सत्यमेव जयते

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NATIONAL HEALTH MISSION
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Training Manual on Adolescent Health Care Services for Community Health Officer

at Ayushman Bharat – Health and Wellness Centres

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CONTENTS

ANNEXURE

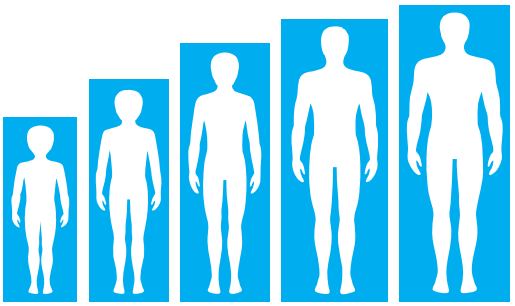
List of Abbreviations:

AB-HWC	Ayushman Bharat-Health and Wellness Centre
AH	Adolescent Health
AFHC	Adolescents Friendly Health Clinic
AHD	Adolescent Health Day
AIDS	Acquired Immunodeficiency Syndrome
ARSH	Adolescent Reproductive Sexual Health
ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AWC	Anganwadi Centre
AWW	Anganwadi Worker
BMI	Body Maas Index
CHC	Community Health Centre
CHO	Community Health Officer
DH	District Hospital
FRU	First Referral Unit
HIV	Human Immunodeficiency Virus
HWC	Health and Wellness Centre
ICDS	Integrated Child Development Services
ICTC	Integrated Counselling and Testing Centres
IDU	Injectable Drug User
IEC	Information Education Communication
IMR	Infant Mortality Rate
LBW	Low Birth Weight
MHS	Menstrual Hygiene Scheme
MMR	Maternal Mortality Ratio
MNCH	Maternal, Newborn and Child Health
MPW	Multipurpose Health Worker
MO	Medical Officer
NCD	Non communicable Diseases
NDD	National Deworming Day
NFHS	National Family Health Survey
NRHM	National Rural Health Mission
PE	Peer Educator
PHC	Primary Health Centre
PID	Pelvic Inflammatory Disease
RCH	Reproductive and Child Health
RTA	Road Traffic Accident
RKSK	Rashtriya Kishore Swasthya Karyakram
RTI	Reproductive Tract Infection
SHC	Sub Health Centre
SHP	School Health Programme
STI	Sexually Transmitted Infection
UNFPA	United Nation Population Fund
UNICEF	United Nation Children's Fund
VHSNC	Village Health, Sanitation and Nutrition Committee
VHSND	Village Health, Sanitation and Nutrition Day
WHO	World Health Organization
WIFS	Weekly Iron Folic Acid Supplementation

1 IMPORTANCE OF ADOLESCENT HEALTH

Health Status of Adolescents and Service Delivery Framework

Adolescence (10-19 years) is a phase of life which has recently gained recognition as a distinct phase with its own special needs. This phase is characterised by acceleration of physical, psychological and behavioural changes thus bringing about transformation from childhood to adulthood. Adolescence is divided into three phases: early, middle, and late adolescence, referring to ages 10 to 13 years, 14 to 16 years, and 17 to 19 years respectively.



Age group	Age	Source
Children	0-18 years	Convention on the right of the child
Adolescent	10-19 years	UNFPA, WHO, UNICEF
Very Young Adolescent	10-14 years	UNFPA, UNICEF
Youth	15-24 years	UNFPA, WHO, UNICEF
Young People	10-24 years	UNFPA, WHO, UNICEF

The percentage of adolescents (10-19 years) in India is increasing and comprises of more than one-fifth of the total population. The adolescents face multi-complex issues such as malnutrition, gender discrimination, violence, and early marriage followed by complications during pregnancy and childbirth. Almost 60% of premature deaths among adults are associated with behaviours and conditions that begin or occur during adolescence such as tobacco and alcohol use, poor eating habits, lack of exercise, high risk of RTI/STI and HIV/AIDS[1]. While injuries and communicable diseases are prominent causes of disability and deaths in the 10-14 years age group, outcomes of high-risk sexual behaviour and mental health becomes significant for the 15 to 19 years age group[2].

Adolescent health and nutrition status has an inter-generational effect. Anemia and malnutrition are major factors which affect adolescent's physical development, for e.g., in adolescent girls, nutritional deprivation reduces their school attendance, learning ability and overall performance. Adolescent boys in India face different sets of problems, their own inhibitions do not allow them to express their problems and needs easily. Sedentary lifestyle, changing dietary patterns, increasing consumption of alcohol and smoking are key risk factors which increase the incidence of non-communicable conditions in their later stages of life.

Adolescents face a lot of pressure which range from interpersonal issues with friends and family to poverty, adapting to cultural norms, difficulties in dealing with past traumas, such as sexual harassment, violence such as domestic violence and gender-based violence. This often has an impact on their wellbeing and behaviour which can lead to stress and if unaddressed can lead to more complex mental disorders such as depression and eating disorders.

1 Source 2002. World Health Report. Geneva: WHO

2 WHO, Global Health Estimates (GHE) 2016

There is lack of information, poor knowledge, and unavailability of counselling services for adolescents, and when present, the services are influenced by factors such as lack of adequate privacy, confidentiality and judgmental attitude of service providers, who often lack counselling skills.

Many time adolescents require socio-psychological support and motivation to deal with their personal and family relationships, physical and psychological changes in their body, peer pressure and emotions.

As a leader of the AB-HWC at SHC, your role will be to ensure quality delivery of adolescent friendly health interventions through proper counselling. The following table on Service delivery framework will help you understand in depth the activities that need to be undertaken to support adolescents.

Table 2: Service Delivery Framework

Care at Community level	Care at SHC, AB-HWC	Care at referral sites
Counselling on: • Improving nutrition. • Sexual and reproductive health. • Enhancing mental health. • Promoting supportive attitudes for preventing injuries and violence. • Preventing substance abuse. • Promote healthy lifestyle. • Personal hygiene - Oral Hygiene . • Menstrual hygiene. • Peer counselling. • Identification and management of anemia, with referral if needed. • Provision of IFA tablets (prophylactic and therapeutic) under Anemia Mukt Bharat. • Bi-annual Deworming under National Deworming Day.	• Adolescent health counselling • Detection of cases of substance abuse, referral and follow up • Detection and Treatment of Anaemia (nutritional and non-nutritional) and other deficiencies in adolescents • Detection and referral for growth abnormality and disabilities, with referral as required	• Screening for medical disorders and treatment, with referral if required • Management of growth abnormality and disabilities, with referral as required • Management including rehabilitation and counselling services in cases of substance abuse • Counselling at Adolescent Friendly Health Clinics (AFHC)

Why it is important to focus and invest in health and development of adolescents:

Adolescence is characterised by physical, psychological and social transitions, all of which carry new risks but also present opportunities to positively influence the immediate and future health of young people.

The present scenario related to adolescent health in India, mentioned in Figure 1, shows that the focus on adolescent health is very crucial for social and economic future of the country. In order to enable adolescents to fulfil their potential, substantial investments must be made in education, health and development and other areas like nutrition and mental wellbeing. Reasons for investing in adolescent health is shown in Figure 2. Investments in adolescents will have returns, which are immediate and cause direct positive impact on India's health goals, achievement of SDGs goals and at the same time enhance economic productivity, effective social functioning, and overall population development.

Figure1: Importance of focusing on Adolescent Health (Census and NFHS 4 data):

- Adolescents constitute 19.6% of population.
- 33% girls married by 18 years.
- Unmet need for family planning (15-49 years) - 22.2%.
- Only15% of currently married women aged 15-19 use a contraceptive method and 10% use a modern contraceptive method.
- 7.9% of currently married women aged 15-19 years have already begun childbearing.
- Prevalence of anemia in adolescent girls – 54%.
- Miscarriages are particularly high (10%) for women aged 15-19 years.
- 17% of women aged 15-19 years experience physical violence.

Figure 2: Reasons for investing in adolescent health & development.

- To develop the capacity to cope with daily life situations and deal with them effectively.
- To inculcate healthy habits and behaviours.
- To reduce adolescent morbidity and mortality.
- To impact national indicators like high TFR, IMR. MMR and arrest HIV epidemic.
- A healthy adolescent grows into a healthy adult.
- Economic benefits: Increase productivity, averting future health cost of treating tobacco, alcohol & other substance abuse related illness, AIDS, & lifestyle illnesses.
- As a human right, adolescents have a right to achieve optimum level of health.

2 THE HEALTH PROBLEMS THAT ADOLESCENTS FACE

The health status of an adolescent determines his/her health as an adult. Many serious diseases of adulthood have their roots in adolescence. Also, many adolescents die prematurely due to reasons that are either preventable or treatable, and many more suffer from chronic illnesses and disability. Young and growing children have poor knowledge and lack awareness about physical and psychological changes that occur during adolescence. The key health problems during adolescence are mentioned below:

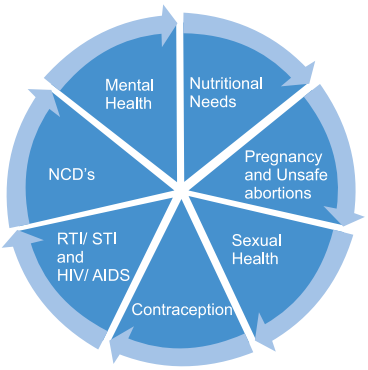


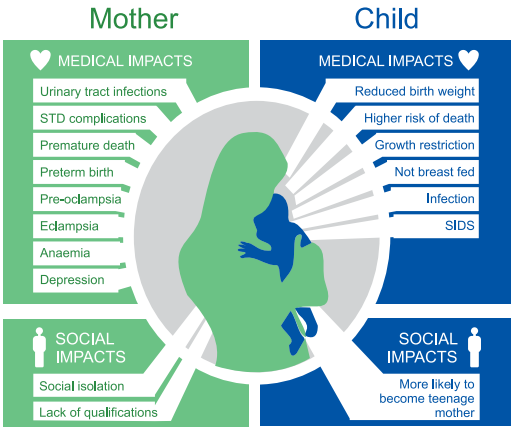
Table 3: Key Health Problems of Adolescents

Sexual and Reproductive Health	Other Issues

• Teenage pregnancy
  ▸ Risk to mother
  ▸ Risk to baby
• Health problems during pregnancy and childbirth
• Unsafe abortions
• Reproductive tract infections, sexually-transmitted infections & HIV
• Menstrual problems (scanty, irregular, painful, excessive)
• Vaginal discharge
	• Injuries from accidents/near-drowning
	• Intentional violence
	• Mental health problems
	• Substance abuse such as tobacco, alcohol etc.
	• Malnutrition & micronutrients deficiency
	• Worm infestations
	• Other infectious diseases

Teenage Pregnancy:

An early marriage inevitably puts the adolescent girl at the risk of getting pregnant. High fertility and discontinued education after marriage remain the other facets of concern but the greatest risk from teenage pregnancy is the higher rate of pregnancy-related complications which lead to high morbidity and mortality both in the mother and the baby. The available evidence suggests that maternal deaths are considerably higher among adolescents as compared to older women. Also, the babies born to them have low birthweight and are more likely to die at birth or in infancy.



