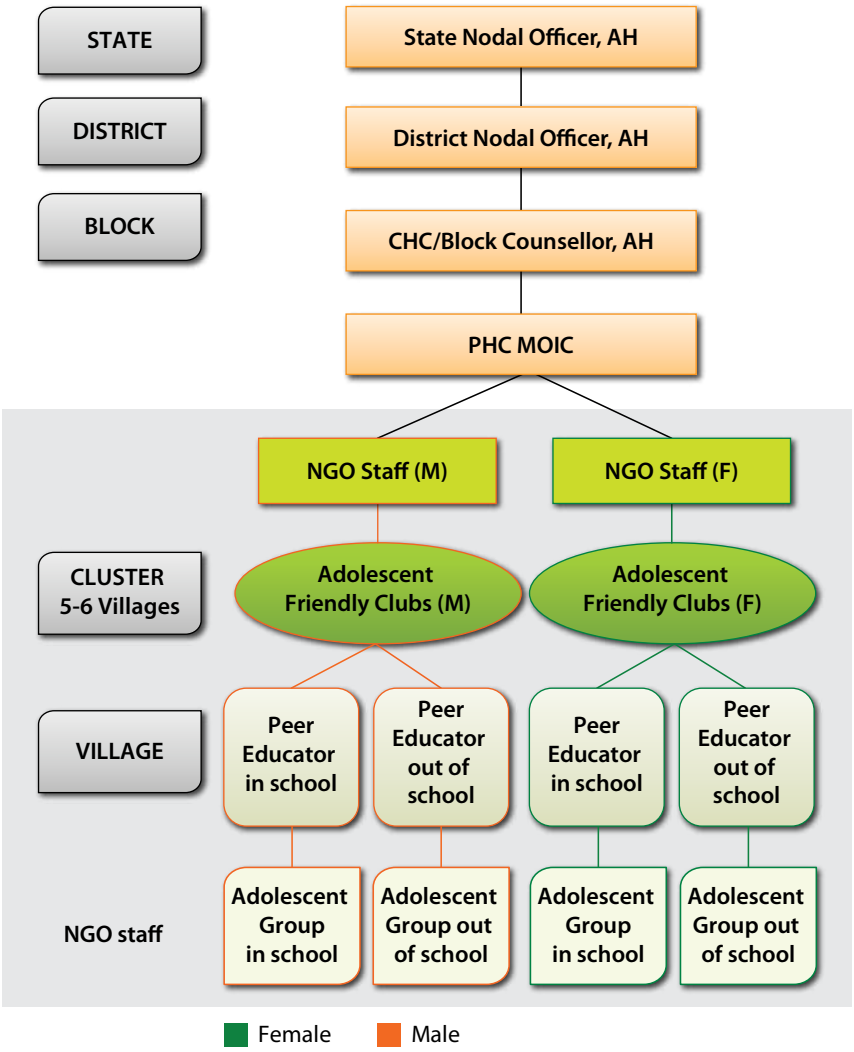
NGO Implementation Model

2.6 Where well-established field-level NGOs (in particular those implementing the District ASHA Resource Centre) are in place and it is difficult for the PHC MOIC, ANM/MPW and ASHA to allocate the above time, implementation by NGOs could be considered (Exhibit 2.04). The NGO is more likely to bring in the necessary commitment and resources to implement an intensive community based PE programme; however, the NGO staff is unlikely to match the degree of rapport between the community and ASHA.

2.7 Where implementation has been outsourced to NGOs, the following processes should be put in place to further enable the sustainability and effectiveness of PE programme outsourced to NGOs:

- Tendering process for selecting the most qualified field-level NGOs for one or more blocks. As far as possible, NGOs that have adequate capacity and at least two or more years of experience in implementing similar health/ community based programmes should be selected.
- Well-defined system of monitoring the performance of NGOs i.e. District and Block AH Counsellor should work with the selected NGOs to define targets and conduct six-monthly performance reviews based on: 1) monitoring reports submitted by the implementing agencies/NGO; and 2) random visits to implementation sites. Where performance is found to be weak, states should consider not renewing the NGO's contract.
- Phasing out the role of NGOs once the PE programme has been running for at-least two years and has been embedded within the community.

Exhibit 2.04: NGO/Outsourced Model Implementation Structure



NGO/Outsourced Model

The State Nodal Officer, would be responsible for the overall management and monitoring

The District, Nodal officer, AH and CHC/Block Counsellor, AH would be responsible for ensuring:

- Management and monitoring of NGOs
- Training
- Supply NGOs with Peer Educator kits
- Arrange non-financial incentives for Peer Educators

NGOs will be responsible for:

- Recruiting staff with a degree in MSW or a minimum of two years of counselling experience to support village and AFC level activities.
- Engendering community and parental support
- Selecting Peer Educators, with input from community leaders, ANMs, ASHAs, Teachers (where feasible) etc.
- Training of Peer Educators and distribution of PE kits
- Formation of Adolescent Groups
- Facilitating AFC meetings and monitoring PE sessions
- Reporting on progress to PHC MOIC, Block Counsellors, AH and District Nodal Officer, AH

Prepare a Work Plan and Budget

2.8 States should develop a work plan for the implementation of PE in each selected district. In order to do this, state should issue guidelines for districts to develop an annual work plan and budget.

2.9 The work plan should identify key activities and timeframe. It is broadly expected that over a twelve month period:

- Planning, and contracting out services to NGOs where relevant will take three months.
- Preparatory activities, including creating community support, recruitment/selection and training of stakeholders will take at least three months.
- PE sessions for each Adolescent Group would be conducted over a six-month period (minimum of four PE sessions per month).
- AFCs meetings to be held once every month over a six-month period.

2.10 Districts should then determine what human, financial and nonfinancial resources will be required for implementing each activity and budget accordingly. For instance, incentives for ASHA for providing supportive supervision, number of PE kits required and non-financial incentives for Peer Educators should all be budgeted for.

2.11 The work plan and budget for PE should be integrated into the overall District Health Plan.

Coordinate with Other Departments

2.12 States and Districts should consider exploring opportunities for working with the Department of Education and Women and Child Development where feasible. For instance, Peer Education could be implemented in schools, with nodal teachers responsible for selecting peer educators, facilitating and monitoring PE sessions held at schools. Similarly for adolescent girls out of school, Peer Education could be implemented in conjunction with the Sabla Scheme at ICDS centers.

2.13 Similarly, VHSNC may be involved to meet once in a month to discuss Adolescent Health issues, where the Peer Educator may provide inputs based on their experience from the weekly sessions.

3

Recruitment and Retention

3.1 This section explains how to select peer educators and ensure their retention through supportive supervision and non-financial incentives.

Criteria for Selecting Peer Educators

3.2 States should consider developing criteria for selecting peer educators. This should include factors such as:

- The Peer Educator must be a volunteer
- Age—between the ages of 15 to 19
- Similar social and demographic characteristics as adolescent groups—e.g. sex and educational level;
- Ability and willingness to dedicate adequate time to the program
- Personality traits such as high motivation, entrepreneurism, leadership qualities etc.
- Preference to be given to adolescents involved in similar work in related schemes such as SABLA.
- Appropriate representation of under-privileged socio-economic group.

Selection of Peer Educators

3.3 As mentioned in the preceding section, four peer educators per village or UPHC should be selected with input from stakeholders. At the village level, VHNSCs will facilitate the selection of PEs and ASHAs will coordinate the selection process.

3.4 To select peer educators, a community event could be organised, where interested adolescents (between the ages of 15 to 19), community leaders, local stakeholders and parents would be invited. At the start of the event, the following should be clearly communicated: (i) the importance of the PE programme, (ii) the amount of time peer educators will be expected to give i.e. six days of training plus two hours each week, (iii) their roles and responsibilities, and (iv) the non-financial incentives available for peer educators.

3.5 A friendly competition amongst interested adolescents should then be conducted to test their knowledge of adolescent health as well as their leadership and team building skills. The four most successful adolescents (two boys and two girls) should then be selected as peer educators by community leaders and be registered using the form provided in ***Annexure I (A)***.

System for Providing Incentives

3.6 A system for non-financial incentives and positive feedback should be developed. These could include exposure visits/camps, public recognition and awards, sponsorship to English language or computer courses, goods such as computers, etc. States and districts should also consider exploring options for corporate or community sponsorship. Direct financial incentives are not recommended.

Transition of Peer Educators

3.7 An exit interview should be considered, which involves meeting with departing peer educators to determine why they wish to leave and obtain feedback. To ease transition, departing peer educators should as a part of a scheduled PE session—1) ask members of their group to vote for their replacement; and 2) if feasible, support/advise the newly appointed peer educator.

4 Training and Development

4.1 This section highlights the process of planning and organizing training of peer educators. For details on the content of training programmes and PE kit, please refer to the PE facilitator training guide, Peer Education curriculum, and PE kit guidelines developed and/or issued by the Ministry of Health and Family Welfare.

Training Plan and Process

4.2 States should use the existing ASHA training system for training of peer educators (6 days); it may be necessary to stagger the training in response to participant requirements. For other target groups consider either: (i) outsourcing training to a well-established and reputed training agency or (ii) directly conducting training. The advantage of the first option is that it may be more efficient depending on the capacity of SIHFW although it may be more expensive.

4.3 The AH training programmes for MO, ANM, counsellors and ASHA have PE related modules. State should ensure that the above personnel in the identified districts are first trained before roll out of the PE programme.

Development of Peer Educators

4.4 It is recommended that the skills of peer educators should be continuously developed through:

- Exposure visits, which may include attending state or district level conferences/sessions on AH, or visiting successful PE sessions conducted by other peer educators.
- Supportive supervision, including feedback and suggestions for improving the quality of PE sessions, through monthly AFC meetings of peer educators and assessment of one PE session per month for every peer educator.

4.5 Peer educators should be advised to:

- Tailor PE sessions such that the needs of specific sub-groups of adolescents are met. Here characteristics such as age, vulnerability, marital status, and level of risk for HIV, and pregnancy should be taken into consideration.
- Conduct participatory sessions using the PE Kit, with opportunities for adolescents to ask questions either annonymously using the question box during the PE session or privately after the session.
- Develop a schedule that encourages regular attendance. For example, a group might determine that they will meet weekly every Sunday for two hours over a six month period in a place that is convenient for all.
- Refer adolescents to Adolescent Helpline, AFHCs, AHDs and other places such as vocational training institutes.

5 Monitoring and Reporting

5.1 This section provides guidelines for monitoring and illustrative tools/reporting forms for the peer education programme. This should enable states and districts to determine what aspects of the programme are working well as well as identify further areas for improvement.

Monitoring Progress in Each District

5.2 District Nodal AH officers are advised to:

- Set targets at the start of the programme (for indicators refer to Chapter 2 of the Operational framework for AH).
- Prepare, analyze and submit a monthly progress report by the 15th of each month for state level consolidation. An illustrative format has been included in ***Annexure I(B)***;
- Communicate feedback down the line, along with suggestions for course correction. This should be based on an assessment of the overall performance of peer educators and an analysis of monthly reports and quarterly trends.

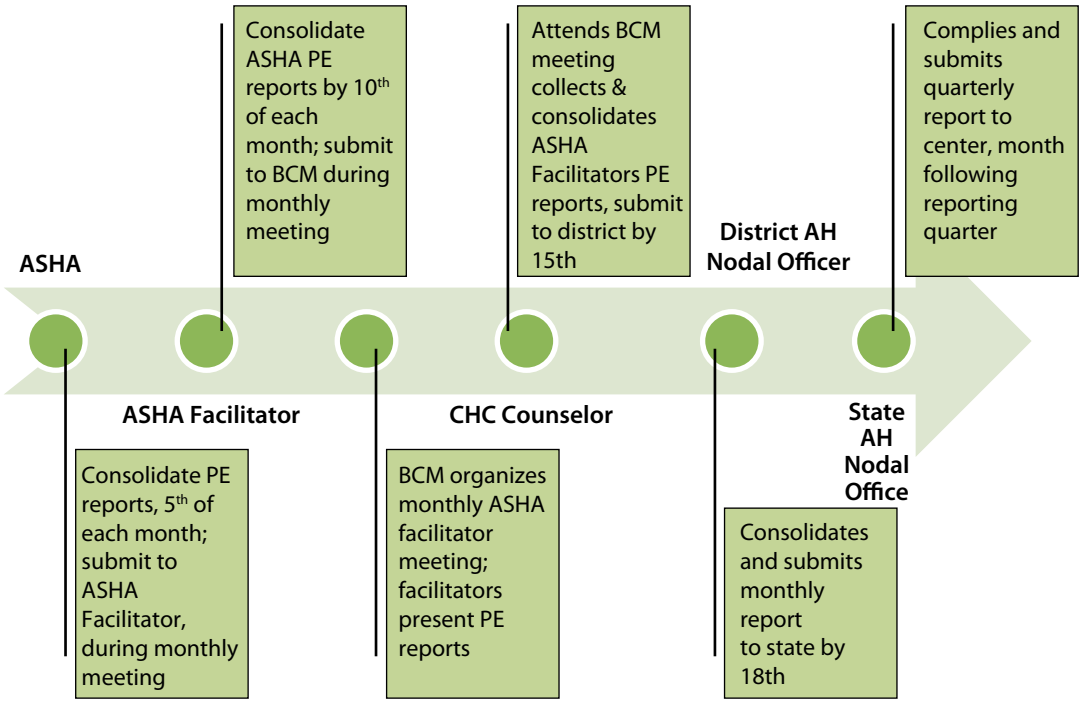
5.3 Quarterly consolidated state reports, based on district PE monitoring reports[2] should be submitted to MoHFW in the month following the reporting quarter.