Early pregnancy has serious psychological, social, and economic consequences too. It continues to be an impediment to improvement in the educational, economic, and social status of women, and is likely to have an adverse impact on the quality of life of the family.

The other lesser talked about issues of pregnancies outside marriage, as an outcome of rape, sexual coercion or sexual abuse bears a terrible stigma and puts the adolescent at a far greater risk of both physical and mental trauma.

Factors That Lead to Teenage Pregnancy:

- Customs and traditions that lead to early marriage
- Lack of education and information about reproductive sexual health, including lack of access to tools that prevent pregnancies
- Peer pressure to engage in sexual activity/substance abuse
- Incorrect use of contraception
- Exposure to abuse, violence, and family strife at home
- Low self-esteem
- Low educational ambitions and goals

Table 4: Complications of Adolescent Pregnancies:

Antenatal Period	During Labour and Delivery	Post-Partum Period	Problems affecting the baby
• Pregnancy-induced hypertension/Pre-eclampsia /Eclampsia • Anemia • STI/HIV infection • Abortion • Intra Uterine Growth Retardation	• Pre-term labour • Obstructed/Prolonged labour • Birth injuries	• Nutritional deficiency • Anemia • Eclampsia • Postpartum depression • Puerperal sepsis	• Low birth weight • Premature baby • Inadequate childcare and breastfeeding practices • Birth defect

Fig: 3 Role of CHO in case of adolescent pregnancy

- Refer the adolescent pregnant girl (married/unmarried) to an FRU/higher facility where gynaecologist is available (irrespective of whether she wants to continue with the pregnancy or wants an abortion).
- Counselling on intake of balanced, nutritious diet and birth preparedness, breastfeeding, complications of early pregnancy, use of contraceptive methods in future.
- Follow-up care.
- CHO should also try to counsel the parents/caregivers of the teenage girls to avert early marriages.

Unsafe Abortions:

Adolescent pregnancy often leads to unsafe abortion especially if the girl is unmarried. The consequences of this type of abortion can be life threatening. Although abortion is legal in India, it is estimated that 8 lakh Indian women still resort to illegal abortions per year because of social stigma, lack of awareness and lack of access to health facilities that offer technically competent services.

Factors contributing to unsafe abortions in adolescents:

- Delay in seeking abortion is the most important factor and the most common cause of complications and death among adolescents. Delay is again due to ignorance (not aware that pregnancy has occurred) or hoping to hide pregnancy till it becomes too late.
- The judgmental and unwelcoming attitudes of health providers can also lead to delay in reaching them.

- It is common among adolescents to go to untrained and unskilled providers especially when they are unmarried, or if married and the pregnancy is unintended, the adolescent wants to get rid of it clandestinely (without informing the in-laws). The younger they are, it is more likely that they will be forced to opt for a potentially unsafe abortion conducted in an unhygienic condition by an unskilled provider.
- There is a general lack of awareness among adolescents about the 'Medical Termination of Pregnancy' that can be availed at registered health facilities. These are inaccessible because of the family's need for secrecy, confidentiality, and pressure from societal and community demands.
- Use of dangerous methods are also common in adolescents, especially unmarried girls who are advised by mothers, untrained birth attendants, quacks, to insert foreign bodies (sticks, roots etc.) into the cervix un-hygienically or ingest certain potions or drugs.
- Even after a spontaneous abortion, an adolescent may have post abortion complications, if the abortion is not complete or some infection has occurred or unhygienic practices were followed.

Reproductive Tract Infections (RTIs) and Sexually Transmitted Infections (STIs)

Fig 4: Role of CHO in safe abortion services

- CHO should support the ASHA and MPW of the SHC-HWC to increase awareness in the community regarding risks and consequences of adolescent pregnancy, childbirth, and unsafe abortions.
- Provide easily available, friendly, non-judgemental, confidential family planning, counselling, and services.
- Recognition of signs and symptoms of abortion complications (heavy bright red vaginal bleeding with or without clots, pallor etc).
- Refer to appropriate referral site for safe abortion services. For medical method of abortion up to 7 weeks refer to PHC-MO and to CHC/DH if pregnancy is 8 weeks to 20 weeks.
- With approval of two registered medical practitioners, termination of pregnancies can be done between 20 to 24 weeks. The termination of pregnancies up to 24 weeks will only apply to specific categories of women, as may be prescribed by the government guidelines.
- Follow up for any post abortion complications and refer to higher facility if needed.
- Provide post abortion contraceptive counselling.

Due to high-risk sexual behaviour, young generation face the risk of RTIs and STIs like HIV-AIDS. Many adolescents engage in sexual intercourse with multiple partners without contraceptives, placing them at risk of contracting sexually transmitted infections, including herpes genitals, syphilis, gonorrhoea, chancroid, genital warts, and HIV.

Consequences of Unsafe Sexual Behaviour among Adolescents

- Early pregnancy and parenthood
- Higher percentage of Low Birth Weight (LBW) babies and increased infant morbidity and mortality
- Abortions and its related complications
- RTI/STI including HIV/AIDS

Consequences that are higher in adolescents even if it has been 'safe sex'

- Emotional impact – guilt, stress, anxiety, suicide
- Social impact – stigma
- Economic impact – hindrance to academic and career progression

RTI is an infection of the genital tract. The infection can affect vulva, vagina, cervix, uterus, tubes, and ovaries in women. Infection of uterus and the tube, known as Pelvic Inflammatory Diseases (PID), can result in infertility. RTIs include all infections of the reproductive tract, whether transmitted sexually or not.

STI is transmitted from one person to another primarily by sexual contact. Some STIs can be transmitted by exposure to contaminated blood, or from a mother to her unborn child. This is a major public health problem for two reasons:

- STIs result in serious negative medical and psycho-social effects in the infected individual. In case of infected females, there is the added risk of infection and illness in the unborn child.
- STIs, especially those with genital ulcers, facilitate the transmission of HIV between sexually active partners. The prevention and treatment of STIs, therefore, is a key component of the strategy to prevent transmission of HIV.

Human Immunodeficiency Virus (HIV)/Acquired Immuno-Deficiency Syndrome (AIDS) in Adolescents

Table 5: Symptoms of STIs in Adolescents

Symptoms in both boys and girls	Symptoms in girls	Symptoms in boys
• Genital ulcers (sores) • Burning sensation while passing urine • Swelling in the groin • Itching in the genital region • Pain during sexual intercourse • Genital swelling • Pain in lower abdomen • Painful vesicles on genitalia	• Unusual vaginal discharge • Pain in lower abdomen • Change in menstrual flow • Vaginal/vulvar itching	• Discharge from the penis • Painful scrotal swelling

If any adolescent reports such a sign/symptom, you should guide and refer him/her to STI/RTI clinics/ AFHC

Fig 5: Role of CHO in prevention of RTI/STI

- Create awareness on RTI/STI among adolescents
- CHO should counsel on the following topics to prevent RTI/STIs:
  - Maintaining proper genital hygiene. Maintaining proper menstrual hygiene
  - Practicing responsible sexual behaviour
  - Practicing safe sex – using condom during intercourse
  - Avoiding sexual contact if either of the partner has an STI
  - Unusual genital discharge
  - Ensuring complete treatment of self and sexual partner
  - Opting for institutional delivery
  - Availing safe abortion services

- In 2017, the HIV prevalence in adolescents in India was estimated at 0.22%. The adult HIV prevalence was estimated at 0.25% among males and at 0.19% among females. (Source: HIV Estimation 2017)
- The adult HIV prevalence at national level has continued its steady decline from an estimated peak of 0.38% in 2001-03 to 0.34% in 2007, 0.28% in 2012, 0.26% in 2015, and 0.22% in 2017. (Source: HIV Estimation 2017)

Transmission of HIV

- Different forms of sexual contact including unprotected anal, vaginal, or oral sex.
- From an infected mother to her child (Mother to Child Transmission: MTCT) during pregnancy, delivery, or breastfeeding.
- Sharing of infected syringes and needles contaminated with infected blood and other body fluids, such as injectable drug users, use of contaminated skin-cutting tools, and needle stick injuries in health care settings.
- Transfusion of infected/unsafe blood or blood products.

Preventing HIV/AIDS transmission - Provide counselling to adolescents on:

- Practicing safe sex.

- Avoid use of unsterilised needles and other injecting equipment.
- Injectable Drug Users (IDUs) must not share syringes or needles (Needle exchange programme).
- Avoid unsafe blood transfusion.
- Pregnant women should have access to ICTC (Integrated Counselling and Testing Centres).

Mental Health:

Poor mental health in adolescents can lead to adverse social outcomes, such as poor interpersonal relationships, violent behaviour, high consumption of alcohol, tobacco and illicit substances use, school dropout, conduct disorders and delinquent behaviour. These problems may increase in adolescence due to the hormonal and other physical changes during puberty, along with changes in adolescent's social environment. Mood fluctuations, transient depressive feelings, and anxiety are most common, but sometimes they may be as serious as suicidal thoughts or even attempting suicide, disproportionately affecting adolescents. Violence, humiliation and feeling devalued can increase the risk of developing mental health problems.

Here is an example of how you may do a sexual and reproductive health assessment:

- Do you know what a sexually transmitted infection is?
- Have you learned about reproductive health at school, at home or elsewhere? **Note:** Probe to find out whether the adolescent is knowledgeable about basic anatomy and functioning, menstruation, pregnancy and contraception, and sexually transmitted infections.
- Do you know how one could get pregnant?

Table 6: Risk and Protective Factors for Depression among Adolescents

	Risk factor	Protective factor
Family	Family conflict	Positive relationships Encouragement of self-expression
School	Bullying	Safe environment Supportive staff
Community	Ethnic clashes	Positive relationship with different community members
Beliefs		Having a spiritual belief

Source: Broadening the horizons: Balancing protection and risk for adolescents. Geneva, World Health Organization, 2001.

Consequences of mental illnesses in adolescents

- Suffering (e.g., personal distress, family distress)
- Functional impairment (e.g., inability to study, work, raise a family or be independent)
- Stigma and discrimination (e.g., isolation, missed opportunities, abuse from others)
- Increased risk-taking behaviour (e.g., unprotected sex, excessive alcohol use) and premature death (e.g., violence, suicide, overdose of drugs)

Suggested hints to assess an adolescent's mental health:

- What the adolescent says about their thoughts and feelings.
- What the adolescents say they do (self-reported behaviour).
- Observing how the adolescent looks (personal care) and sounds (tone of voice) –self-care behaviour.
- What others (e.g., parents, teachers, other adults, siblings, peers) say the adolescent does or says about his or her thoughts and feelings, if possible.
- Observing the adolescent's interaction with other people and behaviour.
- Medical records.
- You can use **'HEADS framework'** to obtain an adolescent's psychosocial history **(Annexure 1)**.

Mental illness presenting as physical symptoms:

Mental illness may be present as ill-defined physical symptoms or unexplained illness, e.g.:

- Sleep problems or unexplained tiredness
- Anxiety and palpitations
- Dizziness, trembling and sweating
- Generalised aches and pains (including of the head, chest and abdomen)
- Poor appetite or loss of weight
- History of high-risk behaviour or substance dependence, alcohol etc.
- Social withdrawal or reduced participation in school, work or social activities
- Declining academic performance
- Self-report or report by others of frequently engaging in high-risk behaviour, e.g., reckless driving or playing with firearms
- For the first five symptoms, a medical illness should be ruled out before suspecting mental health issues

You should provide counselling and refer for detailed history, examination and management at referral centre with a mental health expert in position.

Injuries:

Violence and unintentional injuries are two of the interrelated areas of vulnerability that adolescents may encounter. Alcohol use by adolescents increases the risk of both violence and Road Traffic Accidents (RTA). According to WHO, around 50% of deaths are reported due to RTA among adolescents (Global status report on road safety, 2018, WHO). Counselling of adolescents about safe driving, promoting nurturing relationships between parents and children early in life, and reducing access to alcohol can help to prevent injuries and deaths due to violence.

Substance Abuse:

The use of alcohol, tobacco and drugs by adolescents is associated with physical violence, depression, suicide and increased risky behaviours, such as unsafe sex or dangerous driving. It is an underlying cause of injuries (including those due to road traffic accidents), violence and premature deaths. It can also lead to health problems in later life such as diabetes, cardiovascular diseases etc. which affects overall life expectancy.

Common reasons among adolescents for substance misuse behaviours are shown in figure given below:

Fig 6: Role of CHO in preventing substance use

- Counselling of adolescents regarding harmful effects of substance misuse during Adolescent Health Days and VHSNDs at SHC-HWC.
- Counselling of parents to keep communication open with their children, try to be a positive role model and monitor children's activities closely.

Non-Communicable Diseases (NCDs):

Across the country in the past two decades, people have experienced a dramatic change in the pattern of diseases. There is a declining trend in infectious (communicable) diseases and a steady rise in the so-called lifestyle diseases or non-communicable diseases.

Diet and lifestyle are two major factors thought to influence susceptibility to many diseases. Drug abuse, tobacco use, smoking and alcohol consumption, as well as lack of exercise may increase the risk of developing certain diseases in later part of life. There is greater rate of obesity due to sedentary lifestyles, more time on computers/phones and increased intake of high energy sugary and fried foods and drinks. In the age group 15-19 years nearly 2 per 1000 girls and 1 per 1000 boys suffer from diabetes (NFHS-3).

Adolescence provides an opportune time for positive behaviour modification, to mitigate the emergence of risk factors of NCDs. The main preventable risk factors for NCDs such as tobacco and alcohol consumption, poor dietary habits, sedentary lifestyle, and stress have their beginnings often in this age group. So, it is imperative to initiate the promotion of healthy lifestyle habits at a younger age to prevent NCDs.

Nutrition during adolescence

Adolescence is a significant period for physical growth and sexual maturation. Nutrition being an important determinant of physical and mental growth of adolescents as an important area that needs attention.

Inadequate nutritional intake during adolescence can have serious consequences throughout the reproductive years and beyond. Poor nutrition during adolescence can impair the work capacity and productivity of adolescent boys and girls in their later years. Further, an undernourished girl is at the risk of developing complications during pregnancy and the chances of her giving birth to a low-birth-weight baby increases, thus perpetuating a vicious cycle of malnutrition and ill-health, and an intergenerational effect.

About half of the adolescent girls (15-19 years) suffer from anemia (NFHS-4). 42% of adolecent girls and 45% of adolescent boys of the same age group are reported to have Body Mass Index (BMI) below 18.5 (NFHS-4). Iodine Deficiency Disorders can lead to growth retardation, delayed puberty and menarche, juvenile hypothyroidism etc. Missing meals, eating junk food and food fads are equal in rural and urban areas among adolescents, affecting their health adversely. This is driven by fancy towards role models and publicity from the food industry.

Balanced Diet

A balanced diet is one that provides all nutrients in required quantity and proportions for maintaining health and general well-being and makes a small provision for extra nutrients to withstand short duration of illness. It can be achieved through a blend of the basic food groups namely carbohydrates, proteins, fats, vitamins, and minerals. As these are present in different types of food items like pulses, cereals and millets, green vegetables and milk, egg, fish, meat etc., it is important to eat these food items in the right mix every day.

Recommended Dietary Allowance of Nutrients for adolescents in 24 hours.

Table: 7: Recommended Dietary Allowance of Nutrients for adolescents (10-18 years) in 24 hours						
	Male			**Female**		
	10-12 Years	13-15 Years	16-18 Years	10-12 Years	13-15 Years	16-18 Years
Estimated Energy requirement (Kcal)	2200	2860	3320	2060	2400	2500
Protein (Gms)	31.8	44.9	55.4	32.8	43.2	46.2
Calcium (Mg)	850	1000	1050	850	1000	1050
Iron (Mg)	16	22	26	28	30	32

Source: ICMR-NIN (2020)

Malnutrition:

Nutrition influences growth and development throughout infancy, childhood, and adolescence. It is, however, during the period of adolescence that nutrient needs are the greatest.

Malnutrition can be classified as under-nutrition, over-nutrition (overweight and obesity), and micronutrient deficiency. Under-nutrition is when someone is not getting enough calories or nutrients; it can be due to either an insufficient diet or a problem in assimilating nutrients. Over-nutrition occurs when too many nutrients are ingested. Deficiency of micronutrients such as vitamins, iron, calcium, zinc, etc. affects body's immune system. All types of malnutrition can lead to serious health problems which can be fatal.

The signs and symptoms of malnutrition include:

- Fatigue and low energy
- Problems with learning
- Bloated stomach
- Slowed reaction times and trouble paying attention
- Dizziness
- Poor immune function (which leads to frequent illnesses in the adolescent)
- Dry, scaly skin, swollen and bleeding gums
- Decaying teeth
- Underweight and poor growth
- Muscle weakness and bones that break easily

Management of Nutrition

Nutrition Assessment and Counselling in adolescents

Nutritional assessment is an important part of evaluation of an adolescent. A stepwise approach should be adopted.

Step 1: History - Nutritional history in adolescence

History about foods and eating habits should be taken primarily from the adolescent alone, and from parents also but separately. This is important as adolescent may not reveal some of the eating behaviours in front of the parents. It should be clarified to the adolescent that the purpose is to find out problem areas and not to find faults in them. In nutritional history, all details about food pattern, past and present

illness, daily physical activities should be noted. You can refer RKSK resource book for medical officer for detail.

Step 2: Physical Examination

It is important to take weight, height. Weight should be taken in minimum clothes, height with a measuring scale. Weight and height should be plotted on the charts and interpreted accordingly. The signs (pallor palm and conjunctiva and nail beds) and symptoms (easily fatigued, headache, pain in limbs, shortness of breath etc.) of anemia should also be checked. Other signs of vitamins and other deficiencies may be found.

Step 3: Laboratory Test

Generally, no laboratory tests are required if only mild inadequacies are noted. For severe malnutrition (under or overweight) the adolescent should be referred to an expert. The CHO should enquire if haemoglobin estimation of the adolescent has been done within one year at school or AWC as part of annual screening under Anemia Mukt Bharat programme. If not, Hb estimation should be done to check for anemia and should be managed accordingly (prophylaxis or therapeutic).