Monitoring the Performance at Block Level

5.4 An illustrative block level reporting format is provided in ***Annexure I(C)***, which should be consolidated into a block level report by CHC counsellor by the 10th of each month. CHC counsellor should collect monthly report from the Block Community Mobiliser (BCM) during the monthly ASHA facilitator meeting. An indicative data flow mechanism is provided in Exhibit 5.01.

[2] This would be a report covering all AH interventions. For format refer to Annexure VI.

Exhibit 5.01: Data flow for Monitoring PE Activities



Monitoring the Performance of Peer Educators

5.5 ASHA may assess the performance of peer educators and provide suggestions for improvements. This should be based on:

- Analysis of monthly reports submitted by peer educators by the 5th of each month. ***Annexure I(D)*** includes an illustrative format
- Review of Peer Educator Diaries. See ***Annexure I(E)*** for an illustrative format
- Feedback on quality of PE sessions submitted by ASHAs should be based on visits to PE sessions, where attendance rates of participants, level of interaction, coverage of materials, participant knowledge of source materials and referral etc. should all be reviewed.

6

Implementation Process for Peer Education Programme

6.1 For planning, implementing and monitoring of the PE programme, an indicative step wise implementation process at state level has been provided in Exhibit 6.01, similar implementation process for district, block, facility and community has been provided in Exhibits 6.02, 6.03 and 6.04 respectively. The implementation process is based on the assumption that DHFW would implement the programme directly (and not through NGOs).

Exhibit 6.01: State Level Implementation Process for PE Programme

Steps	Activity	Frequency and timing	Primary responsibility
1.	Development of a three year plan for PE, with a detailed annual plan and budget (to be integrated into the state AH component of NHM PIP)	Annual; in line with time line for preparation of state NHM PIP	State level AH nodal officer
2.	Adapt and if necessary translate national level PE guidelines and training modules	One time	State level AH nodal officer
3.	Print and distribute PE guidelines and monitoring forms	One time	State level AH nodal officer
4.	Adapt (where necessary) and print training materials including PE Kits	Annual; immediately after approval of state NHM PIP	State level AH nodal officer
5.	Select and train master trainers/ agency (in line with PE training strategy)	Annual	State level AH nodal officer
6.	Monitoring progress of PE programme States to prepare and submit quarterly progress reports to the centre. This will be based on a consolidation of monthly districts progress reports submitted by 15th of each month (refer Annexure VI for format).	Quarterly	State level AH nodal officer; no later than the end of the month following the reporting quarter

Exhibit 6.02: District Level Implementation Process for PE Programme

Steps	Activity	Frequency and timing	Primary responsibility
1.	Development of a three year plan, with a detailed annual plan and budget (to be integrated into the overall District Health Plan) District PE work plan should detail implementation modalities, key activities and timeframe. This will be based on the following assumptions: • Preparatory activities, including creating community support, selection and training of peer educators, and formation of adolescent groups will take three months. • PE sessions for each Adolescent Group will be conducted over a six-month period (a total of 24 PE sessions). • AFCs meetings would be held once every month over a six-month period. Districts should then determine what human, financial and nonfinancial resources will be required and budget accordingly for implementing each activity. For instance, incentives for ASHA for every PE session attended, number of PE kits required and non-financial incentives for Peer Educators should all be budgeted for. (Use formats in Annexure V)	Annual; in line with time line for preparation of state NHM PIP	District level AH nodal officer
2.	Convergence with other departments Districts should explore opportunities for working with the Department of Education and Women and Child Development where feasible. For instance, Peer Education could be implemented in schools, with nodal teachers responsible for selecting peer educators, facilitating and monitoring PE sessions held at schools. Similarly for adolescent girls out of school, Peer Education could be implemented in conjunction with the Sabla Scheme at ICDS centers. A proposal for the above should be prepared by the District Nodal Officer, AH and necessary approvals obtained.	One time; in line with time line for preparation of state NHM PIP	District Magistrate/ Collector; CMHO; District Programme manager; District level AH nodal officer
3.	Organise AH programme and sensitization training for staff.	One time; immediately after approval of district NHM PIP with periodic refresher training	District level AH nodal officer (or independent agency if training is outsourced)/ District Training Center
4.	Organise non-financial incentives for peer educators	Annual; distribution of awards could be timed with the AHD in the fourth quarter of each year.	District level AH nodal officer

Contd...

Steps	Activity	Frequency and timing	Primary responsibility
5.	Monthly monitoring and reporting This involves: • Preparing, analysing and submitting a monthly progress report for state level consolidation (use format in Annexure VI). • Communicating feedback, along with suggestions for course correction.	By the 10th of each month for the previous month.	District level AH nodal officer

Exhibit 6.03: Block Level Implementation Process for PE Programme

Steps	Activity	Frequency and timing	Primary responsibility
1.	Organize training of Peer Educators (a six-day training programme–could be staggered over a six-month period.)	Immediately after approval of district NHM PIP.	SIHFW
2.	Monthly monitoring and reporting This involves: • Routine monitoring of activities, through field visits • Preparing, analysing and submitting a block monthly progress report for district level consolidation. • Communicating feedback, along with suggestions for course correction.	By the 5th of each month for the previous month.	Block AH counsellor/ Block NHM Program manager

Exhibit 6.04: Facility Level Implementation Process for PE Programme

Steps	Activities	Frequency and timing	Primary responsibility
	PHC level		
1.	Monitoring This involves field visits to assess the quality of Peer Education. Approximately two adolescent groups per village should be covered at least once during the year	As and when/as a part of routine visits	PHC MOIC/Counsellor under out reach sessions
2.	Reporting, analysis and feedback This involves: A) Preparing, analyzing and submitting a monthly progress report for block level consolidation; B) Communicating feedback, along with suggestions for course correction.	By the 5th of each month for the previous month	PHC MOIC, with support from ANMs and MHWs.

Contd...

Steps	Activities	Frequency and timing	Primary responsibility
	SHC level		
1.	Organise monthly Adolescent Friendly Club (AFC) at Sub-Centre/appropriate location convenient for peer educators.	Monthly, over the six-month implementation period each year.	NM/MHW
2.	Reporting, analysis and feedback This involves: A) Preparing, analyzing and submitting a monthly progress report for block level consolidation; B) Communicating feedback, along with suggestions for course correction.	By the 5th of each month for the previous month	ANM/MHW

Exhibit 6.05: Community Level Implementation Process for PE Programme

Steps	Activity	Frequency and timing	Primary responsibility
1.	Create community support through sensitization.	Annually (once at the start of the programme)	ASHA
2.	Select four peer educators.		
3	Form adolescent groups.	Annually (once at the start of the programme)	Peer Educator, with support from ASHA
4.	Conduct PE sessions and maintain session dairy.	Four sessions per month	Peer Educator
5.	Organize monthly AFC meeting.	Monthly	ANM
6.	Reporting PE session progress. Monthly report based on a consolidation of weekly activities.	Monthly	Peer Educator
7.	Reporting, analysis and feedback. This involves: A) Preparing, analyzing and submitting a monthly progress report for block level consolidation; B) Communicating feedback down the line, along with suggestions for course correction.	Monthly	ASHA Facilitator

Annexure I (A)

Peer Educator Registration Form

S. No.

Date: _____

Photo

Name of Peer Educator: _____

Sex (Male/Female): _____

Age: _____

Name of Guardian/Parent: _____

Address: _____

_____

School/out of school: _____

If in school, please specify class/school name and address: _____

_____

If out of school, please specify occupation if relevant: _____

_____

Phone/mobile number: _____

Email ID (if any): _____

Annexure I (B)

State Quarterly Peer Education Progress Reporting Form

	Indicators	Planned	Actual	Variance
Name of District:		Reporting Quarter:		
	Coverage			
1	Number of villages covered by PE programme			
2	Number of blocks covered by PE programme			
3	Number of MHWs or NGO staff (male) in place			
4	Number of ANMs or NGO staff (female) 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)			

Contd...

	Indicators	Planned		Actual		Variance	
	Peer Groups						
		10-14 yr	15-19 yr	10-14 yr	15-19 yr	10-14 yr	15-19 yr
14	Number of out of school male adolescents reached through village based peer educators in this quarter						
15	Number of out of school female adolescents reached through village based peer educators in this quarter						
16	Number of in-school male adolescents reached through village based peer educators in this Quarter						
17	Number of in-school female adolescents reached through village based 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 by peer educators in this quarter						

Annexure 1(C)

District Monthly Peer Education Progress Reporting Form

	Indicators	Planned	Actual	Variance
Name of District:		Reporting Quarter:		
	Coverage			
1	Number of villages covered by PE programme			
2	Number of blocks covered by PE programme			
3	Number of MHWs or NGO staff (male) in place			
4	Number of ANMs or NGO staff (female) in place			
5	Number of ASHAs in place			
	PE Enrollment			
6	Number of Peer Educators enrolled			
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 reporting month			
10	Number of Health staff (MOs, ANMs, ASHAs) that received sensitization/AH training in reporting month			
11	Number of peer educators trained in reporting month			
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)			

Contd...

	Indicators	Planned		Actual		Variance	
	Peer Groups						
		10-14 yr	15-19 yr	10-14 yr	15-19 yr	10-14 yr	15-19 yr
14	Number of out of school male adolescents reached through village based peer educators in reporting month						
15	Number of out of school female adolescents reached through village based peer educators in reporting month						
16	Number of in-school male adolescents reached through village based peer educators in reporting month						
17	Number of in-school female adolescents reached through village based peer educators in reporting month						
18	Total number of adolescent reached through village based peer educators in reporting month						
	Peer Education Sessions with Adolescent Group						
19	Number of sessions held by peer educators in reporting month						
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 reporting month						
23	Number of male adolescents referred by PE to AFHC in reporting month						
	Adolescent Friendly Club (AFC)						
24	Number of AFC held by peer educators in reporting month						

Annexure I(D)

PHC Monthly Progress Reporting Form

	Indicators	Planned	Actual	Variance
Name of District:		Reporting Quarter:		
	Coverage			
1	Number of villages covered by PE programme			
2	Number of blocks covered by PE programme			
3	Number of MHWs or NGO staff (male) in place			
4	Number of ANMs or NGO staff (female) in place			
5	Number of ASHAs in place			
	PE Enrollment			
6	Number of Peer Educators enrolled			
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 reporting month			
10	Number of Health staff (MOs, ANMs, ASHAs) that received sensitization/AH training in reporting month			
11	Number of peer educators trained in reporting month			
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)			

Contd...

	Indicators	Planned		Actual		Variance	
	Peer Groups						
		10-14 yr	15-19 yr	10-14 yr	15-19 yr	10-14 yr	15-19 yr
14	Number of out of school male adolescents reached through village based peer educators in reporting month						
15	Number of out of school female adolescents reached through village based peer educators in reporting month						
16	Number of in-school male adolescents reached through village based peer educators in reporting month						
17	Number of in- school female adolescents reached through village based peer educators in reporting month						
18	Total number of adolescent reached through village based peer educators in reporting month						
	Peer Education Sessions with Adolescent Group						
19	Number of sessions held by peer educators in reporting month						
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 reporting month						
23	Number of male adolescents referred by PE to AFHC in reporting month						
	Adolescent Friendly Club (AFC)						
24	Number of AFC held by peer educators in reporting month						

Annexure I (E)

Peer Educator Monthly Reporting Form

Month/Year: _____

Name of Peer Educator: _____

Phone: _____

Parent name and address: _____

_____

Village name: _____

Block: _____

District: _____

Peer Education training received (yes/no): _____

PE Kit received (yes/no): _____

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

Number of adolescents enrolled: _____

Type of Adolescent Group:

In-School/Out of School: _____

Boys/Girl: _____ 10-14 yrs: 15-19 yrs: Total:

Number of Peer Education Sessions conducted this month: _____

_____

Average attendance rate: _____

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: _____

_____

Annexure I (F)

Peer Educator Diary Format

First page

Name of Peer Educator: _____

Phone: _____

Parent name and address: _____

Village name: _____

Number of adolescents enrolled	
Type of Adolescent Group	School/Out of School: Boys/Girl (Total): Boys/Girl in 10-14 yrs age group: Boys/Girl in 15-19 yrs age group:

	Name of adolescent registered	Age	Phone number	Parent Name & Address
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				

Peer Education Session Format

A. For one to one interactions

Date/Month/Year_____

S. No.	Name of Adolescent/Stakeholder reached (To be kept confidential)	Sex (M/F)	Age	Issue/problem discussed	Referral, if any

B. For Group Interactions

Date/Month/Year_____

S. No.	Venue	Name of Participants	Sex	Age	Issues discussed in session	Referrals, if any

C. Weekly Compilation Sheet

Month and Year_____

Week	Days							
	M	T	W	T	F	Sa	Su	Total
Week 1								
No. of adolescents reached between 10-14 (boy/girl)								
No. of adolescents reached between 15-19 years (boy/girl)								
No. of group sessions conducted								
No. of adolescents referred for AFHC services (boy/girl) for:								
Nutritional problem Mental health problem SRH problem Injuries/violence Substance misuse General health problem Counselling								
No. of community awareness and advocacy campaigns organized								

D. Action Plan/Content Check List for Peer Educator (to be maintained for one or more peer group being facilitated by each PE)

Session/Topic to be covered by PE through Group Sessions Those covered should be ticked and those not covered can be crossed			
Pre and post session Information: About Adolescent Health Programme, MoHFW Introducing Peer Educator and Peer coordinators (ASHA, ANM) Informing about providers and service delivery points (including referral service) to seek services and help if required			
Pubertal Changes	Menstruation	Night Fall	Personal Hygiene
Gender Identity	Respecting Diversity	Under Nutrition and Anemia	Risk factors for health conditions related to life style
Dealing with Peer Pressure	Preventing Substance Misuse (Alcohol and Smoking)	Managing Emotion and Stress	Minimizing risks to prevent Accidents and Injuries
Child Marriage	Preventing Adolescent Pregnancy	RTIs and STIs	Preventing HIV and AIDS
Responding to Violence against Children/Adolescents	Preventing Gender based Violence (Violence against Adolescent Girls and Women)	Knowing our Rights and Entitlements	Community Sanitation and Hygiene

[i] Adapted from: Evidence-Based Guidelines for Youth Peer Education (2010); USAID, FHI.