Step 4: Nutritional Counselling

All points noted in history and examination should be reviewed carefully and habits related to nutrition should be identified and shared with adolescent and parents (with permission of the adolescent client). It is important to make them understand about the importance of nutrition, how to choose healthy food and drinks. CHOs should help them to make healthy meal plan.

Anemia:

Anemia is a condition in which the number of red blood cells (RBCs), and consequently their oxygen-carrying capacity, is insufficient to meet the body's physiological needs. Anemia is a significant public health challenge in India. It results from one or more of the following process: defective red cell

Fig 7: Role of CHO in prevention of Malnutrition

- Counselling:
  - Consumption of healthy, nutritious, and balanced diet. Avoid frequent consumption of junk/unhealthy food.
  - Avoid consumption of alcohol, tobacco, and drugs.
  - Regular physical activity is required for maintaining good metabolism so that the food ingested is properly assimilated and utilised to have a healthy body. Regular physical activity is also important for reducing stress. Other activities like yoga sessions etc. also aid in maintaining hormonal balance, improving flexibility of body, and reducing mental stress.
- Yoga Sessions:
  - Organise yoga sessions at HWC-SHC.
- Support peer educator to discuss about nutrition and nutritional requirement during adolescent friendly club meeting.
- Aware members of VHSNC on adolescent nutrition and promote discussion on adolescent nutrition during VHSNC meeting

production, increased red cell destruction or blood loss.

In 2018, the MoHFW launched the Anemia Mukt Bharat (AMB) strategy to reduce the anemia prevalence in six target age groups, namely children 6-59 months, children 5-9 years, adolescents 10-19 years, pregnant women, lactating women and women of reproductive age (15-49 years). The strategy adopts a multi-pronged 6x6x6 approach to address both nutritional and non-nutritional anemia through continuum of care.

Types of anemia:

1. **Nutritional Anemia:** It is caused due to deficiency of micro-nutrient such as minerals (iron, zinc, copper, selenium etc.) and vitamins (Folic acid, Vit B12, Vit B6)
2. **Non-nutritional Anemia:** Due to hemoglobinopathies (thalassemia and sickle cell anemia), Soil Transmitted helminths inflammation, fluorosis and malaria and diseases such as tuberculosis etc.

Nutritional Anemia:

In nutritional anemia, due to the decrease in haemoglobin level below normal (Hb less than 12gm %), every tissue cell suffers from lack of oxygen. Grading of anemia as per WHO is as mentioned in Table 8

Most common prevalent nutritional deficiency in India is iron deficiency anemia (50%).

Table 8: Grading of anemia

Population	Anemia		
	Mild	Moderate	Severe
Adolescent girls 10-19 years	10.0-11.9 gm/dl	7-9.9 gm/dl	<7gm/dl
Adolescent boys 10-19 years	12-12.9 gm/dl	9.0-11.9 gm/dl	< 9 gm/dl

The cause, signs, and symptoms of nutritional anemia is as under

Table 9: Causes, sign and symptoms of Nutritional Anemia

Causes	Signs and symptoms
• Inadequate intake of the dietary iron. • Improper absorption of iron. • Loss of iron from the body. • Worm infestations.	• Tiredness and weakness. • Breathlessness. • Pale face, nails, tongue, and conjunctiva of eyes. • Lack of concentration: ▸ Reduces capacity to work thus decreased productivity. ▸ Limit learning ability. ▸ Causes loss of appetite. ▸ Affects the growth and development. ▸ Increases vulnerability to infections due to decrease in immunity.

Anemia in girls has deleterious consequences. Anemic girls on entering the reproductive age, will have lower pre-pregnancy iron stores and are at an increased risk of giving birth to pre-term newborns, babies with a low birth weight (below 2,500 grams) and have complications during child birth.

Non-nutritional anemia:

Non-nutritional anemia can be due to chronic blood loss in conditions such as heavy menstruation and/or hemorrhoids. Non-nutritional anemia can also be due to hemoglobinopathies such as sickle cell disease and thalassemia. In areas endemic for malaria, fluorosis and haemoglobinopathies, non-nutritional anemia is a common finding.

In the endemic areas, special focus should be given to integrate screening and treatment of anemia, along with screening and treatment of malaria, haemoglobinopathies and fluorosis, respectively.

Prevention & Control of anemia: Intake of adequate and balanced nutrition will cover all the required nutrients to prevent nutritional anemia.

Sources of dietary iron: Iron from food comes in two forms: heme and non-heme. Heme is found only in animal flesh like meat, eggs and fish etc. Non-heme iron is found in plant foods like whole grains, nuts, seeds, legumes, and leafy greens. Non-heme iron is also found in animal flesh (as animals consume plant foods with non-heme iron) and fortified foods.

Other than dietary supplements, management of anemia through iron folic acid supplementation should be done as per the table 10 mentioned below:

Table 10: Prophylactic management of nutritional Anaemia

Drugs	Intervention/dose	Regime	Service delivery

Figure 8 : Heme and non-heme sources of dietary iron

Table 10: Prophylactic management of nutritional Anaemia			
Iron Folic Acid Supplementation (IFA Tablets)	60 mg of elemental iron and 500 mcg of folic acid	Weekly, one IFA tablet	• For school going boys and girls through teachers in the school • For out of school adolescent girls through AWW in AWC. • Mobilisation by ASHA
Deworming	400 mg of Albendazole (one tablet)	Biannual	Under National Deworming Day (10th February and 10th August): • For school going children through teachers in the school • For out of school adolescents through AWW • Mobilisation of out-of-school children by ASHA to the Anganwadi centres
Therapeutic management of nutritional anemia (Mild, Moderate and Severe)			
Mild and Moderate Anemia (Girls: Hb 11.9-7 gm/dl; Boys 12.9-9 gm/dl)			
First level of treatment (at all levels of care)	Two IFA tablets (each with 60 mg elemental iron and 500 mcg folic acid), once daily for 3 months, orally after meals		
Follow up	• Line listing of all moderate anemic cases to be maintained by the ANM/LHV/MPW of the designated area. • Follow-up by ANM/LHV/MPW of designated area, as feasible for the State • Encourage parents to ensure follow-up of adolescents after 60 days and -90 days at the nearest Sub-Health Centre/ Health and Wellness Centre • If the haemoglobin levels have improved to normal, discontinue the treatment, but continue with the prophylactic IFA dose		
If no improvement after the first level of treatment	• If no improvement after three months of treatment (i.e., still in mild/moderate category), CHO/ANM of the nearest HWC to refer adolescents to the First Referral Unit (FRU)/District Hospital		
Severe Anemia (Girls: Hb<7 gm/dl; Boys: Hb<9 gm/dl)			
• Management of severe anemia in adolescents is to be done by the medical officer at the FRU/DH based on investigation and subsequent diagnosis. • Complete Blood Count (CBC) should be done to ascertain the cause of anemia (nutritional and non-nutritional). • Iron supplementation is contraindicated in severe anemia for patients with thalassemia major and sickle cell disease.			

Weekly Iron Folic Acid Supplementation (WIFS)

The MoHFW is implementing the Iron and Folic Acid Supplementation Programme under the Anemia Mukt Bharat strategy to meet the challenge of high prevalence and incidence of anemia amongst adolescent girls and boys.

Target groups:

- School-going adolescent girls and boys in 6th to 12th class enrolled in government/government aided/municipal schools.
- Out-of-school adolescent girls 10-19 years; married or unmarried will be reached through AWW.

Intervention in schools and AWC*:

- Administration of supervised Iron-folic Acid tablet of 60 mg elemental iron and 500 ug folic acid every week using a fixed day approach.
- Screening of target groups for mild/moderate/severe anemia using digital hemoglobinometers and referring the severe anemic cases to an appropriate nearby government health facility.
- Biannual de-worming (Albendazole 400 mg), six months apart, for control of helminths infestation.
- Information and counselling for improving dietary intake and prevention of intestinal worm infestation.

*AWW with the help of ASHA will mobilise out-of-school adolescent girls at AWC on a fixed day in a week. On that day one IFA tablet will be provided to each girl by AWW and she will ensure supervised ingestion of IFA tablets by adolescent girls.

The programme also encourages and provides for the consumption of IFA tablets by the frontline workers such as AWW, ASHA, and teachers to enhance the value of IFA among adolescents and community members.

In order to screen adolescents for mild/moderate/severe anemia at schools and AWCs RBSK-Mobile Health Teams have been trained to estimate Hb level using digital invasive hemoglobinometers.

Fig 8: Role of CHO in Prevention of Anemia

- CHO should counsel adolescent and community on:
  - Intake of iron rich food like green leafy vegetables, whole grains, meat, fish, jaggery, nuts etc.
  - Tannins in tea and caffeine in coffee and calcium supplements should be avoided with or immediately before or after meals as they reduce iron absorption.
  - Adding vitamin C rich foods (such as amla, lemon, tomato, guava etc) to regular diet can improve the absorption of iron.
  - Access to schemes of food supplementation (under ICDS scheme).
  - Ensure and encourage intake of weekly IFA supplements by the adolescents seeking care for any ailments.
  - Creating awareness on adolescent's health nutrition issues through various platforms like VHND, convergent meeting, village functions etc.
  - Ensure having a discussion or session on anemia in adolescents in VHSNC meeting and other village meetings.
  - Refer severely anemic adolescents to the linked PHC/CHC/DH for further management and treatment. Review follow up of cases by ASHA and ANM.
  - In areas endemic for haemoglobinopathies, sensitisation of the population on screening for haemoglobinopathies through CBC and monitor treatment compliance to be ensured by ANM.
  - Refer the identified cases of haemoglobinopathies to higher centres for further confirmation and treatment in areas endemic for malaria, with the help of ASHA and ANM, ensure every household in the village is provided with LLIN.
  - Visit schools in your catchment area to supervise the IFA supplementation.
  - Oversee the availability of IFA, supply chain, adverse events reporting for the catchment area and sharing about the gaps found, if any, with MO of concerned PHC.
  - Coordinate with AWW and provide her the details of unserved or underserved out of school beneficiaries as well as the vulnerable AH group to enhance the coverage of out-of-school adolescent girls.
  - Prevention from worm infestations and promotion of sanitary practices.