[ii] Adapted from: Evidence-Based Guidelines for Youth Peer Education (2010); USAID, FHI.

Annexure II

Operating Guidelines for Adolescent Health Day

Contents

1 Introduction

1.1 A key component of the National Adolescent Health (AH) Strategy is the Adolescent Health Day (AHD). The Adolescent Health Day is independent of, and in addition to, all the activities carried out for adolescents under the aegis of any other ministry and is a mandatory activity. It has four key objectives:

- Improve coverage with preventive and promotive interventions for adolescents
- Increase awareness among parents and other key stakeholders on adolescent health needs
- Increase awareness among adolescents about the determinants of adolescent health such as nutrition, SRH, mental health, injuries and violence (including GBV), substance misuse and conditions for NCDs
- Improve awareness of other AH related services, in particular Adolescent Friendly Health Clinics (AFHCs).

1.2 The AHD will be organized in every village once every quarter on a convenient day following the VHND. In 'Sabla' districts, this day could coincide with the existing Kishori Diwas. Similar linkages should be made with 'SAKSHAM' and NYKS districts. Venues for the AHD could include Anganwadi Centres and other community spaces.

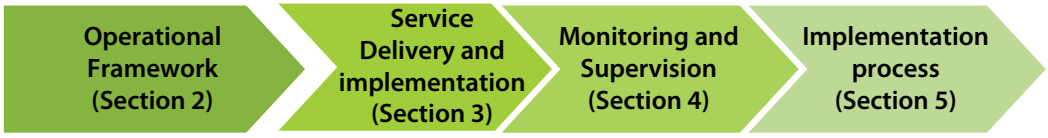
1.3 Services at AHDs should ensure that all adolescent sub-groups are reached i.e. male and female; adolescents between the ages of 10-14 and 15-19; school going and drop out; and married adolescents. Efforts should also be made to reach out to other stakeholders including parents, community leaders such as Panchayat and VHSNC members, and teachers to sensitize them on adolescent health needs. It is important to have group/individual sessions with parents by MO or the trained ANM to sensitize them on the adolescent health needs.

Purpose of These Guidelines

1.4 This document highlights the key processes for implementing Adolescent Health Day (AHD) at the village level. It begins with a section on the overall operational framework for AHD. This is followed by separate sections on service delivery (which includes a list of AHD services and checklists for implementation) and monitoring.

1.5 This document will support programme managers at the state, district and block level to rollout the AHD program. It includes tools to enable planning, implementation and monitoring.

Exhibit 1.01: Structure of This Document



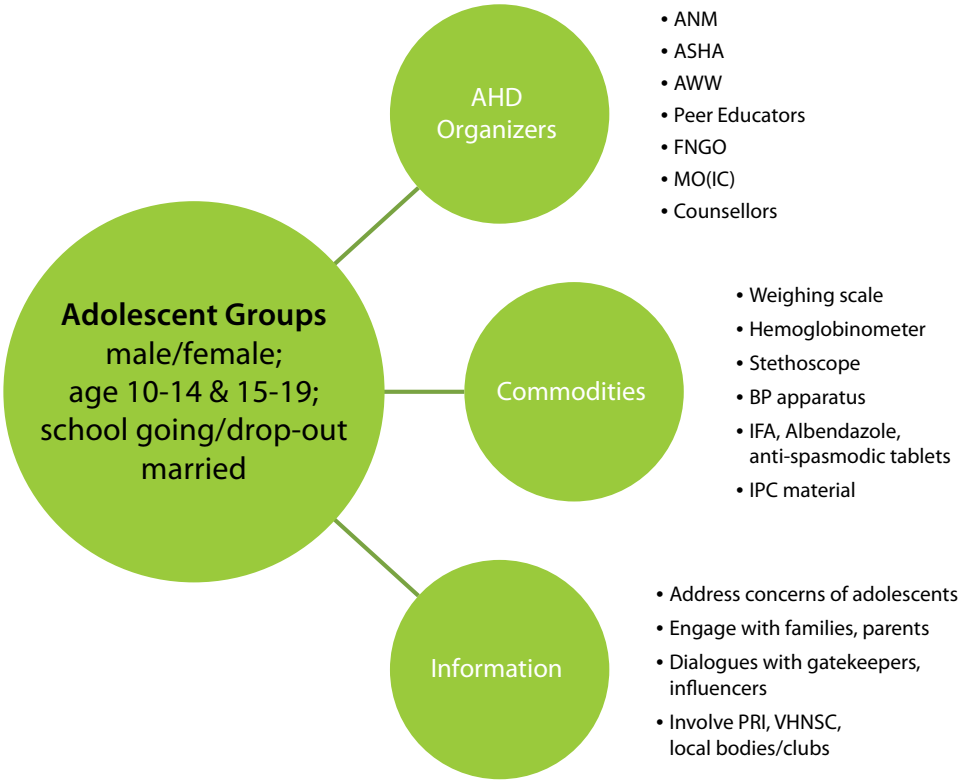
2 Operational Framework

About the Adolescent Health Day

2.1 On the appointed day, Peer Educators, ASHAs, AWWs, and others (including FNGOs, where present) will mobilize adolescents, parents and other stakeholders, to assemble at the nearest AWC or community space. To gain attention of the target group and to transfer knowledge on adolescent health, various "infotainment" activities can be organised, such as skits, plays, puppet shows etc.

2.2 It is important to have the ANM and other health personnel present during the AHD to provide services and educate/orient the target groups. During the AHD, the target groups should be able to interact with the health personnel and obtain basic services and information. They can also learn about the preventive and promotive aspects of adolescent health care, which will encourage them to seek health care at adolescent friendly health clinics.

Exhibit 2.01: Requirements for AHD



Publicity for AHD

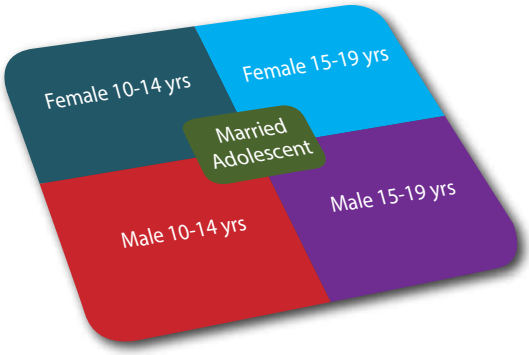
2.3 Publicizing AHD is important for ensuring that the community—adolescents, parents and other key stakeholders—are aware of services available through AHD. Various methods such as wall writings, hoardings, handbills and pamphlets may be used for publicity. Publicity materials should clearly spell out day and time; venue and key services.

2.4 Publicity should also be driven through community leaders—PRI and VHSNC committee members, field level functionaries—ASHA, ANMs, AWW, peer educators and local NGOs, SHGs and teachers. The district nodal officer for AH and the CHC adolescent health counsellor would be responsible for planning and publicity of AHD.

Target Group

2.5 AHD targets all adolescents between the age of 10 to 19 years. (In Sabla districts, Kishori Diwas is organized only for adolescent girls). Keeping in view the need to provide age-appropriate attention for certain components, the target group may be subdivided into following categories (Exhibit 2.02):

Exhibit 2.02: Target Groups for AHD



TARGET GROUPS

- **Female: 10-14 years**
  Including school going and drop outs
- **Female: 15-19 years**
  Including school going and drop outs
- **Male: 10-14 years**
  Including school going and drop outs
- **Male: 15-19 years**
  Including school going and drop outs
- **Married Adolescents: male & female**
  Including school going and drop outs between the age group of 15 to 19 years

2.6 AHDs should also be used as a platform for sensitising other stakeholders such as **parents** and community leaders on adolescent health needs. MO or the trained ANM should conduct separate group/individual sessions with parents to sensitize them on adolescent health needs.

Services to be Provided

2.7 The following services should be provided during an AHD (detailed list in Exhibit 2.03):

- **Information:** IEC and IPC on Nutrition, SRH, Mental Health, GBV, NCD, Substance misuse
- **Commodities:** Sanitary Napkins, IFA, Albendazole, anti-spasmodic tablets and contraceptives
- **Services:** Registration, general health check-up, (BMI, anaemia and diabetes), Referral to AFHCs (for counselling and clinical services)

Exhibit 2.03: AHD Service List

Nutrition
• BMI Screening • Anaemia testing • Provision for IFA tablets and Albendazole • Discussion/IPC/orientation on nutrition and balanced diet • Addressing gender biased food distribution in households • Referral

Sexual and Reproductive Health
• Conversations about the harmful practice of child marriage • Information about adverse consequences of teenage pregnancy • Provision for sanitary napkins • Discussion/IPC/orientation on SRH including Information on RTI, STI, HIV and AIDS; Contraception and choices; Age of marriage, Abortion, Pre-marital counselling, contraceptive etc. • Referral to AFHC/health clinic

Mental Health
• Discussion/IPC/orientation on Mental Health issues including age-specific mental health issues among adolescents and ways to overcome them including stress, depression, suicidal tendency etc. • Referral to AFHC for regular counselling

Gender Based Violence
• Discussion/IPC/orientation on Gender based violence

Non Communicable Diseases
• Discussion/IPC/orientation on NCD, exercise and healthy life style and personal hygiene • Focused discussion on prevention of NCD through exercise, healthy life style and avoidance of tobacco and alcohol • Referral to health clinics

Substance Misuse
• Discussion/IPC/orientation on harmful effects and consequences of substance misuse

2.8 IEC/IPC topics during AHD should be target audience specific and should be done independently with each specific target group as mentioned in Exhibit 2.03. Various media and platforms, including skits and plays can be used for communicating key messages to the target groups.

Exhibit 2.04: Information for AHD

Discussion Points	Female		Male		Married Adolescents	Other Stakeholders
	10-14	15-19	10-14	15-19		
Nutrition						
Information on nutrition and need for balanced diet	✓	✓	✓	✓	✓	✓
Signs of anaemia and treatment	✓	✓	✓	✓	✓	✓
Sexual, reproductive and maternal health						
Common Sexual Health issues faced by adolescents and their prevention/treatment	×	✓	×	✓	✓	✓
Age of marriage and issues due to early marriage	×	✓	×	✓	×	✓
Contraception and choices	×	✓	×	✓	✓	✓
Information on RTI, STI, HIV and AIDS	×	✓	×	✓	✓	✓
Prevention of STI	×	✓	×	✓	✓	✓
Menstrual Hygiene	✓	✓	×	×	✓	✓
Pregnancy care including ANC, complication readiness and birth preparedness	×		×	✓	✓	✓
Early parenting	×	×	×	×	✓	✓
Mental Health						
Most common age-specific mental health issues among adolescents and ways to overcome them	✓	✓	✓	✓	✓	✓
Injuries and violence						
Gender based violence and education on prevention of injuries like road traffic injuries, agricultural injuries, drowning, sports injuries etc. and on violence prevention e.g. conflict resolution etc.	✓	✓	✓	✓	✓	✓
Substance misuse						
Substance misuse and problems and support (including prevention of tobacco use)	×	✓	×	✓	✓	✓
Non Communicable Disease						
Common non communicable diseases among adolescents and prevention	✓	✓	✓	✓	✓	✓
Exercise and healthy lifestyle	✓	✓	✓	✓	✓	✓
Personal Hygiene	✓	✓	✓	✓	✓	✓
Others						
Importance of AFHCs and facility level services available for adolescents including importance of seeking timely help from parents, teachers or health workers	✓	✓	✓	✓	✓	✓

2.9 Specific emphasis should be given to communicate with parents during the AHD. Given that family environment and support is central to the wellbeing of adolescents, the content offered to parents during AHD should include:

- Information: Exhibit 2.01 provides topics of discussion with parents. In addition feedback should be collected on the area specific adolescent and parenting problems, and efforts should be made to help parents get information on resolving these issues.
- Skills: Efforts should be made to help parents develop/enhance skills on communicating with adolescents, such as talking with adolescents about sex, listening to adolescents' concerns, or talking without shouting.
- Support: Parents should be educated and sensitized on the resources available for assisting them in managing adolescent issues.

Identification of Cases for Referral

2.10 During AHD efforts should be made to identify adolescents with following issues for referral to AFHCs for clinical services or counselling:

- Adolescents with high or low BMI
- Severe and moderate cases of anaemia
- Pregnant adolescents
- Adolescents with symptoms of RTI/STI
- Adolescents with chronic/severe mental health issues
- Adolescents who have been subjected to GBV
- Adolescents with NCDs

Data Collection and Compilation

2.11 AHD data should be collected in the format provided in the Monitoring section. Data should be compiled at block, district and state level.