Over nutrition (Overweight and Obesity):

Overweight and obesity are mainly due to an imbalance between energy intake and energy expenditure (through physical activities and bodily functions). Obesity leads to high blood cholesterol, high blood pressure, heart disease, diabetes, and certain types of cancer.

Genetic and environmental factors also play a role but paying attention towards diet and physical activity is important not only for preventing weight gain, but also for weight loss and subsequent maintenance to stay fit and active.

Nutritional programme for adolescents.

There are many related to prevention of malnutrition in India. Table: 11:

Nutrition Programme	Ministry
Anemia Mukt Bharat strategy	Ministry of Health and Family Welfare
National Deworming Day (NDD)	Ministry of Health and Family Welfare
Special Nutrition Programme	Ministry of Social Welfare
Integrated Child Development Services	Ministry of Women & Child Development
Mid-Day Meal Scheme	Ministry of Education
Iodine Deficiency Disorders Control Programme	Ministry of Health and Family Welfare
Kishore Shakti Yojna	Ministry of Women and Child Development
School Health & Wellness Programme under Ayushman Bharat	Ministry of Health and Family Welfare& Ministry of Education jointly
Scheme for Adolescent Girls (SAG)	Ministry of Women and Child Development

3 RASHTRIYA KISHORE SWASTHYA KARYAKARAM

Overview of Rashtriya Kishor Swasthya Karyakaram (RKSK)

In order to respond to the health and development needs of adolescents in a holistic manner, the government is implementing Rashtriya Kishor Swasthya Karyakaram. This programme has shifted the focus from the existing clinic-based curative services to a more comprehensive preventive and promotive care for the adolescents within their community and schools.

Target Population: Includes all adolescents in the age group of 10-19 years; girls and boys, urban and rural, in school and out of school, married and unmarried adolescents. There is special focus on adolescents of vulnerable and marginalised population groups including urban slums, tribal areas, migrants, working adolescents and those with mental/physical disability, street children, those in care homes, and juvenile homes.

Table 11: RKSK includes six strategic priorities and objectives:

There are many related to prevention of malnutrition in India. Table: 11:

S.no	Strategic priorities	Objectives
1	Enable Sexual and Reproductive Health	• Improve knowledge attitude and behaviour in relation to menstrual hygiene. • Reducing teenage pregnancies. • Improve birth preparedness and complications readiness. • Provide parenting support for adolescent parents.
2	Improve Nutrition	Reduce prevalence of malnutrition and Iron deficiency anaemia.
3	Address Non-communicable diseases	Promote behaviour change in adolescents to prevent NCDs.
4	Prevent Substance misuse	Increase adolescent awareness on the adverse effects of substance abuse.
5	Prevent Injuries and violence	Promote favourable behaviour and attitudes for preventing injuries and violence including gender-based violence.
6	Enhance Mental health	Improve knowledge and skills on mental health issues of adolescents among health workers.

Implementation includes provision of services at three level given in Table 12 below:

Table 12: Implementation approach of RKSK

Facility based approach	Community based approach	School based approach
• Adolescent Friendly Health Clinics (AFHCs) providing clinical and counselling services • Adolescent Health Resource Centre at District Hospital	• Weekly Iron Folic Acid Supplementation (WIFS) • National Deworming Day (NDD) • Provision of sanitary napkins (MHS) • Peer Education Programme (PE) • Quarterly Adolescent Health Days (AHD) • Adolescent Friendly Clubs (AFCs)	• Strengthening of school health activities (School Health Programme) • Screening of adolescents for 4 Ds (RBSK) • National Deworming Day (NDD) • Provision of sanitary napkins (MHS) • Peer Education Programme (PE)

Adolescent Friendly Health Clinics (AFHCs)

Adolescent Friendly Health Clinics (AFHCs) serve as the primary care services for adolescent issues. AFHCs are established at the levels of CHC/SDH/DH and Medical College where services are provided on daily basis. A dedicated counsellor is available on all days at higher facilities – CHC and above.

Sub-centres identified as HWC can function as walk- In- Clinics for adolescents coming to these centres and services at sub centre will be provided by the CHO/ANM while the trained Medical Officer and ANM can provide Adolescent friendly services at the PHC on a weekly basis.

Package of services at Adolescent Friendly Health Clinics and referral in the same health institution:

- BMI (Body Mass Index) Screening
- Haemoglobin testing
- RTI/STI management
- ANC for pregnant adolescents
- Management of menstrual problems
- Management of iron deficiency anaemia
- HIV testing and Counselling
- Treatment of NCDs
- Management of injuries related to accident and violence
- Counselling by counsellors on: Nutrition, puberty related concerns, Pre-marital Counselling, Sexual Problems, Contraception, Abortion, RTI/STI, Substance abuse, Learning problems, Stress, Depression, Suicidal Tendency, Violence, Sexual Abuse, Other Mental Health Issues, healthy lifestyle

Fig 9: Role of CHO towards AFHC

- Sensitise adolescents and the community on adolescent health needs, common problems in adolescence and the services available under RKSK with the help of primary care team.
- Screening of adolescent clients and provide basic adolescent health information and services.
- Ask ASHA to mobilise the adolescents to SHC-HWC once in a month so that you can inform the adolescents regarding common health issues in adolescence period and measures to manage and prevent them.
- Refer the adolescents to the AFHCs in case they need clinical and counselling/services by counsellor and do the follow-up

Peer Education Programme

The adolescents in the community are covered through Peer Education (PE) Programme in about 200 districts across the country. The selected and trained Peer Educators called Saathiya ensure that adolescents benefit from regular and sustained peer education sessions covering all six themes of RKSK. This approach would facilitate the coverage of out of school adolescents in addition to the school-going adolescents.

Key Features:

- Four peer educators (two boys and two girls) are selected per village/1000 population/ASHA habitation to reach out to adolescents.
- Saathiya selection is facilitated by ASHA in consultation with Village Health Sanitation and Nutrition Committee.
- Each Saathiya forms a group of 15-20 boys or girls from their community and conducts weekly one to two-hour participatory sessions using PE kits.
- Saathiya also maintains a diary, including a brief overview of each session and the number of participants.
- A non-monetary monthly incentive of Rs. 50 is paid to the Saathiya.
- They will sensitise adolescents towards their health and inform them about existing adolescent friendly health services, so that all the adolescents may optimally utilise it.

- Saathiya facilitates the organisation of the quarterly Adolescent Health Days (AHD) and participate in the Adolescent Friendly Club (AFC) meetings also. They will discuss with their group on the objectives and process of AHD; mobilise the group to reach out to all the adolescents in the village to communicate the date, venue and the benefits of attending AHD.
- ASHA acts as the village level Saathiya coordinator and takes the lead in ensuring that the peer education activities are carried out smoothly at the village level. If required CHOs/MPWs will moderate the monthly AFC sessions at HSC.
- CHO to attend at least one PE session during his/her monthly meeting with ASHAs to understand and resolve any issues raised by ASHAs/Peer Educators and provide inputs & feedback.
- PHC MOIC will assess the quality of Peer Education, as a part of existing routine field visits. Approximately two adolescent groups should be covered in a month.

Adolescent Friendly Club Meetings

Adolescent Friendly Club (AFC) meetings are also organized once a month at SHC-HWC level under the overall guidance of CHO. These typically cover 5 villages/5000 population composed of 15-20 Saathiya each. During meetings, Saathiya from different villages meet and clarify issues which they have encountered during their weekly sessions with the help of CHO/ANM.

The community level implementation process of peer education program given below:

Table 13: Community Level Implementation Process for PE Programme

Steps	Activity	Frequency & timing	Responsible person
1	Create community support through sensitisation	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	Organise monthly AFC meeting	Monthly	CHO/ANM
6	Reporting PE session progress. Monthly report based on a consolidation of weekly activities	Monthly	Peer Educator
7	A) Preparing, and submitting a monthly progress report for block level consolidation B) Communicating feedback down the line, along with suggestions for course correction	Monthly	ANM

Fig 10: Role of CHO in Peer Education Program

- Ensure timely selection of peer educators by ASHA and VHSNC.
- Supervise the selection of the peer educator at the village level and help the ASHAs in the entire process.
- Ensure that Peer Educational (PE) sessions are carried out smoothly at village level
- You should attend at least one PE session during monthly meeting with ASHAs to understand and resolve any issues raised by ASHAs/Peer Educators and provide inputs and feedback.
- Collect and consolidate Peer Educator monthly report which is collected by ASHAs (Annexure 2)
- Monitor the monthly Adolescent Friendly Club (AFC) meetings at SHC-HWC/appropriate location convenient for peer educators. The AFC meeting should be moderated by CHO/ANM with the aim of supporting and further developing the skills of Peer Educators.

Adolescent Health Days

The Quarterly Adolescent Health Day (AHD) is one of the interventions under RKSK to improve preventive and promotive interventions for adolescents and to increase awareness among adolescents, parents, families and stakeholders about issues and needs related to adolescent health.

Key Features:

- AHDs are conducted at the village level at either Anganwadi Centres or any other public place where adolescents and all stakeholders have easy accessibility.
- Provision of Rs. 2,500 for organising quarterly AHD.
- Provision of incentive of Rs. 200 per ASHA for mobilisation of adolescents and other stakeholders to the AHDs.
- On the appointed day, Peer Educators, ASHAs, AWWs, and others will mobilise adolescents, parents, and other stakeholders, to assemble at the nearest AWC or pre-decided community space.
- To gain attention of the target group and to transfer knowledge on adolescent health, various health check-ups, infotainment activities can be organised, such as skits, plays, puppet shows etc.
- It is important to have the CHO and ANM 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.