3

Service Delivery and Implementation

3.1 This section provides checklists for Peer Educators, ASHAs, ANMs, AWWs, and PRI members to facilitate implementation of step-by-step activities for organizing the AHD. The ANM has the primary responsibility for conduct of the AHD.

ANM Checklist

3.2 Actions to be taken:

- Ensure that the AHD is held; make alternative arrangements in case some of the service providers are not available
- Ensure supplies of the commodities (IFA, Albendazol, sanitary napkins and contraceptives) reaches the site before the AHD
- Ensure that all instruments, drugs and other materials are in place
- Carry communication materials including IEC pamphlets
- Ensure reporting of AHD to the MO in charge
- Coordinate with FNGO (if present), ASHA and AWW

Peer Educator (Male and Female) Checklist

3.3 Actions to be taken before the AHD:

- Visit all households in the village and make a list of all adolescents
- As far as possible, identify adolescents who have specific needs (e.g. RTI/STI, malnutrition, menstrual hygiene, contraceptive needs etc.)
- Discuss with their group on the objectives and process of AHD
- Mobilize the group to reach out to all the adolescents in the village to communicate the date, venue and the benefits of attending AHD

3.4 Actions to be taken on the day:

- PE along with her/his group should mobilize all the adolescents in the village to attend the AHD
- Encourage adolescents to discuss issues with the service providers

ASHA Checklist

3.5 Actions to be taken before the AHD:

- Co-ordinate with PEs, FNGO (if present), ANM and AWW.

3.6 Actions to be taken on the day:

- Guide PEs to mobilize all the adolescents to attend the AHD
- Assist ANM and AWW

AWW Checklist

3.7 Actions to be taken:

- Help ASHA and PEs to mobilize adolescents and other stakeholders in the village to attend AHD
- Make AWC available for the AHD (clean AWC, provision for privacy for health check-up, availability of clean drinking water)
- Coordinate with FNGO, PEs, ASHA and ANM

PRI Checklist

3.8 Actions to be taken:

- Coordinate to invite all members of VHSNC to support and attend AHD
- Coordinate participation of school teachers, parents, PRI members and other opinion leaders
- Provision for clean drinking water, proper sanitation, and convenient approach to the AWC
- In case of non-availability of AWC, coordinate with other members of the community to identify a community space for organizing the AHD, and communicate the same to the service provider/ FNGO

Field NGO Checklist

3.9 If a Field NGO is available for implementation of adolescent health strategies, then the NGO could:

- Co-ordinate with service providers, village PRI and opinion leaders to finalize date and venue for organizing the AHD
- Visit and inspect the venue for AHD, ensure that the venue has enough privacy for health check-up. If not, then make necessary arrangements for ensuring privacy
- Communicate with MO, Counsellor, ANM, ASHA, AWW and PE regarding the dates, venue and logistic arrangements for the AHD
- Discuss with PEs, ASHA and AWW to plan mobilization of adolescents in the village for the AHD
- Day before the AHD, FNGO representative should visit the venue to double check arrangements for the AHD

3.10 Actions to be taken on the day:

- Ensure that key stakeholders such as PRI members and opinion leaders attend the AHD
- Data collection and compilation

4 Monitoring and Supervision

4.1 This section provides guidelines for monitoring AHD using appropriate tools/reporting forms. Monitoring should enable states and districts to determine which aspects are working well and what needs improvement and subsequently take corrective action.

Data Collection and Compilation

4.2 Annual Health Day is one of the key strategies of the adolescent health program and hence at all programmes meetings at state, district and block levels, the programme should be reviewed. Each district and block should keep a record of number of AHDs planned and held. During AHD, ANM should maintain a register for data collection; indicative format for AHD data collection is provided in Exhibit 4.01; this should be filled on completion of each AHD by the ANM and sent to the CHC/ Block Counsellor at the end of each month and compiled on a monthly basis at block and district level. District should send the data to the state by the 5th day following each quarter:

Exhibit 4.01: Format 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:

..... (MO in charge)

..... (ANM)

..... (Counsellor)

..... ( )

..... ( )

Other organizers

..... (ASHA)

..... (AWW)

..... (PE Female)

..... (PE Male)

..... ( )

..... ( )

AHD attended by:

(a) PRI members : Yes / No (b) Other VHSNC members: Yes/ No

Contd...

B. Coverage

1. Total Village population:.....

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

		Total Population	Attendance at AHD
Female 10-14 yrs	In-school		
	Drop out		
Female 10-14 yrs	In-school		
	Drop out		
Male 10-14 yrs	In-school		
	Drop out		
Male 15-19 yrs	In-school		
	Drop out		
Married Adolescents			
Total Number of adolescents			

3. Total number of parents who attended the AHD: .....

C. Services

Services	Female				Male				Married Adol	Parents	Other Stake holders	Total
	10-14		15-19		10-14		15-19					
	IS	DO	IS	DO	IS	DO	IS	DO				
1. BMI Screening												
2. Anaemia testing												
3. Number of adols. provided IFA tablets												
4. No. of adols. Provided Albendazole tablets												
5. No. of adolescents provided contraceptives												
a Condom												
b OCP												
c ECP												
6. RTI/STI screening and clinical services												
7. No. of adols. provided sanitary napkins												
8. 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												

* IS = In school
DO = Drop out
Stakeholders includes parents, school teachers, PRI etc.

Contd...

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

4.3 Data should be compiled at block, district and state levels. The following output indicators need to be monitored to understand the progress of AHD:

- Number and percentage of AHD planned and held
- Total number of adolescents visiting AHD
- Total number of adolescents referred to AFHCs during AHD
- Total number of parents attending AHD
- Percentage of parents who were sensitized through IPC/Orientation/discussion during AHD (out of total no. of parents who attended the AHD)

Supervision

4.4 For improvement in Annual Health Day, efforts should be made by program managers at block, district and state level to visit the venue and monitor the activities. Exhibit 4.02 provides supervision checklist and Exhibit 4.03 provides an indicative supportive supervision mobility plan.

Exhibit 4.02: Checklist for AHD Supervision

Purpose:

- The purpose is to collect information on operational status of AHDs, identify gaps and problems faced.
- The organization of the AHD on a regular basis as per the guidelines will result in the achievement of the following objectives:
  - Improve coverage with preventive and promotive interventions for adolescents
  - Increase awareness among adolescents and stakeholders about the determinants of adolescent health such as nutrition, SRH, Mental Health, injuries and violence (including GBV), substance misuse and addressing NCDs
  - Improve knowledge about the services offered under the various Adolescent Health strategies including Adolescent Friendly Health Clinics

1. General information

- Session site Anganwadi/ Other place (is it suitable, is it centrally located)
- Session Date (is Programme for AHD displayed)
  - How many of planned sessions have been held
  - What alternate arrangements are made when MO/ ANM/ Counsellor is on leave on a session day
- Timing Displayed
- Availability of staff at the session site: MO, ANM, Counsellors, ASHA, AWW, PRI members, PE (male and female)

2. Check Records of ASHA

- Does she have an updated list of adolescents in the village?
- Does she have list of adolescents classified into different categories: Male, Female, age group: 10-14 & 15 -19, in school, drop-out and married adolescents.
- Has she made a priority list of Adolescents who need to come for AHD

3. Check an ongoing AHD for

Clients

- Percentage of adolescents who have come for AHD (check record)
- Is there a specific target group which has a very thin/no attendance in the AHD? Check reason

Supplies

Drugs & related supplies

- IFA tablets, Albendazole, Paracetamol, Condoms, OCPs, ECPs, Sanitary Napkins, Hemoglobin meters (check if Hb is being done), Gloves

Equipment, Instruments

- Weighing scale, measuring tape
- Stethoscope and blood pressure instrument (check if BP is regularly measured for adolescents)
- IEC material for communication and counselling

Talk to Peer Educators (male and female) for their knowledge on adolescent health and referral mechanism.

Client satisfaction

Exit interviews with some adolescents about the AHD and services offered. Check for convenience of attending AHD and improvement required to conduct the next AHD

4. Coordination with AWW and PRI – discuss

5. IEC/BCC: Find out from the community if any demand generation activities were conducted prior to the AHD. Also, find out from ASHA, ANMs, AWWs and PEs if they received any training on interpersonal communication.

Exhibit 4.03: AHD supportive Supervision Mobility Plan

Visiting official	Periodicity of visit	Supervision report submit to	Reporting period	Submission of action taken report
Block nodal officer/ counsellor (AH)	4 visits per month, 1 per week	District nodal officer (AH)	Within 2 days of field visit	Within 15 days of field visit
Block Program Manager	1 visit per month	DPM	Within 2 days of field visit	Within 15 days of field visit
Block M&E manager	1 visit per month (to ensure data quality)	BPM	Within 1 day of field visit	Within 10 days of field visit
District nodal officer (AH)	4 visits per month	State nodal officer (AH)	Within 2 days of field visit	Within 15 days of field visit
CMO	1 visit per month	DPM	Within 5 days of field visit	Within 10 days of field visit
District QA officer	1 visit per month	District nodal officer (AH)	Within 2 days of field visit	Within 15 days of field visit
District IEC officer	1 visit per month	District nodal officer (AH)	Within 2 days of field visit	Within 15 days of field visit
State nodal officer (AH)	1 visit per month	Director H&FW	Within 5 days of field visit	Within 10 days of field visit
Other officials who may visit AHD for supportive supervision:		District IEC officer, District M&E officer, District PHN, Director H&FW, PO (WIFS), PO (ARSH), PO (MHS), PO (RBSK), MD (NRHM)		

5 Implementation Process for Adolescent Health Day

5.1 For planning, implementing and monitoring of AHD, an indicative step wise implementation process at state level has been provided in Exhibit 5.01; while steps to be undertaken at district and block/community levels have been provided in Exhibit 5.02 and 5.03 respectively.

Exhibit 5.01: State Level Implementation Process for AHD

Steps	Activities	Description	Frequency	Responsibility
1	***Adapt guideline and translate where necessary***	The Guideline should be reviewed and adapted to reflect state specific requirements; subsequently translate the Guideline into local language (If required)	One time	State Nodal Officer (AH)
2	***Disseminate the AHD guideline***	The translated AHD guideline should be disseminated to the concerned officers at state, district and block program management unit	One time	State Nodal Officer (AH)
3	***Prepare Standard Operating Procedures (SOP) for AHD***	Prepare a SOP for AHD keeping in mind local needs and challenges. SOP should be based on the AHD guideline and in consultation with PMUs and other health division's (MH, CH, FP, NCD, IEC etc.)	One time	State Nodal Officer (AH)
4	***Convergence meeting***	Convergence meeting within health (MH, FP, CH, etc) and outside health (WCD, etc.) for support on AHD	Quarterly	Director H & FW
5	***Consultation and orientation training on AHD implementation***	Based on the guideline and SOP, orient: • CMO • District PMU staff on the implementation and monitoring Consult with them on preparation of detail implementation plan	One time (phased manner)	State Nodal Officer (AH)
6	***Prepare detailed implementation plan***	In consultation with the districts and other stakeholders, prepare detailed AHD implementation plan: • Prioritize districts for implementation; plan for phase implementation throughout the state • Staff orientation and mobilization plan • Communication (IEC/BCC) plan • Commodities procurement plan • Convergence plan within health and outside health (WCD etc.) • Budget for implementation	Annually	State Nodal Officer (AH)

Contd...

Steps	Activities	Description	Frequency	Responsibility
7	*Government/ Office order for implementation*	GO/ OO should be issued to districts for implementation of AHD as per the plan	One time (phased manner)	Director H&FW
8	*Design IEC/ BCC materials*	Design communication materials for addressing the information needs for various target groups. Apart from regular posters, innovative and interesting communication platforms should be used such as skits, plays, videos etc.	One time, with annual review	State Nodal Officer (AH)/IEC division
9	*Procurement/ sourcing of commodities*	Procurement or sourcing of commodities as applicable (Contraceptive, IFA, Sanitary Napkin, weighing scale, curtains etc.)	Once in 6 months	State Nodal Officer (AH)/ Procurement div
10	*Monitoring and supervision*	Monitoring and supervision of AHD through field visits and monthly meetings	Monthly	State Nodal Officer (AH)
11	*Data compilation and reporting*	Regular district level data compiled at state level and reporting as per the MIS format	Monthly/ Quarterly/ Annual	State Nodal Officer (AH)/ State MIS officer

Exhibit 5.02: District Level Implementation Process for AHD

Steps	Activities	Description	Frequency	Responsibility
1	*Read the AHD guideline and SOP*	Read AHD guidelines and SOP as provided by the state	One time	District Nodal Officer (AH)/ CMO
2	*Attend orientation meeting on AHD*	Attend the orientation and consultation meeting organized by state on AHD	One time	District Nodal Officer (AH)/ CMO
3	*Consultation and orientation training on AHD implementation*	Based on the guideline and orient, orient MO I/C, block PMU staff on the implementation and monitoring. Consult with them on preparation of detail implementation plan	Annually	District Nodal Officer (AH)/ CMO
4	*Convergence meeting*	Convergence meeting within health (MH, FP, CH, etc) and outside health (WCD etc.) for support on AHD	Quarterly	CMO
5	*Prepare and submit district implementation plan*	Prepare detailed district AHD implementation plan: • Staff orientation and mobilization plan • Communication (IEC/BCC) plan • Inventory management plan • Implementation calendar • Convergence plan within health and outside health (WCD etc.) • Budget for implementation	Annually	District Nodal Officer (AH)

Contd...

Steps	Activities	Description	Frequency	Responsibility
6	*Office order for implementation*	Office order for all the concerned MO I/C should be issued for implementation of AHD as per the plan	One time	CMO
7	*Inventory Management*	Set up and ensure inventory management for AHD	One time	District Nodal Officer (AH)
8	*Monitoring and supervision*	Monitoring and supervision of AHD through field visits and monthly meetings	Monthly	CMO/ District Nodal Officer (AH)
9	*Data compilation and reporting*	Regular block level data compiled at district level and reporting as per the MIS format	Monthly/ Quarterly/ Annual	District Nodal Officer (AH)/ District MIS officer

Exhibit 5.03: Block/Community Level Implementation Process for AHD

Steps	Activities	Description	Frequency	Responsibility
1	*Read the AHD guideline and SOP*	Read AHD guidelines and SOP as provided by the state	One time	Block Nodal Officer (AH)/ MO I/C
2	*Attend orientation meeting on AHD*	Attend the orientation and consultation meeting organized by district on AHD	One time	Block Nodal Officer (AH)/ MO I/C
3	*Consultation and orientation training on AHD implementation*	Based on the guideline, SOP and implementation plan orient, ANMs, ASHAs, AWWs, PEs, FNGOs on the implementation and monitoring. Consult with them on preparation of detail implementation calendar	Annually	Block Nodal Officer (AH)/ MO I/C
4	*Convergence meeting*	Convergence meeting within health (MH, FP, CH, etc.) and outside health (WCD etc.) for support on AHD	Quarterly	Block Nodal Officer (AH)/ MO I/C
5	*Inventory and logistics Management*	Set up and ensure inventory and logistics management for AHD	One time	District Nodal Officer (AH)
6	*Communication/ IEC/ BCC plan*	Preparation based on the communication plan, e.g. outsourcing skits etc. as per local availability	One time	District Nodal Officer (AH)
7	*Planning and orientation meeting with community representatives*	Planning and orientation meeting with community representatives such as PRI, School teachers etc. on implementation of AHD in their community and micro planning for logistics	Quarterly	Block Nodal Officer (AH)/ ANM
8	*Implementation of AHD*	Implementation of AHD as per the guideline, SOP and implementation plan	Quarterly	Block Nodal Officer (AH)/ MO I/C
9	*Data compilation and reporting*	Regular field level data compiled at block level and reporting as per the MIS format	Monthly/ Quarterly/ Annual	Block Nodal Officer (AH)/ Block MIS officer

Annexure III

Operating Guidelines for Adolescent Friendly Health Clinics (AFHC)

Contents

1 Introduction

1.1 Several studies have shown that adolescents fail to access health services because of five key factors—1) lack of knowledge about availability of services and means of access; 2) social and cultural deterrents; 3) perceived lack of privacy or confidentiality; 4) services are difficult to access i.e. too far way or too expensive; 5) staff appear to be unfriendly[i].

1.2 In this context, the recently launched Adolescent Health Strategy highlights the need for rolling out Adolescent Friendly Health Clinics (AFHC) across the country. The aim is to provide clinical and counselling services to adolescents through the existing health system. With a slight physical makeover, training of existing staff, introduction of a counsellor and provision of commodities, existing facilities would be equipped to provide adolescent friendly health services.

1.3 Going forward, it is expected that AFHC services will be delivered through Sub-Health Centers (SHCs), Primary Health Centers (PHCs), Community Health Centers (CHCs) and District Hospitals (DHs).

Objective of AFHC

1.4 As outlined in Implementation Guide ARSH 2006, the key 'friendly' component of AFHC mandates facility based clinical and counselling services for adolescents, such that they are

- *Equitable*—services are provided to all adolescents who need them.
- *Accessible*—ready access to services is provided.
- *Acceptable*—health meets the expectation of adolescents who use the services.
- *Appropriate*—the required care is provided, and unnecessary and harmful care is avoided.
- *Effective*—healthcare produces positive change in the health 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.

Purpose of the Operating Guideline

1.5 This document highlights the key changes required for effectively operationalizing AFHCs in existing health facilities and builds on the progress made under RCH II. It includes a section on the overall operational framework for AFHCs, on supportive supervision and monitoring, and finally, the implementation process. This will enable programme managers at the state, district and block level to rollout AFHCs.

2 Operational Framework

2.1 This section provides an overview of the overall framework for AFHCs, which should enable planning and implementation. It assumes that—1) AFHCs will operate out of existing health facilities; and that 2) states will operationalize AFHCs in a phased manner.

Overview

2.2 There is growing evidence to show that interventions are more effective when effort is made to reduce barriers that adolescents face in accessing health services[ii]. This is best achieved when services conforms to following seven standards as per Implementation Guide ARSH 2006[iii]:

- Health facilities provide specified package of services that adolescents need
- Health facilities deliver effective services to adolescents
- Adolescents find environment at health facilities conducive to seek services
- Service providers are sensitive to adolescents needs and are motivated to work with them
- An enabling environment exists in the community for adolescents to seek services
- Adolescents are well informed about the health services
- Management systems are in place to improve quality of service

To complement these, AFHCs should also provide:

- Support to adolescents through interaction at times of concern or crisis through counselling
- Provide referral linkages with secondary and tertiary level facilities
- Make links with other services such as ICTC, de-addiction centres, ICDS counselling services, school education, social workers and legal system
- Treat conditions that give rise to ill health or cause adolescents concern

2.3 In this context, the following paragraphs provide guidelines for how existing health facilities can be adapted to provide adolescent friendly health services. It is important to recognise that AFHCs is a part of a wider package of AH services, including Peer Education and Adolescent Health Day, which among other things emphasize engendering community support for AH and educating adolescents about how and when to access services at AFHCs.

Structure of AFHC Services

2.4 It is recommended that AFHCs should be set-up at the following levels of the existing health care delivery system:

- At Primary Health Center (PHC) level for a population of 20,000 in hilly and 30,000 in plain area; and at Urban Primary Health Centers (UPHC) for a population of 50,000
- At Community Health Center (CHC) level for a population of 80,000 in hilly and 1,20,000 in plain areas.
- At District Hospital (DH) and medical colleges at district headquarters

Package of AFHC Services

2.5 Adolescence is characterised by physical, emotional and psychological development. It is a time when young people are faced with risks and challenges that can lead to:

- Psychological issues such as depression/ low self esteem
- Health issues such as anaemia, under/over nutrition
- Anxiety about pubertal issues, stress etc.
- Sexual and reproductive health issues such as symptoms of RTIs, STIs, HIV/AIDS, early and unwanted pregnancy, menstural problems etc.
- Injury and violence i.e. sexual assault, rape, domestic violence, road traffic accidents, agricultural practices, drowning etc.
- Use of tobacco, alcohol and other substances.

2.6 It is therefore important that both clinical and counselling services are provided to effectively address the needs of young people.

2.7 The following Exhibit 2.01 details the services that will be offered at each level of facility and Exhibit 2.02 provides the suggested working hours for AFHCs at various levels. Please note that counsellors at CHCs/DHs will also be expected to organise and conduct outreach services for adolescents and their parents, potentially at schools and colleges/other platforms.

Exhibit 2.01: AHFC Service Package

	Service Package	DH	CHC	PHC	Outreach
Information	IEC and IPC for Nutrition, SRH, Mental Health, GBV, NCD, Substance misuse	✓	✓	✓	✓
Commodities	IFA/Albendazole tablets	✓	✓	✓	✓
	Sanitary napkin	✓	✓	✓	✓
	Contraceptives (condoms, OCP, ECP)	✓	✓	✓	✓
	Other medicines (e.g. Paracetamol, anti-spasmodic and first aid)	✓	✓	✓	✓
	Pregnancy testing kits	✓	✓	✓	✓
Services	BMI screening	✓	✓	✓	✓
	Hb testing	✓	✓	✓	✓
	RTI/STI management	✓	✓	✓	✓
	ANC for pregnant adolescents	✓	✓	✓	✓
	Counselling on Nutrition, puberty related concerns, Pre-marital Counselling, Sexual Problems, Contraceptive, Abortion, RTI/STI, Substance abuse, Learning problems, Stress, Depression, Suicidal Tendency, Violence, Sexual Abuse, Other Mental Health Issues, health lifestyle, risky behaviour	✓	✓	✓	✓
	Management of Menstrual problems	✓	✓	✓	
	Management of Iron deficiency Anaemia	✓	✓	✓	
	Screening for diabetes and hypertension	✓	✓	✓	
	Management of common adolescent health problems	✓	✓	✓	
	HIV testing and couselling	✓	✓		
	Management of physical violence and sexual abuse	✓	✓		
	Linkages with de-addiction centres and referrals	✓	✓		
	Treatment by specialists	✓	✓		
	Referral	✓	✓	✓	✓

Exhibit 2.02: Suggested Working Hours for AHFCs

PHC	CHC	DH	Medical College
Weekly AFHCs from 2 to 4 p.m. by ANMs and MOs	Daily AFHCs from 9 a.m. to 4 p.m. Two-hour daily clinic from 2 to 4 p.m. at the AFHCs by MOs, with support from staff nurses	Daily AFHCs from 9 a.m. to 4 p.m. Two-hour daily clinic from 2 to 4 p.m. at the AFHCs by MOs, with support from ANMs Counsellor will ensure linkages with specialist in hospital, in case medical care is needed by adolescent client	Speciality-AFHC with different specialties from 9 a.m. to 1 p.m. and counsellors

Staffing

2.8 Exhibit 2.03 indicates staffing/manpower for AFHCs. It highlights that in addition to existing staff that deliver clinical services at facilities, states should recruit counsellors.

Exhibit 2.03: Manpower at Each Level

	DH	CHC	PHC	Outreach
Manpower	2 dedicated counsellors (1 male and 1 female)/ICTC counsellor 2 MO – 1 male and 1 female Specialist - 1 (Gynecologist, Pediatrician, Surgeon, Dermatologist, Psychiatrist, mental health) 2 Staff Nurse	2 dedicated counsellors (1 male and 1 female)/ICTC counsellor 2 MO – 1 male and 1 female 2 Staff Nurse	2 MO – 1 male and 1 female 1 ANM/LHV 1 Health Assistant (F) (ANM can be trained to provide counselling to girls)	Counsellors ANM

Role and Recruitment of Counsellors

2.9 A counsellor's role is critical for identifying and addressing the needs of a adolescents, so as to ensure provision of support, buidling of self esteem and resilience to setbacks.

2.10 The quality of counselling services will largely depend on the knowledge, attitude and skills of a counsellor. And in this context, the selection of Counsellors is important. Counsellors should ideally be:

- Between the age of 25 to 30 years.
- Capable of maintaining privacy and confidentiality
- Open, compassionate and willing to listen and engage young people
- Non-judgmental, with a progressive attitude i.e. in no circumstances, should the counsellor try to impose his or her values
- Qualified with a degree in Social Work preferably a Masters
- Someone who demonstrates a clear understanding of laws, policies and procedures pertaining to informed consent and confidentiality, contraceptive services, abortion, STI/HIV testing and treatment, substance abuse treatment, management of mental health and sexual abuse/domestic violence cases etc.

2.11 A board or panel including an AH expert should ideally be set up to recruit counsellors. The recruitment process may involve the following four stages:

- Initial short-listing based on age, educational qualifications and previous work experience
- Group discussion i.e. short-listed candidates should be divided into a small group of 4-5 people, and be given a case study (covering a sensitive topic such as homosexuality) for discussion. This should be evaluated by at least two members of the panel, and candidates that arrive at an appropriate response, demonstrate sensitivity and leadership qualities (such as consensus building) should be invited to the next round.
- Personal Interview i.e. the panel should conduct a final interview to determine suitability, based on candidates' expectations, availability and why they want the job.

Training

2.12 States may consider either: (i) outsourcing training to a well-established and reputed training agency or medical colleges and universities with expertise in psychology and counselling or (ii) directly conducting training. The first option would be preferable, if there is inadequate in house (SIHFW) capacity although it may be more expensive.

2.13 The recommended process for AH training involves identifying a core group of district level trainers. They may be identified through SACS—i.e. Master Trainers on AEP or trainers from reputed civil society organizations could be selected based on suitability and availability.

2.14 Trainers would then provide:

- Four day training programme for MOs
- Five day training programme for ANMs
- Six-day training programme for counsellors

2.15 In addition, it is vital to establish a structured support system for counsellors to mitigate 'burnouts' and provide them help when needed. It is suggested to conduct bimonthly session/telephonic consultations of counsellors with trainers/mentors. This will create an opportunity for counsellors to discuss their concerns and issues and seek support.

Infrastructure for an Adolescent Friendly Health Clinic (AFHC)

2.16 Broadly, AFHCs should be characterised by two key factors:

- *A warm and inviting space:* The physical appearance of AFHCs is important for creating an environment where adolescents feel comfortable. A typical health set up might not attract adolescents, but a simple makeover with wall paint, colorful furniture, bright posters, LCD screens with appropriate health messages etc. can all transform the facility.
- *Privacy:* Globally studies have shown that the two expectations that adolescents have from the services are that—a) they want to be treated with respect; and b) confidentiality is protected.[iv] In this context, care should be taken to ensure that the AFHC is separate from the general OPD. Efforts should be made to maintain privacy and confidentiality, to ensure that adolescents are comfortable attending clinics.

Exhibit 2.04: Benchmarks for an AFHC

- Infrastructure clean, bright and colorful
- Can be easily accessed by the adolescents (distance, convenient working hours and cost)
- Adolescents are aware about the clinic and range of service it provides
- Non judgmental and competent health service providers
- Maintains privacy and confidentiality
- Community members are aware of the services provided and understand the need for the same

Primary Health Center

2.17 Ideally a separate room for counselling and treatment should be allotted for AH. In case of non-availability, the adolescent clinic can be conducted in the OPD space after the completion of general OPD. Under no circumstances should the adolescent clinic be conducted during general OPD hours.