Identification of Cases for Referral: If health screening is carried out during AHD, efforts should be made to identify adolescents for referral to AFHCs /higher centres for clinical services or counselling:

- Adolescents with high or low BMI
- Cases of moderate and severe anemia
- Pregnant adolescents
- Adolescents with symptoms of RTI/STI
- Mental health issues.
- Adolescents who have been subjected to violence including Gender Based Violence.
- Adolescents with NCDs

Data Collection and Compilation:

- During AHD, ANM should maintain a register for data collection; indicative format for AHD data collection is provided in Annexure 3; 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.
- You should ensure the completeness of the report before sending to the block.

Fig 11: Role of CHO in Adolescent Health Days

- Support conducting the quarterly Adolescent Health Day with the help of the ANMs and involve the various stakeholders of adolescent health.
- Generate awareness in community regarding services provided during AHD well in advance.
- 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, Albendazole, sanitary napkins and contraceptives) reach the site before the AHD.
- Ensure that all instruments, drugs, and other materials are in place.
- Ensure that ANM should carry communication material including pamphlets.

Menstrual Hygiene Scheme (MHS)

This scheme is being implemented in majority of the States for promotion of menstrual hygiene among adolescent girls in the age group of 10-19 years living primarily in the rural areas. Now, the scheme is being extended to urban areas in a phased manner with implementation strategy remaining the same as for the rural areas.

Objectives:

- To increase awareness among adolescent girls on menstrual hygiene, build self-esteem, and empower girls for greater socialisation.
- To increase access to and use of high-quality sanitary napkins by adolescent girls.
- To ensure safe disposal of sanitary napkins in an environment friendly manner.

Components of the Programme (As per GoI guidelines for sale to beneficiaries)

1. **Health education and outreach in the target population to promote menstrual health:**

- ASHAs provide sanitary napkins to adolescent girls in schools and within the communities at the subsidised rate of Rs. 6 for a pack of 6 napkins and are entitled to get Re. 1 for every pack sold and one free pack of sanitary napkins per month for themselves.
- The ASHA will maintain the tracking register of all adolescent girls in her catchment area in tracking register (Format A) and submit the report to the CHO on monthly basis in format B. Both format A and B are enclosed in Annexure 4.
- Monthly meetings to be convened by ASHA at the Anganwadi Centre or Panchayat Bhavan for adolescent girls on menstrual hygiene including safe disposal of sanitary napkins. At community level deep pit burial is the main option for disposal.
- ASHA will be paid an incentive from the VHSNC funds for conducting each monthly meeting.
- Monthly meetings should be complemented by household visits to promote menstrual hygiene among girls who are unable to attend the monthly meeting and motivate attendance for future meetings.
- The meeting will focus on issues of menstrual hygiene and also serve as a forum for supplying sanitary napkins to the girls. In addition, other issues that impact adolescent health such as: early marriage, nutrition, gender issues, knowledge of contraceptive choices, understanding of Sexually Transmitted Infection (STI) including HIV and the consequences of high risk behaviour, improving self-esteem and negotiation skills will be discussed.

Ensuring regular availability of sanitary napkins to the adolescents

- In the community
  - At the community level, the ASHA will be responsible for ensuring an adequate supply of sanitary napkins to adolescent girls who require them.
  - Girls who are at homes and unable to attend these monthly meetings will be reached through home visits to ensure supply of sanitary napkins.
- In the school
  - Health education, supply of sanitary napkins both can be done through the mechanisms of ASHA /ANMs.
  - The nodal teachers would be made responsible for storage of sanitary napkins, maintaining record of distribution and for creating awareness about safe disposal.
  - The provision of separate toilets for girls and incinerators for safe disposal of sanitary napkins may also need to be made.

Table 14: Service delivery framework for MHS

At Community Level (ASHA/ SHGs)	At SHC-HWC level (CHOs/ANMs)	At PHC level (PHC-MO/Block account officer)
• Maintain tracking register of adolescent girls • Mobilise adolescent girls, conduct monthly meetings and provide health education • Conduct women's group meetings • Ensure regular refill and supply of sanitary napkins to the village from the SHC- HWC • Distribute/sell sanitary napkins and maintain accounts • Track supplies and estimate requirement for the following month • Submit progress report on key indicators	• Training of the ASHA on menstrual hygiene booklet and conduct periodic refreshers • Monitor the monthly meetings periodically • Transport the sanitary napkin stock from block PHC to SHC-HWC • Ensure safe storage and proper distribution of the sanitary napkin • Supply requisite number of sanitary napkin packs to ASHA in her SHC-HWC area • Provide transportation costs to ASHA • Conduct spot checks during regular field and VHSND visits • Review and validate ASHA tracking system and accounts register • Maintain inventory, tracking and accounts register (Annexure 6)	• Ensures that ASHA training on menstrual hygiene takes place • Ensure safe storage of sanitary napkins • Conduct spot checks during regular field visits • Maintain inventory, tracking and accounts register

Operationalisation of the programme:

- The ANM will collect the sanitary napkins from the block during her monthly meeting visit and transport it to the SHC-HWC. It will be stored at the SHC-HWC or at a place rented for this particular purpose if the space in the SHC-HWC is insufficient.
- The CHO/ANM will provide the ASHA with a one-time imprest fund of Rs. 300 from the untied funds pool of the Sub-Centre.
- The ASHA will use fund to purchase sanitary napkins from the CHO/ANM.
- ASHA will also get a pack of sanitary napkins free every month for her own use to be able to become an effective agent for change.
- The ASHA will sell sanitary napkins to the adolescent girls at a subsidised rate of Rs. 6 for a pack of six napkins and is entitled to get Re. 1 for every pack sold.
- The ASHA will retain the amount recovered from the sale to replenish the imprest amount which she will use for subsequent purchase.
- The CHO/ANM will deposit the funds obtained from the sale of napkins to the ASHA in a separate account meant for MHS.
- A part of these funds may be used for meeting the costs of transportation from Block to Sub-Centre and then to the village and rental to store the sanitary napkins at the Sub-Centre level if required.
- CHO will remit the balance fund, after meeting the above costs to the block and block will remit to the District Health Society. The District Health Society will deposit this amount in a separate account meant for MHS.

Monitoring and Supervision

The distribution and sale of sanitary napkins will be monitored at sub-centre:

The ASHA would maintain a monthly record of sanitary napkin packs sold to adolescent girls and keep accounts of funds recovered. The register and accounts would be co-signed by a designated female member of the VHSNC.

- The CHO/ANM and the VHSNC will do the monitoring at the village level to ensure proper access to all adolescent girls.

- CHO in coordination with ASHA will oversee that adequate supply of sanitary napkins is available with her and the targeted population is covered every month.
- CHO should attend at least one monthly meeting per quarter. She/he will pay the ASHA the incentive for holding the meeting only after the verification of the report.

School-based adolescent health services

Apart from school-level activities conducted by school Health and Wellness Ambassadors (HWA) under Ayushman Bharat School Health Programme, CHOs should visit schools for conducting various adolescent health activities and also to oversee the SHP session. CHOs, being a medical staff, can focus more on scientific and medical aspects of the issues, availability of services at HWC and AFHC. School plays an important role in building life skills of adolescent through creating an enabling and supportive environment.

Activities included under School based adolescent service and the role of CHO

- CHOs can conduct as many need-based sessions depending on the number of schools and the number of students in the schools. Multiple visits to the same school can also be conducted if required. But once a week he/she must visit schools of their catchment area.
  - CHOs can conduct sessions on identified adolescent health themes focusing on locally prevalent issues if requested by the school principal.
  - This platform can also be utilised for referral of cases to the appropriate facility.
  - The session can last for an hour per week.
- The trained HWA (teacher) will act as a link between HWC and school for all AH activities.
- CHOs will also be trained to provide support to school-going children on mental health and sexual and reproductive issues.
- CHO/MO partnering with the school principal can ensure that wellness activities are being conducted at school on a weekly basis.
- If need be, HWA can refer the children to the CHOs who if required can refer the children to the AFHCs and DEICs.
- Common Block review meeting should be held where both the MO/CHO and principal from the school under the AB-HWA may participate.
- CHO can support the question box replies in the schools visited.
- CHO should inform the school about the services available for adolescents at HWC.

Roles & responsibilities of HWC team towards services of Adolescent Health

Roles of ASHAs

- Enrol all adolescents (girls and boys).
- Facilitation of selection of Saathiya (peer educator) in consultation with VHSNC.
- ASHA acts as the village level Saathiya coordinator and takes the lead in ensuring that the peer education activities are carried out smoothly at the village level.
- Ensure distribution and consumption of IFA tablets by adolescents with the support of AWW.
- Ensure referral of adolescent girls with moderate/severe anemia to a nearby HWCs.
- ASHA will encourage adolescents to be tested for anemia at HWCs.
- Ensure distribution of sanitary napkins.
- Create awareness among adolescent girls about adolescents needs and issues.
- Roles of MPWs
- Ensure to run outreach programs smoothly such as AHD/kishori diwas/Peer educators' session.

- Capacity building of ASHA, AWW, peer educators and teachers to identify anemic adolescents through the simple method of comparing the colour of their own nail beds and tongue with those of adolescents for the presence of pallor.
- Ensure screening of adolescents for anemia, BMI, NCD, mental health problems etc.
- Ensure supply of IFA and deworming tablets to school as per the requirements.
- MPW will undertake quarterly nutrition and health education on VHSND and Kishori Diwas.
- Ensuring monthly reporting.
- Ensuring quarterly visit to school.
- Engage local sport club, leaders in adolescent health programmes and campaign.
- Referring adolescents to HWC for clinical management.