2.18 The registration desk should be manned by a Health Assistant (F), who should demonstrate sensitivity and be welcoming. The registration desk can also be used to provide medicines and contraceptives.

2.19 It is recommended that there should be a small waiting area adjacent to registration desk. This should ideally be painted in bright colours, and have IEC materials like posters in local language, booklets and pamphlets. A screen may also be arranged to play audio-visual materials i.e. short films for adolescents.

Community Health Center/District Hospital

2.20 AFHCs at both the CHC and District Hospital should have the same physical infrastructure and appearance as that of the PHC AFHC. However at a CHC/DH a staff nurse would manage the registration desk and be responsible for administering/providing medicines and contraceptives.

3

Monitoring and Supportive Supervision

3.1 The following section provides guidelines for monitoring AFHCs using appropriate tools/reporting forms. Monitoring should enable states and districts to determine which aspects are working well and what needs improvement.

Overview

3.2 State and districts should regularly monitor and report on the following indicators to understand the functioning of AFHCs at each level:

- Percentage and number of AFHC operationalised against planned (at PHC, CHC, DH/Medical College)
- Client load at Adolescent Friendly Health Clinics per month (no.)
- Client referred from community to AFHC per month (no.)
- Percentage of adolescents accessing adolescent clinics for puberty-related problems, RTIs/STIs, mental health concerns, abortion care, nutrition
- Percentage and number of AH counsellors recruited against planned
- Total number of clients counselled
- Percentage and number of trained counsellors in place against planned
- Proportion of trained counsellors to total number of adolescents
- Percentage and number of MO trained in AFHS (male/female) against planned
- Percentage and number of ANMs/LHVs trained on AFHS against planned

3.3 Data should be collected from each AFHC through various records and registers as detailed below. As far as possible, regular feedback should be collected from adolescents on improving the clinic and the services of AFHC.

Monitoring and Supportive Supervision Process

3.4 The following paragraphs highlight the process for supportive supervision and provide illustrative reporting formats/tools.

Primary Health Center

3.5 At the PHC level, the BPHN is responsible for providing supportive supervision to PHC AFHC staff. BPHNs are expected to visit each PHC AFHC at least once a month. And every month on a fixed day a meeting should be

arranged with all the Health Workers (Female) from the PHCs with their reports. PHC level AFHC data should be collated and submitted to BPMU by the 5th of each month.

3.6 For monitoring, PHCs will be expected to maintain the following:

- **AFHC prescription** for every adolescent visiting the AFHC, with a registration number. Counsellor will fill up the initial findings, followed by doctor filling in treatment details. The AFHC prescription will be kept by the adolescent. An indicative format of the AFHC prescription is provided in Exhibit 3.01
- **Enrollment and clinical register** for registering adolescents who have come to the AFHC. This should be maintained by the health assistant (f) managing registration. An indicative format is provided in Exhibit 3.02
- **Counselling register** maintained by the Counsellor.
- **Stock register (existing format used in the PHC).** This would be maintained by the health assistant (female) at the registration desk

Exhibit 3.01: AFHC Prescription Format

AFHC PRESCRIPTION

Name (optional) ..... Registration # .....

Address ..... Date .....

Height ..... Weight .....

Age ..... Gender: Male/Female

School going/Drop out Marital Status .....

Problem (here the counsellor will write only the physical problem faced by the adolescent):

.....

.....

.....

Treatment (to be filled by doctor):

.....

.....

.....

Advice by the counsellor:

.....

.....

.....

Follow up required: Yes No

Follow up visit details: .....

.....

Referral details: .....

.....

Exhibit 3.02: Enrollment and clinical register

Date	Registration#	Name	Village/SC	Age	Sex	Height (ft/inch)/weight (kg)	Marital Status	In school/drop out	Type of visit (first/follow up)	If referred (by PE/ASHA/ANM)	Nature of physical problem	Treatment	Medicine/IFA/ contraceptive/ Sanitary napkins	Referral

Community Health Center/District Hospital

3.7 It is recommended that the District nodal officer, Adolescent Health should provide supportive supervision to counsellors at CHCs, DHs and Medical Colleges. Districts should consider organising a quarterly meeting for all counsellors to discuss difficult cases and other issues.

3.8 CHCs, DHs and Medical colleges should maintain similar records as PHCs. A consolidated report based on the compilation of block AFHC data, CHC and DH AFHC data should be submitted to the District Data Manager latest by 10th of each month.

3.9 Finally, a consolidated district level report should be submitted to the state by 15th of each month. Based on these district monthly progress reports, states are expected to send a quarterly progress report[1] to the centre.

Quality Assurance

3.10 To ensure quality of service delivery, it is recommended that the District Nodal Officer, Adolescent Health should visit and assess the following facilities at least once a quarter:

- All AFHCs at CHCs/DHs/Medical Colleges
- 10% of PHC level AFHCs

3.11 Assessment will typically involve reviewing progress documented in counselling registers, observing clinical and counselling practice and getting feedback from visiting adolescents and peer educators. Exhibit 3.03 provides an illustrative checklist for assessment.

3.12 Based on the quarterly assessment, feedback should be given to counsellors on which aspects are working well, what can be improved and how it can be improved.

[1] This would be a report covering all AH interventions. For format refer to Annexure VI.

Exhibit 3.03: Checklist for AFHC Assessment

Checklist

Date of visit .....

Name of the supervisor ..... Name of the facility .....

Overall scenario

Timing of AFHC

	Remarks	
Staff trained in AH		
MO trained	Yes	No
Counsellor trained	Yes	No
SN/ANM trained	Yes	No
Vacant position (if any)	_____	
Registers properly maintained and updated		
Enrollment registers	Yes	No
Counselling registers	Yes	No

Average clients per clinic session

Interview with the counsellor

Clarity on role and responsibility	Yes	No
Clarity on importance of privacy And confidentiality	Yes	No

Observation

Signboard indicating location and timing of clinic

Waiting space available

Medicines available

Equipment available

IEC material available

Feedback from adolescents

Findings and recommendations

4 Implementation Process for AFHC

4.1 For planning, implementing and monitoring of AFHC, an indicative step wise implementation process at state and district level has been provided in Exhibit 4.01 and 4.02 respectively.

Exhibit 4.01: State Level Implementation Process for AFHC

Steps	Activities	Description	Frequency	Responsibility
1	*Adapt/translate guideline*	Adapt the AFHC Operating Guideline to meet state specific conditions. Translate into local language (If required)	One time	State Nodal Officer (AH)
2	*Disseminate and read the AFHC guideline*	The translated AFHC guideline should be disseminated to the concerned officers at state, district and block program management unit	One time	State Nodal Officer (AH)
3	*Prepare Standard Operating Procedures (SOP) for AFHC*	Prepare a SOP for AFHC keeping in mind local needs and challenges. SOP should be based on the AFHC guideline and in consultation with PMUs and other health divisions (MH, CH, FP, NCD, and IEC etc.)	One time	State Nodal Officer (AH)
4	*Assessment of the existing ARSH clinics*	An assessment of existing ARSH facilities operating in the State (including HR and training needs)	During program inception and every 3 years after	RCH Manager and State Nodal Officer (AH)
5	*Prioritization of districts*	Based on the assessment districts can be prioritized for operationalization of AFHCs. This can be phased across 3 years	In 3 batches	State Nodal Officer (AH)
6	*Detail implementation plan*	In consultation with the districts and other stakeholders, prepare detailed AFHC implementation plan: • Prioritize districts for implementation; plan for phase implementation throughout the state • Facility upgradation plan • Staff orientation and mobilization plan • Communication (IEC/BCC) plan • Commodities procurement plan • Budget for implementation	Annual	State Nodal Officer (AH)
7	*Government/ Office order for implementation*	GO/ OO should be issued to districts for implementation of AFHC as per the plan	One time (phased manner)	Director H & FW

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Steps	Activities	Description	Frequency	Responsibility
8	*Procurement and recruitments: HR/furniture/ equipment*	Based on the assessment calculate the HR required and also provision for space/furniture/equipments in the selected District/facilities. Procure equipments and furniture and recruit staff	Annually	SPM/ State Nodal Officer (AH)
9	*Training*	• Translate and print training manuals • Training of trainers – identification of trainers and forming a pool at the state level. • Preparing a training calendar to train all the MO, Specialists, SN, HA (f) and the counsellors associated to the AFHC • Training as per categories in batch not more than 25-30; Refresher training (this can be made part of the existing RCH training)	One time	State Nodal Officer (AH)/ SIHFW
10	*Rolling out MIS*	• All formats and registers are printed and distributed to the districts • Defining the MIS process (data collection and compilation) • Training of Data Managers at state and district level on AFHC MIS	Continuous	SPM/ State Nodal Officer (AH)
11	*Procurement/ sourcing of commodities/ medicines*	Procurement or sourcing of medicines and commodities as applicable (Contraceptive, IFA, Sanitary Napkin)	Continuous	State Nodal Officer (AH)/ Procurement division
12	*Monitoring and supportive supervision*	Monitoring and supportive supervision of AFHC through facility visits and meetings	Monthly	State Nodal Officer (AH)
13	*Data compilation and reporting*	Regular district level data compiled at state level and reporting as per the MIS format	Monthly/ Quarterly/ Annual	State Nodal Officer (AH)/ State MIS officer

Exhibit 4.02: District Level Implementation Process for AFHC

Steps	Activities	Description	Frequency	Responsibility
1	*Read the AFHC guideline and SOP*	Read AFHC guidelines and SOP as provided by the state	One time	District Nodal Officer (AH)/ CMO
2	*Prepare and submit district implementation plan*	Prepare detailed district AFHC implementation plan: • Staff orientation and mobilization plan • Communication (IEC/BCC) plan • Inventory management plan • Implementation calendar • Budget for implementation	Annually	District Nodal Officer (AH)

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Steps	Activities	Description	Frequency	Responsibility
3	***Office order for implementation***	Office order for all the concerned MO I/C should be issued for implementation of AFHC as per the plan	One time	CMO
4	***Inventory Management***	Set up and ensure inventory management for AFHC	One time	District Nodal Officer (AH)
5	***Monitoring and supportive supervision***	Monitoring and supportive supervision of AFHC through facility visits and meetings	Monthly	CMO/ District Nodal Officer (AH)
6	***Data compilation and reporting***	Regular block level data compiled at district level and reporting as per the MIS format	Monthly/ Quarterly/ Annual	District Nodal Officer (AH)/ District MIS Officer

[i] Adolescent Friendly Health Services—An Agenda for Change (2002), World Health Organisation.

[ii] Making Health Services Adolescent Friendly: developing national quality standards for adolescent-friendly health services (2012), World Health Organisation.

[iii] Making Health Services Adolescent Friendly: developing national quality standards for adolescent-friendly health services (2012), World Health Organisation.

[iv] Adolescent Friendly Health Services—An Agenda for Change (2002), World Health Organisation.

Annexure IV

Key Programmes for Adolescent Health and Development

Key Programmes for Adolescent Health and Development under Various Ministries and Suggested Areas of Convergence[1]

GoI Ministry	Programmes	Ground-level Linkages
Health and Family Welfare	• Family Planning • Maternal Health • SCH • National AIDS Control Programme • National Tobacco Control Programme • National Mental Health Programme • National Programme for NCDs	• Strengthen existing linkages with NACO, Family Planning and Maternal Health divisions for information, including existing programmes and schemes, counselling, services and commodities • Family planning: Provision of contraceptives and pregnancy kits to adolescents; capacity building of health functionaries regarding varied contraceptive needs of adolescents; incentivisation of ASHAs for delaying first pregnancy in married adolescents. • Maternal health-tracking of adolescent pregnancy for birth preparedness and complications prevention; capacity building of health functionaries to manage adolescent pregnancy and its complications. • SHP: Universal screening to include mental health problems such as depression, suicidal tendencies, risk of substance abuse and NCDs. Linkages between SHP and adolescent health clinics; peer educators to be involved in the implementation of universal screening. • 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)—linkages with NCD clinics at CHC and DH levels; inclusion of health promotion on NCD prevention in training modules of MOs, ANMs, staff nurses, teachers and peer educators • National Tobacco Control Programme (NTCP): Trigger behaviour change to eliminate tobacco use among adolescents through peer educators, role models and school-based activities of NTCP • Service providers/volunteers at schools, AWCs and teen clubs to be trained in health promotion
Women and Child Development	• ICDS • *Kishori Shakti Yojana* (KSY) • *Balika Samriddhi Yojana* (BSY) • Rajiv Gandhi Scheme for Empowerment of Adolescent Girls (*Sabla*) • *Swadhar* Scheme • *SAKSHAM*	• AWC to be the hub of activities for out of school girls (*Sabla* and KSY to serve as platforms) • Linkages with BSY for community awareness on legal age at marriage • AWWs to be trained in health promotion for adolescent health programme areas, viz., nutrition and healthy lifestyles; SRH in order to inform mobilise/influence adolescents, care-givers and the community through regular contact and *Kishori Diwas* • AWWs to select and mentor peer educators under *Sabla* (use *Sakhi Saheli* when possible) • 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*) • AWWs will also undertake screening for BMI and palmar pallor (pale palms) and the implementation of WIFS, and refer adolescents girls, as and when required, to the health service providers/facilities • AWWs to ensure supplementary nutrition and early registration of pregnant adolescent girls • Use of *Sabla* module to train ANMs

Contd...

[1] Source: Extract from National Adolescent Health Strategy, MoHFW.

GoI Ministry	Programmes	Ground-level Linkages
Human Resource Development	• AEP • MDM scheme under the SSA • RMSA • Sakshar Bharat • National Population Education Project (NPEP)	• AEP to cover all the secondary and senior secondary schools of the country. AEP-trained teachers from CBSE, *Kendriya Vidyalayas* (KVs), and *Navodaya Vidyalaya* Schools (NVS) and State Board schools, to provide health education on SRH, HIV/AIDS, and substance abuse • Teachers to select, and mentor peer educators—incentive-based activity • Teachers to be the first point of contact for guidance and counselling for Nutrition, SRH, substance misuse, mental health, NCD-related issues of adolescents • Adolescent health development and promotion to be included in pre-service and in-service training of teachers so that every school has at least one trained teacher • Linkages with MDM for provision of supplementary nutrition and implementation of WIFS • Nodal teachers for WIFS to conduct Nutrition, Health and Education sessions in schools • Linkages with *Sakshar Bharat* for information on nutrition • Inclusion of topics related to mental health, substance abuse, NCDs, nutrition and violence in the curricula of secondary and senior secondary schools • Peer educators enrolment from schools and provision of scholarships and certificates for peer educators • Using the platform of schools to increase awareness about facility-based health services for adolescents at Adolescent 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 Service Scheme • NYKS Programmes • NPYAD	• Adolescents, who have undergone 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 utilised to provide counselling services to adolescents • Trained District Youth Coordinators and Project Coordinators can be trained on adolescent health and development • NYKS has linkages with local NGOs, the capacity of which can be built through training provided by skilled personnel from the Health Department

Annexure V

Budget Format

Adolescent Health Detailed Budget: 2014-15

S.No.	Budget Head	Progress FY 2013-14				Proposed 2014-15												Remarks
		Physical Progress		Financial Progress (Rs. Lakhs)				Quarter 1 (Apr - Jun 2014)		Quarter 2 (Jul - Sep 2014)		Quarter 3 (Oct - Dec 2014)		Quarter 4 (Jan - Mar 2015)		Total Proposed (Apr 2014 - Mar 2015)		State to mention whether the activity proposed is new or to be continued from previous year. Justification to be given
		Targets 2013-14	Achievement (as on__ 2013)	Budget 2013-14	Expenditure (as on__ 2013)	Unit of Measure	Unit Cost (Rs.)	Quantity / Target	Budget (Rs. Lakh)	Quantity / Target	Budget (Rs. Lakh)	Quantity / Target	Budget (Rs. Lakh)	Quantity / Target	Budget (Rs. Lakh)	Quantity / Target	Budget (Rs. Lakh)	
A.4	*Adolescent Health*																	
A.4.1	**Adolescent health services**																	
A.4.1.1	Dissemination/ meetings/workshops/ review for AH (including WIFS, MHS)																	
A.4.1.2	Establishment of new clinics at DH/Medical college level																	
A.4.1.3	Establishment of new clinics at CHC/PHC level																	
A.4.1.4	Operating expenses for existing clinics																	
A.4.1.5	Non financial incentives for Peer Educators																	
A.4.1.6	Organizing Adolescent Health day																	
A.4.1.7	Mobility Support for AH/ICTC counsellors																	
A.4.1.8	**Others**																	
A.4.1.8.1	Translation and printing of strategy and operating guidelines																	
A.4.1.8.2																		
A.4.1.8.3																		
A.4.1.8.4																		
A.4.1.8.5																		
A.4.1.8.6																		
A.4.1.8.7																		

Contd...

S.No.	Budget Head	Progress FY 2013-14				Proposed 2014-15												Remarks
		Physical Progress		Financial Progress (Rs. Lakhs)				Quarter 1 (Apr - Jun 2014)		Quarter 2 (Jul - Sep 2014)		Quarter 3 (Oct - Dec 2014)		Quarter 4 (Jan - Mar 2015)		Total Proposed (Apr 2014 - Mar 2015)		State to mention whether the activity proposed is new or to be continued from previous year. Justification to be given
		Targets 2013-14	Achievement (as on__ 2013)	Budget 2013-14	Expenditure (as on__ 2013)	Unit of Measure	Unit Cost (Rs.)	Quantity / Target	Budget (Rs. Lakh)	Quantity / Target	Budget (Rs. Lakh)	Quantity / Target	Budget (Rs. Lakh)	Quantity / Target	Budget (Rs. Lakh)	Quantity / Target	Budget (Rs. Lakh)	
A.4.1.8.8																		
A.4.1.8.9																		
A.4.1.8.10																		
A.4.2	Weekly Iron and Folic Acid Supplementation Programme activities (procurement to be budgeted under B16)																	
A.4.3	Scheme for Promotion of Menstrual Hygiene activities (procurement to be budgeted under B16)																	
A.4.4	National Iron Plus Initiative (procurement to be budgeted under B16)																	
A.4.5	**Other strategies/ activities (please specify)**																	
A.4.2.1																		
A.4.2.2																		
A.4.2.3																		
A.8	*Human Resource*																	
A.8.1.7.5	**Counsellors**																	
A.8.1.7.5.2	Adolescent Health counsellors																	
A.8.1.7.7	Others (pl specify)																	
A.9	*Training*																	
A.9.1	**Development of training packages**																	

Contd...

S.No.	Budget Head	Progress FY 2013-14				Proposed 2014-15												Remarks
		Physical Progress		Financial Progress (Rs. Lakhs)				Quarter 1 (Apr - Jun 2014)		Quarter 2 (Jul - Sep 2014)		Quarter 3 (Oct - Dec 2014)		Quarter 4 (Jan - Mar 2015)		Total Proposed (Apr 2014 - Mar 2015)		State to mention whether the activity proposed is new or to be continued from previous year. Justification to be given
		Targets 2013-14	Achievement (as on__ 2013)	Budget 2013-14	Expenditure (as on__ 2013)	Unit of Measure	Unit Cost (Rs.)	Quantity / Target	Budget (Rs. Lakh)	Quantity / Target	Budget (Rs. Lakh)	Quantity / Target	Budget (Rs. Lakh)	Quantity / Target	Budget (Rs. Lakh)	Quantity / Target	Budget (Rs. Lakh)	
A.9.1.1	Development/ translation and duplication of training materials																	
A.9.6	**Adolescent Health Trainings**																	
A.9.6.1	**Adolescent Friendly Health Service trainings**																	
A.9.6.1.1	TOT for Adolescent Friendly Health Service training																	
A.9.6.1.2	AFHS training of Medical Officers																	
A.9.6.1.3	AFHS training of ANM/ LHV																	
A.9.6.1.4	AFHS training of AWW/ MPW																	
A.9.6.1.5	Training of counsellors																	
A.9.6.2	**Training of Peer Educators**																	
A.9.6.2.1	State level																	
A.9.6.2.2	District level																	
A.9.6.2.3	Block Level																	
A.9.6.3	**WIFS trainings**																	
A.9.6.3.1	State																	
A.9.6.3.2	District																	
A.9.6.3.3	Block																	
A.9.6.4	**MHS trainings**																	
A.9.6.4.1	State																	
A.9.6.4.2	District																	

Contd...

S.No.	Budget Head	Progress FY 2013-14				Proposed 2014-15												Remarks
		Physical Progress		Financial Progress (Rs. Lakhs)				Quarter 1 (Apr - Jun 2014)		Quarter 2 (Jul - Sep 2014)		Quarter 3 (Oct - Dec 2014)		Quarter 4 (Jan - Mar 2015)		Total Proposed (Apr 2014 - Mar 2015)		State to mention whether the activity proposed is new or to be continued from previous year. Justification to be given
		Targets 2013-14	Achievement (as on__ 2013)	Budget 2013-14	Expenditure (as on__ 2013)	Unit of Measure	Unit Cost (Rs.)	Quantity / Target	Budget (Rs. Lakh)	Quantity / Target	Budget (Rs. Lakh)	Quantity / Target	Budget (Rs. Lakh)	Quantity / Target	Budget (Rs. Lakh)	Quantity / Target	Budget (Rs. Lakh)	
A.9.6.4.3	Block																	
A.9.6.4.4	SHG training																	
A.9.6.6	**Other Adolescent Health training**																	
A.9.6.6.1																		
A.9.6.6.2																		
A.9.6.6.3																		
A.9.6.6.4																		
A.9.6.6.5																		
A.9.8	**Programme Management Training (e.g. M&E, logistics management, HRD etc.)**																	
A.9.8.4.1	Training of SPMU, DPMU and BPMU staff on Adolescent health strategy, Operating manual and SOPs																	
A.10	*Programme Management*																	
A.10.1	**Strengthening of State society/ State Programme Management Support Unit**																	
A.10.1.5.1	Program Officer -WIFS																	
A.10.1.5.2	Program Officer -ARSH																	
A.10.1.5.3	Program Officer -Menstural Hygine																	
A.10.1.5.4	Program Officer -WIFS																	
A.10.1.5.5	State Nodal Officer - Adolescent Health																	

Contd...

S.No.	Budget Head	Progress FY 2013-14				Proposed 2014-15												Remarks
		Physical Progress		Financial Progress (Rs. Lakhs)				Quarter 1 (Apr - Jun 2014)		Quarter 2 (Jul - Sep 2014)		Quarter 3 (Oct - Dec 2014)		Quarter 4 (Jan - Mar 2015)		Total Proposed (Apr 2014 - Mar 2015)		State to mention whether the activity proposed is new or to be continued from previous year. Justification to be given
		Targets 2013-14	Achievement (as on__ 2013)	Budget 2013-14	Expenditure (as on__ 2013)	Unit of Measure	Unit Cost (Rs.)	Quantity / Target	Budget (Rs. Lakh)	Quantity / Target	Budget (Rs. Lakh)	Quantity / Target	Budget (Rs. Lakh)	Quantity / Target	Budget (Rs. Lakh)	Quantity / Target	Budget (Rs. Lakh)	
A.10.2	**Strengthening of District society/ District Programme Management Support Unit**																	
A.10.2.4	District Nodal Officer - Adolescent Health																	
A.10.3	**Strengthening of Block PMU**																	
A.10.3.7.1	Block Nodal Officer - Adolescent Health																	
A.10.7	**Mobility Support, Field Visits**																	
A.10.7.4.1	Supportive supervision for AH strategies (AFHC, AHD, PE, WIFS, MHS)																	
B1	*ASHA*																	
B.1.1.3.4	Adolescent Health incentives for ASHA																	
B.1.1.3.4.1	Incentive for support to Peer Educator																	
B.1.1.3.4.2	Incentive for mobilizing adolescents for AHD																	
B8	*Panchayati Raj Initiative*																	
B8.3.1	Orientation workshops of PRI and VHSC members on Adolescent Health																	
B.10	*IEC-BCC NRHM*																	
B.10	**Strengthening of BCC/ IEC Bureaus (state and district levels)**																	
B.10.1	Development of State BCC/IEC strategy																	

Contd...

S.No.	Budget Head	Progress FY 2013-14				Proposed 2014-15												Remarks
		Physical Progress		Financial Progress (Rs. Lakhs)				Quarter 1 (Apr - Jun 2014)		Quarter 2 (Jul - Sep 2014)		Quarter 3 (Oct - Dec 2014)		Quarter 4 (Jan - Mar 2015)		Total Proposed (Apr 2014 - Mar 2015)		State to mention whether the activity proposed is new or to be continued from previous year. Justification to be given
		Targets 2013-14	Achievement (as on__ 2013)	Budget 2013-14	Expenditure (as on__ 2013)	Unit of Measure	Unit Cost (Rs.)	Quantity / Target	Budget (Rs. Lakh)	Quantity / Target	Budget (Rs. Lakh)	Quantity / Target	Budget (Rs. Lakh)	Quantity / Target	Budget (Rs. Lakh)	Quantity / Target	Budget (Rs. Lakh)	
B.10.2.4	**BCC/IEC activities for AH**																	
B.10.2.4.1	Mass media																	
B.10.2.4.2	Mid-media																	
B.10.2.5	Other activities (please specify) (include initiatives for delay in age of marriage)																	
B.10.2.6	IPC initiatives/tools																	
B.10.3	Health Mela (Adolescent Health Day)																	
B.10.4	Creating awareness on declining sex ratio issue																	
B.10.5	**Other activities**																	
B.10.5.2	Printing of WIFS cards etc.																	
B.10.5.4	**Other printing**																	
B.10.5.4.1	Printing of NIPI compliance cards																	
B.10.5.4.2	AFHC cards/registers/ AHD formats etc.																	
B.10.5.4.3																		
B.13	***PPP/ NGOs***																	
B.13.3	NGO Programme/ Grant in Aid to NGO																	
B.13.3.1																		
B.13.3.2																		
B.14	**Innovations (if any)**																	
B.14.1	Intersectoral convergence																	
B.14.2																		

Contd...

S.No.	Budget Head	Progress FY 2013-14				Proposed 2014-15												Remarks
		Physical Progress		Financial Progress (Rs. Lakhs)				Quarter 1 (Apr - Jun 2014)		Quarter 2 (Jul - Sep 2014)		Quarter 3 (Oct - Dec 2014)		Quarter 4 (Jan - Mar 2015)		Total Proposed (Apr 2014 - Mar 2015)		State to mention whether the activity proposed is new or to be continued from previous year. Justification to be given
		Targets 2013-14	Achievement (as on__ 2013)	Budget 2013-14	Expenditure (as on__ 2013)	Unit of Measure	Unit Cost (Rs.)	Quantity / Target	Budget (Rs. Lakh)	Quantity / Target	Budget (Rs. Lakh)	Quantity / Target	Budget (Rs. Lakh)	Quantity / Target	Budget (Rs. Lakh)	Quantity / Target	Budget (Rs. Lakh)	
B.16	*Procurement*																	
B16.1.6	**Equipments for AH/ RBSK**																	
B16.1.6.1	Equipments for AFHCs and AHD																	
B.16.2	**Procurement of Drugs and supplies (other than national free drug scheme)**																	
B.16.2.1.3.1	IFA and albendazole for AH																	
B.16.2.3.1	Contraceptives for AH																	
B.16.2.5	**General drugs & supplies for health facilities**																	
B.16.2.5.2	OPD (AFHC)																	
B.16.2.6	**Drugs & supplies for WIFS**																	
B.16.2.6.1	IFA																	
B.16.2.6.2	Albendazole																	
B.16.2.7	**Drugs & supplies for RBSK**																	
B.16.2.7.2.3	Children 10-19 years (in school till 18 years both boys and girls and till 19 years out of school adolescent girls)																	
B.16.2.10	Sanitary napkins procurement																	
B.18	*New Initiatives/ Strategic Intervention*																	
B.18.1	Adolescent Helplines																	
	Grand Total																	

Contd...

Adolescent Health Budget Summary: 2014-15

S. No.	Budget Head	Budget Proposed 2014-15				
		Q 1	Q 2	Q 3	Q 4	Total Proposed (Apr 2014- Mar 2015)
		Budget (Rs. Lakhs)	Budget (Rs. Lakhs)	Budget (Rs. Lakhs)	Budget (Rs. Lakhs)	Budget (Rs. Lakhs)
A.4	**Adolescent Health**					
	Adolescent health services (including establishment of new AFHCs, non financial incentive to peer educator, organizing AHD etc.)					
	Others					
A.8	**Human Resource**					
	Counsellors					
A.9	**Training**					
	Development of training packages					
	Adolescent Health Trainings					
	Adolescent Friendly Health Service trainings					
	Training of Peer Educators					
	WIFS trainings					
	MHS trainings					
	Other Adolescent Health training					
	Programme Management Training (e.g. M&E, logistics management, HRD etc.)					
A.10	**Programme Management**					
	Strengthening of State society/State Programme Management Support Unit					
	Strengthening of District society/District Programme Management Support Unit					

Contd...

S. No.	Budget Head	Budget Proposed 2014-15				
		Q 1	Q 2	Q 3	Q 4	Total Proposed (Apr 2014- Mar 2015)
		Budget (Rs. Lakhs)	Budget (Rs. Lakhs)	Budget (Rs. Lakhs)	Budget (Rs. Lakhs)	Budget (Rs. Lakhs)
	Strengthening of Block PMU					
	Mobility Support, Field Visits					
B1	**ASHA**					
	Adolescent Health incentives for ASHA					
B8	**Panchayati Raj Initiative**					
B10	**IEC-BCC NRHM**					
	Strengthening of BCC/IEC Bureaus (development of IEC/BCC strategy)					
	BCC/IEC activities for AH					
	Other activities					
B.13	**PPP/NGOs**					
	NGO Programme/Grant in Aid to NGO					
	Innovations (intersectoral convergence)					
B.16	**Procurement**					
	Equipments for AH/RBSK					
	Procurement of Drugs and supplies (other than national free drug scheme)					
	General drugs & supplies for health facilities					
	Drugs & supplies for WIFS					
	Drugs & supplies for RBSK					
B.18	**New Initiatives/Strategic Intervention (Adolescent Helpline)**					
	Grand Total					

Adolescent Health District Wise Budget: 2014-15

S.No.	Budget Head	Budget Proposed 2014-15						
		State		District 1		District 2		Total Proposed (Apr 2014 - Mar 2015)
		Tribal	Total	Tribal	Total	Tribal	Total	Budget (Rs. Lakhs)
A.4	**Adolescent Health**							
	Adolescent health services (including establishment of new AFHCs, non financial incentive to peer educator, organizing AHD etc.)							
	Others							
A.8	**Human Resource**							
	Counsellors							
A.9	**Training**							
	Development of training packages							
	Adolescent Health Trainings							
	Adolescent Friendly Health Service trainings							
	Training of Peer Educators							
	WIFS trainings							
	MHS trainings							
	Other Adolescent Health training							
	Programme Management Training (e.g. M&E, logistics management, HRD etc.)							
A.10	**Programme Management**							
	Strengthening of State society/State Programme Management Support Unit							
	Strengthening of District society/District Programme Management Support Unit							
	Strengthening of Block PMU							

Contd...

S.No.	Budget Head	Budget Proposed 2014-15						
		State		District 1		District 2		Total Proposed (Apr 2014 - Mar 2015)
		Tribal	Total	Tribal	Total	Tribal	Total	Budget (Rs. Lakhs)
	Mobility Support, Field Visits							
B1	**ASHA**							
	Adolescent Health incentives for ASHA							
B8	**Panchayati Raj Initiative**							
B10	**IEC-BCC NRHM**							
	Strengthening of BCC/IEC Bureaus (development of IEC/BCC strategy)							
	BCC/IEC activities for AH							
	Other activities							
B.13	**PPP/NGOs**							
	NGO Programme/Grant in Aid to NGO							
	Innovations (intersectoral convergence)							
B.16	**Procurement**							
	Equipments for AH/RBSK							
	Procurement of Drugs and supplies (other than national free drug scheme)							
	General drugs & supplies for health facilities							
	Drugs & supplies for WIFS							
	Drugs & supplies for RBSK							
B.18	**New Initiatives/Strategic Intervention (Adolescent Helpline)**							
	Grand Total							

Adolescent Health Budget: 2014-17

S. No.	Budget Head	Budget Proposed			Total Proposed (2014- 2017)	
		2014-15	2015-16	2016-17		
		Budget (Rs. Lakhs)	Budget (Rs. Lakhs)	Budget (Rs. Lakhs)	Budget (Rs. Lakhs)	% of total AH budget
A.4	Adolescent Health					
A.8	Human Resource					
A.9	Training					
A.10	Programme Management					
B1	ASHA Incentive					
B8	Panchayati Raj Initiative					
B10	IEC-BCC NRHM					
B.13	PPP/ NGOs					
B.16	Procurement					
B.18	New Initiatives/Strategic Intervention (Adolescent Helpline)					
	Grand Total					

Annexure VI

Quarterly Reporting Format

Quarterly Reporting Format for Rashtriya Kishor Swasthaya Karyakaram

Name of State: _____ Reporting period: _____ to _____

A. Basic Information

A1 Total Number of adolescents (10-19 yrs) in the state: _____ *(Provide source)*

A2 Target Groups

		Male		Female		Total (e)
		In school (a)	Drop-out (b)	In school (c)	Drop-out (d)	
A2.1	10 to 14 years old					
A2.2	15 to 19 yrs old					
A2.3	**Total**					

A3 Total number of married adolescents in the state: _____ *(Provide source)*

B. Peer Educator (PE)

		Reporting Period (a)	Cumulative till date (b)	*Indicative Data Source*
B1	Total no. of peer educators planned for enrollment:			*PIP*
B2	Total no. of peer educators enrolled:			*PE monthly report*
B3	Total no. of peer educators trained:			*PE training report*
B4	Total no. of PE session planned:			*PIP*
B5	Total no. of PE session held:			*PE monthly report*
B6	Total no. of adolescents reached through PE sessions:			*PE monthly report*
B7	Total no. of adolescents referred by PE to AFHC:			*PE monthly report*

B8	Percentage of Peer Educator enrolled against planned	*B2a/ B1a*	*B2b/ B1b*
B9	Percentage of peer educators trained (out of total number of PEs)	*B3a/B2a*	*B3b/B2b*
B10	Percentage of adolescents reached through village based PEs	*B6a/A1*	*B6b/A1*
B11	Percentage of sessions held by peer educators against planned	*B5a/B4a*	*B5b/B4b*

Contd...

C. Adolescent Friendly Health Clinics (AFHC)

		Reporting Period (a)	Cumulative till date (b)	%ge		Indicative Data Source
C1	Total no. of adolescents visiting AFHC					*AFHC monthly report*
C2	Total no. of adolescents referred by PE					*"*
C3	Total no. of adolescents referred by community (apart from PE)					
C4	Total no. of adolescents accessing AFHC for:			Reporting period	Cumulative till date	
C4.1	Puberty-related problems			*(C4.1a/ C4.5a)/100*	*(C4.1b/ C4.5a)/100*	
C4.2	RTIs/STIs and abortion care			*(C4.2a/ C4.5a)/100*	*(C4.2b/ C4.5a)/100*	
C4.3	Mental health concerns			*(C4.3a/ C4.5a)/100*	*(C4.3b/ C4.5a)/100*	
C4.4	Others			*(C4.4a/ C4.5a)/100*	*(C4.4b/ C4.5a)/100*	
C4.5	Total	*C4.1a+ C4.2a+ C4.3a+ C4.4a*	*C4.1b+ C4.2b+ C4.3b+ C4.4b*			
C5	Total no. of adolescents counselled					*"*
C6	Total no. of AH counsellors planned for recruitment					*PIP*
C7	Total no. of AH counsellors recruited					*SPMU/ DPMU records*
C8	Total no. of AH counsellors trained					*Counsellors training report*
C9	Total no. of AFHCs planned for opreationalisation					*PIP*
C9.1	PHC					
C9.2	CHC					
C9.3	DH/ Medical colleges					
C9.4	Total	*C9.1a+ C9.2a+ C9.3a*	*C9.1b+ C9.2b+ C9.3b*			
C10	Total no. of AFHCs operationalised					*SPMU/ DPMU records*

Contd...

C10.1	PHC			
C10.2	CHC			
C10.3	DH/ Medical colleges			
C10.4	Total	*C10.1a+ C10.2a+ C10.3a*	*C10.1b+ C10.2b+ C10.3b*	
C11.1	Number of MO (Male) planned for training in AFHC			*PIP*
C11.2	Number of MO (Female) planned for training in AFHC			*PIP*
C12.1	Total no. of MO (Male) trained in AFHC			*MO training report*
C12.2	Total no. of MO (female) trained in AFHC			*MO training report*
C13	Number of ANM/ LHV planned for training in AFHC			*PIP*
C14	Total no. of ANM/LHV trained in AFHC			*ANM/LHV training report*
C15	Percentage of AFHC operationalised against planned	*C10.4a/C9.4a*	*C10.4b/C9.4b*	
C15.1	PHC	*C10.1a/C9.1a*	*C10.1b/C9.1b*	
C15.2	CHC	*C10.2a/C9.2a*	*C10.2b/C9.2b*	
C15.3	DH/ Medical colleges	*C10.3a/C9.3a*	*C10.3b/C9.3b*	
C16	Percentage of AH counsellors recruited against planned	*C7a/C6a*	*C7b/C6b*	
C17	Percentage of trained Counsellors in place against planned	*C8a/C6a*	*C8b/C6b*	
C18	Proportion of trained counsellors to total number of adolescents	*C8a/A1*	*C8b/A1*	
C19	Percentage MO (male) trained in AFHS against planned	*C12.1a/C11.1a*	*C12.1b/C11.1b*	
C20	Percentage MO (female) trained in AFHS against planned	*C12.2a/C11.2a*	*C12.2b/C11.2b*	
C21	Percentage of ANMs/LHVs trained on AFHS against planned	*C14a/C13a*	*C14b/C13b*	

D. Adolescent Health Day (AHD)

		Reporting Period (a)	Cumulative till date (b)	*Indicative Data Source*
D1	Total no. of AHD planned			*PIP*
D2	Total no. of AHD held			*AHD monthly report*
D3	Total no. of adolescents who visited AHD			"

Contd...

D4	Total no. of female adolescents who visited AHD			"
D5	Total no. of adolescents screened for BMI			"
D6	Total no. of adolescents referred to AFHCs during AHD			"
D7	Total no. of AHD where contraceptive was provided			"
D8	Total no. of adolescents provided contraceptives during AHD			"
D9	Total no. of adolescents provided sanitary napkins during AHD			"
D10	Total no. of parents who have attended AHD			"
D11	Total no. of parents who were sensitised through IPC/ Orientation/discussion during AHD			"

D12	Percentage of AHD planned and held	D2a/D1a	D2b/D1b
D13	Percentage of AHDs providing contraceptives	D7a/D2a	D7b/D2b
D14	Percentage of parents who were sensitised through IPC/ Orientation/ discussion during AHD	D11a/D10a	D11b/D10b

E. Weekly Iron Folic Supplementation (WIFS)

		Reporting Period (a)	Cumulative till date (b)	*Indicative Data Source*
E1	Percentage of care-givers (AWWs, teachers) who have been trained on implementation of WIFS			*WIFS monthly report*
E2	Coverage of WIFS: percentage of adolescents given 4 or 5 IFA tablets in the reporting month			"
E3	Coverage of Albendazole: Percentage of adolescents given Albendazole tablets in the last six months			"
E4	Percentage of distribution points for WIFS reporting IFA stock-out			"

F. Menstrual Hygiene Scheme (MHS)

		Reporting Period (a)	Cumulative till date (b)	*Indicative Data Source*
F1	Number of adolescent girls provided free sanitary packs			*MHS monthly report*
F2	Number of sanitary packs distributed to adolescents			"

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