Adolescent immunization

Under Universal Immunization Program (UIP), adolescents aged 10 years and 16 years are to be vaccinated with Tetanus and adult Diphtheria (Td) vaccine as per national immunization schedule (annexure). Different strategies are being followed in the states to optimise adolescent immunization with Td10 and Td16 vaccination:

1. Convergence with Rashtriya Bal Swasthya Karyakram (RBSK) programme to improve Td10 and Td16 coverage mainly at schools.
2. Using VHSNDs and UHSNDs to provide Td10 and Td16 vaccination for out of school children.
3. Organize Td immunization week (s) to improve Td10 and Td16 coverage.
4. School-going adolescents of class 5 and class 10 can be vaccinated using platforms like School Health program (SHP), RBSK as well as by carrying out Td adolescent immunization week once every year. Out of school adolescents can be vaccinated by strengthening the existing routine immunization platforms under VHSND.

Depending on the feasibility and states' prerogative, a combination of the strategies is also being used for more effective coverage outcomes.

Key Strategic Components

1. **Microplanning:** Comprehensive microplanning is the basis for delivery of quality immunization services to the community. The availability of updated and complete microplans at a planning unit (urban/rural) demonstrates preparedness of a unit and directly affects the quality of services provided. Microplans are prepared for a one-year period but must be reviewed every quarter. For Td vaccination two types of microplans need to be prepared: (a) for School going and (b) for out of school adolescents. Specific components of a RI micro plan for Td immunization include:

- Enlisting of all villages/wards/tolas/HRAs
- **Estimation of the target population:**
  - Headcount of all 10 & 16-year adolescents through the house-to-house survey
    - School going and
    - Out-of-school adolescents
  - Enlisting of all schools (government, government-aided, private, religious etc.) of the area.
  - Line listing of all students of class 5th and 10th.
- Planning for sessions:
  - Plan for sessions as per RBSK plan or/and Village Health & Nutrition Days (VHNDs) & Urban Health & Nutrition Days (UHNDs)
  - Estimate and plan the vaccine and logistic requirements including modes of vaccine delivery

- School and outreach specific communication plan to be implemented focusing on adolescent
- Supervision and monitoring plan

2. **Cold Chain and Vaccine Logistics Management:** Ensure availability of vaccines and logistics a t all session sites in HWCs area.

Fig 12: Roles & responsibilities of CHO

Service provision:

- Give administrative and technical support to Health and Wellness Centre under the overall ambit of work defined in HWC guideline.
- Administration of vaccines by authorised personnel.
- Ensure quality head count survey for immunization services by supportive supervision of activities of ANMs and ASHA.
- Ensure meticulous micro planning.
- Supportive supervision of activities of ANMs and ASHA in tracking beneficiaries.
- Ensure availability of vaccines and logistics at cold chain points and session sites in their HWCs area.
- Ensure cold chain and equipment management.
- Supportive supervision of immunization session site and ensure availability of updated due list, proper vaccination technique, vaccine management is undertaken.
- Ensure observance of standard precautions to prevent infection and appropriate waste segregation and disposal.
- Ensure ANMs are providing four key messages after vaccination to caregivers.
- Timely preparation and submission of monthly reports and ensure availability and quality of records-MCP, RCH/ immunization register, RCH Portal.
- Ensuring early identification, classification, recording, reporting and referral for AEFI if any. Management of minor AEFIs (like fever, pain etc.) symptomatically and establish linkages with nearby health facility for management of serious AEFIs.
- Establish linkage with the school authorities and RBSK for adolescent immunization.
- Organise inter-sectoral coordination meetings at with ICDS/ local village administration/ NGOs/ Urban Local Bodies (ULB), education department.
- Monitor surveillance activities undertaken by ANM/ASHA.
- Regular review of AEFI cases including AEFI block register and take appropriate action.

Demand generation:

Using the platforms available for interaction with Adolescents to discuss the importance of adolescent vaccines and their availability

- Organise meetings to discuss and orient ASHA in her area for increasing demand for immunization services, building vaccine confidence among care givers and mobilising beneficiaries for timely vaccination.
- Counsel beneficiaries, handhold ASHAs and partner with community to overcome social, economic, geographic barriers in improving immunization coverage.
- Active mobilisation of all beneficiaries by ASHAs with focus on reaching the marginalised.
- Allay fear of Adverse Event Following Immunization (AEFI).
- Coordination with community/religious/local leaders, teachers and volunteers on regular basis; encourage them to discuss immunization in their meetings.

Adverse Event Following Immunization management: With respect to AEFI surveillance activities, CHO of the HWC will ensure the following:

- ANMs and other staff of the HWC are able to identify serious and severe AEFI cases and know how to report it immediately.
- Provide initial case management of reported AEFI cases.
- Manage allergic reactions by referring the child to the nearest AEFI management centre.
- If anaphylaxis is suspected, authorised personnel may immediately administer an age-appropriate dose of injection Adrenaline through intra-muscular route
- Arrange for immediate treatment of serious and severe AEFI cases (including transportation, if needed).
- In case the HWC is also a cold chain point, then minor, serious and severe AEFI cases to be recorded in the AEFI register.

3. **Recording and Reporting:** Regular reporting at HMIS & RCH Portal, availability and quality data recording – MCP, RCH/immunization register, to be ensured. A periodic analysis of the correct and accurate data may be undertaken aid in identifying the problems and taking corrective actions thereby improving the quality and success of the programme.

4. **Monitoring and Supervision**

- Supportive supervision of immunization session site – ensure sessions held as per plan and availability of updated due list, proper vaccination technique, post vaccination protocols, vaccine management is undertaken. Ensure observance of standard precautions to prevent infection and appropriate waste segregation and disposal.
- Key steps include:
  - Regular field visits to get real-time information
  - Inclusion of Td vaccine components in the existing supervisory checklist of RBSK and immunization program

5. **Communication, Advocacy and Social Mobilisation**

- Advocacy through inter-sectoral coordination meetings at with ICDS/local village administration/ NGOs/Urban Local Bodies (ULB)/education department.
- Organise meetings to discuss and orient ASHA in her area for increasing demand for immunization services, building vaccine confidence among care givers and mobilising beneficiaries for timely vaccination.
- Counsel beneficiaries, handhold ASHAs and partner with community to overcome social, economic, geographic barriers in improving immunization coverage.
- Allay fear of Adverse Event Following Immunization (AEFI).
- Coordination with community/religious/local leaders, teachers and volunteers on regular basis; encourage them to discuss immunization in their meetings.

The roll out plan for each of these strategies has been detailed in the Operational Guidelines for Strengthening Td10 and Td16 Vaccine Implementation which will help professionals in planning their activities systematically to ensure enhanced Td10 and Td16 coverage.

Table 15: National Immunization Schedule (NIS) for Adolescents

Vaccine	When to give	Dose	Route	Site
Td (Tetanus & adult Diphtheria)	10 years & 16 years	0.5 ml	Intra-muscular	Upper Arm

4 DEALING WITH ADOLESCENTS

Due to prevailing psychosocial factors in our society including cultural biases, position in the pecking order, and the lack of understanding of their unique issues by elders, adolescents often do not have the opportunity to freely discuss their concerns, problems and needs. This results in an adolescent's susceptibility to be misguided through inappropriate advises often from their equally unaware peers which can unfortunately affect them adversely both physically and mentally when they are traversing this especially vulnerable period of their lives. This invariably leads to negative health outcomes including malnutrition, substance misuse and risk-taking behaviours, early pregnancy, sexual abuse and RTI/STIs including HIV.

To gain the trust of the adolescents and to identify the factors that influence their decision-making process, CHOs need to understand and acquire effective communication and counselling skills which are tailor made to address the unique adolescent wellbeing issues. This will enable the CHOs to identify early signs of adolescent health issues and risk-taking behaviour which would eventually aid in planning multi-pronged interventions to promote their mental and physical wellbeing.

Adolescent Counselling:

The process involves interaction between an adolescent and a counsellor in a trusting and confidential environment with the purpose of assisting that adolescent explore and make sense of an experience that they have encountered which has affected their wellbeing adversely (e.g., death of a parent, abusive situations, pregnancy etc.).

Before starting the counselling with adolescents, CHO to keep in mind the following points:

- Privacy and confidentiality must be ensured.
- Non-judgmental approach.
- Two-way communication and address all the quires and concerns of adolescents.
- Respect and acceptance of their concerns.
- Avoid any set of discrimination or biases.
- Offer nondirective suggestions.
- Use GATHER approach for counselling (Fig:14).

During communicating with the adolescents, the CHOs should have the skill sets to identify early red flags and provide interventions or may refer to a higher centre for further interventions if required. The CHOs should be sensitised appropriately to be able to discuss issues related to substance abuse, sexual and reproductive health, and mental health along with being adept at identifying/managing other health ailments encountered by adolescents. Following figure (Figure 13) explain the six steps of counselling:

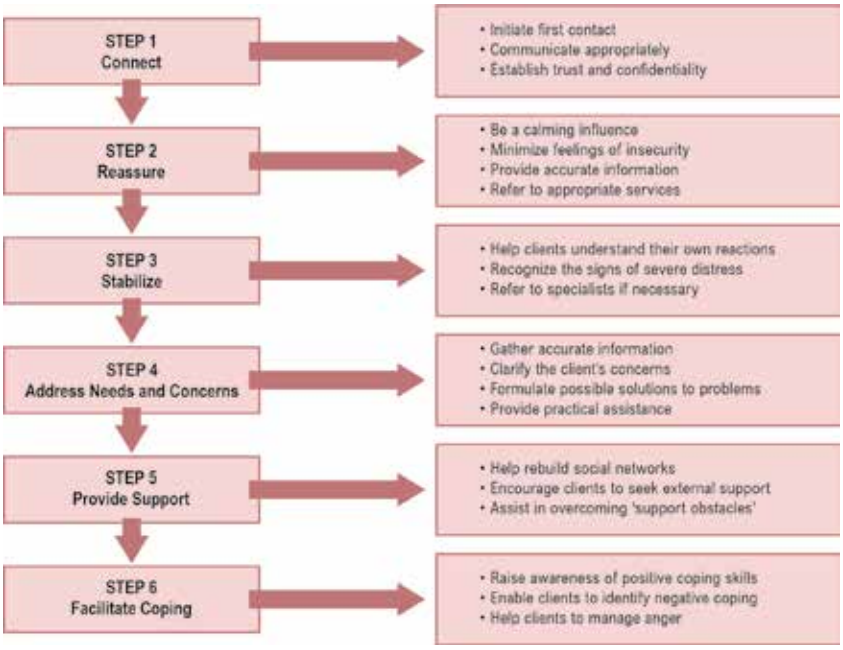


Fig 14: The GATHER approach for counselling

G- Greet the adolescents	▸ Put them at ease, show respect and trust ▸ Emphasize the confidence nature of the discussion
A-Ask how can I help you?	▸ Ask how can I help you? ▸ Encourage them to bring out their anxieties, worries and needs, determine their access to support and help in their family and community ▸ Find out what stepps they have already taken to deal with the situation ▸ Encourage the person to express his/her feelings in their own words ▸ Show respect and tolerance to what they say and do not pass judgement ▸ Actively listen and show that you are paying attention through your body language ▸ Encourage them with helpful questions
T-Tell them any relevant information they need	▸ Provide accurate and specific information in reply to their questions ▸ Give information on what they can do to remain healthy. Explain any background information they need to know about the particular health issue ▸ Keep the language simple, repeat important points and ask questions to check if the important points are understood ▸ Provide important information in the form of a leaflet if possible that they can take away
H-Help them to make decisions	▸ Explore various alternatives ▸ Raise issues which they may not have thought of, Be careful of not letting your own views, values and prejudices influence the advice you give ▸ Ensure that it is their own decision and not the one you have imposed ▸ Help them make a plan of action
E- Explain any misunderstandings	▸ Ask questions to check their understanding on important points ▸ Ask the clients to repeat the key points in their own words
R- Return for follow-up or Referral	▸ Make arrangements for a follow-up visit or referral to other agencies ▸ If a follow-up visit is not necessary, give the name of someone they can contact for any need in future

Right sequence of conversation among the adolescents (HEADS). Please refer Annexure I for details the HEAD tool.

- Home.
- Education/Employment.
- Eating patterns/habit.
- Activity/Leisure time.
- Drugs/substance abuses.

- Sexuality.
- Safety Suicide/Depression.

Assessment

CHO should have the ability to understand the information collected during the counselling process. The CHO should understand the problems from the adolescent's perspective and provide solutions to their problems. The CHO should share assessment of the situation with the client so he/she can understand his/her problems or challenges. Most important thing for CHO is to have the skills to be aware of the limits of their ability to intervene and also have adequate knowledge of whom and when to refer.

Referral Mechanism for Adolescent Program

Being close to the community, HWC teams can play a pivotal role in identification and preliminary management of health and behavioural issues that put adolescents at risk of negative health outcomes. And they should also be aware of when and how to refer adolescents to higher health facilities and/or social service providers, as and when necessary.

Table 16: List of referral conditions under adolescent health services

S. No.	Condition	Referral
1.	Moderate to Severe Anaemia	HWC-PHC/UPHC
2.	Growth Abnormalities/disabilities	SDH/DH
3.	Case of drug/substance abuse	De addiction centre (DH/SDH)
4.	PMS/Menorrhagia	PHC/UPHC-HWC
5.	Mental Health Issues	A-HRC (District)
6.	Management of RTI/STI	HWC-SHC/UPHC/PHC
7.	Early or late appearance of secondary sexual character	SDH/DH
8.	Unsafe abortion	CEmONC facility/SDH/DH
9.	Risk factors (BP, BMI, Random blood sugar, family history of NCD etc.)	PHC/UPHC-HWC
10.	Management of physical violence and sexual abuse	CHC/SDH/DH

Follow-Up

One of the key components of Comprehensive Primary Health Care is the assurance of the mechanism of 'Continuum of Care'. In every adolescent's instance also, care must be ensured from the level of the family/community through the different levels of health care facilities when they are referred. To maintain the trust of adolescents and to provide quality services, continuity of services should be one of the primary focuses.

- Community/Household: The ASHA would undertake home visits to ensure that the adolescent is taking actions for risk-factor modification, provide counselling and support and issue reminders for follow up appointments at AB-HWC and for collection of medications if needed. The CHO should also visit and counsel parents and the community whenever the need is perceived. The service providers should also spread awareness among the adolescents and community regarding Adolescent Friendly Health Services under the RKSK programme, psychological support services, health clinics and the school-based programmes under RBSK.

- AB-HWC: In AB-HWC, dispensation of medicines, repeat investigations/diagnostics as required, identification of complications and facilitating referrals to a higher-level facility/teleconsultation with a specialist as required needs to be undertaken with proper maintenance of records. Adolescents should be referred to AFC for counselling if the need is sensed.

- Higher-Level Facility: The medical officer or specialists at the higher facilities the adolescents are referred to would develop/modify the treatment plan, including instructions for the adolescent as well as a note to the HWC provider, indicating the need for change.

ANNEXURES

Annexure 1

HEADS Assessment Tool

Information that can be obtained from a HEADS Assessment	
Home	▸ Where they live, with whom they live ▸ Whether there have been recent changes in their home situation ▸ How they perceive their home situation
Education/Employment	▸ Whether they study/work ▸ How they perceive how they are doing ▸ How they perceive their relationship with their teachers and fellow students/ employers and colleagues ▸ Whether there have been any recent changes in their situation ▸ What they do during their breaks
Eating	▸ How many meals they have on a normal day ▸ What they eat at each meal ▸ What they think and feel about their bodies
Activity	▸ What activities they are involved in outside study/ work ▸ What they do in their free time – during weekdays and on holidays ▸ Whether they spend some time with family members and friends
Drugs	▸ Whether they use tobacco, alcohol, or other substances ▸ Whether they inject any substances ▸ If they use any substances, how much do they use; when, where and with whom do they use them
Sexuality	▸ Their knowledge about sexual and reproductive health ▸ Their knowledge about their menstrual periods ▸ Any questions and concerns that they have about their menstrual periods ▸ Their thoughts and feelings about sexuality ▸ Whether they are sexually active; if so, the nature and context of their sexual activity ▸ Whether they are taking steps to avoid sexual and reproductive health problems ▸ Whether they have in fact encountered such problems (unwanted pregnancy, infection, sexual coercion). If so, whether they have received any treatment for this ▸ Their sexual orientation
Safety	▸ Whether they feel safe at home, in the community, in their place of study or work; on the road (as drivers and as pedestrians) etc. ▸ If they feel unsafe, what makes them feel so
Suicide /Depression	▸ Whether their sleep is adequate ▸ Whether they feel unduly tired ▸ Whether they eat well ▸ How they feel emotionally ▸ Whether they have had any mental health problems (especially depression). If so, whether they have received any treatment for this ▸ Whether they have had suicidal thoughts ▸ Whether they have attempted suicide

Annexure 2:

Peer Educator Monthly Report

Peer Educator Monthly Reporting Form

Month/ Year:

Name of Peer Educator: _____

Phone: _____

Parent name and address : _____

_____

Village name: _____

Block: _____

District: _____

Adolescent Friendly Club monthly meeting attended (Yes/No) _____

Number of adolescents enrolled: _____

Number of Peer Education Sessions conducted this month:

_____ _____

Average attendance in each session: _____

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

Number of adolescents referred to AFHC:

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

Annexure 3

Format for Basic Data Collection during AHD

B. Coverage Format for Basic Data Collection during AHD

A. Basic Information	
Date of AHD	Name of the village
Venue:	Block: Date:
Name of the service providers who attended the AHD	
Name of the health providers who attended the AHD	
..... (MO in charge)	
..... (ANM)	
..... (Block Adolescent Health Coordinator/ Counsellor)	
Other organizers	
..... (ASHA)	
..... (AWW)	
..... (PE male)	
..... (PE female)	
AHD attended by: (Parents/ Teachers/ PRIs/ NGOs/ Others	

B. Coverage
1. Total Village Population: .....
2. Total Adolescent population in the village and attendance in the AHD: .....
3. Total number of parents who atteded the AHD:

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

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

stacksholder includes parents, school teachers, PRI etc.

D. Remark (include performance, challanges etc.			
Signature			
MO		ANW	
Counseller		ASHA	
AWW		PRI representative	
PE (Female)		PE (Male)	

Annexure 4

Menstrual Hygiene Scheme (for sale to beneficiaries)

Annexure 4.A

ASHA tracking Register for Adolescent girls-month-wise reporting

Name of ASHA	Number of adolescent girls	Month 1		Month 2	
		No of packs of napkins sold	No of AGs attending meeting	No of packs of napkins sold	No of AGs attending meeting

Annexure 4.B

ASHA Monthly Reporting Format

1	Name of ASHA	
2	Name of Village	
3	No of napkin packs at the month beginning	
4	No of napkin packs at the month end	
5	Transportation cost (if any)	
6	Storage cost (if any)	

Annexure 4.C

Monthly monitoring format/Register for Sub-Centre

Name of Village	Name of ASHA	No of Adolescent Girls	Sanitary napkins packs			Incentive paid to ASHA		Amount recouped to HSC
			No received from Block	No sold	Balance	For sale of napkin packs	For monthly meeting	

List of Contributors

Ministry of Health and Family Welfare (MoHFW)	
Dr. Manohar Agnani	Addl. Secretary
Ms. Preeti Pant	Joint Secretary
Dr. Patibandla Ashok Babu	Joint Secretary
Dr. Sumita Ghosh	Addl. Commissioner & Incharge (CH, AH, RBSK, CAC, ADs)
Dr. Sila Deb	Addl. Commissioner & Incharge (CH Nutrition)
Dr. Veena Dhawan	Joint Commissioner - Immunization
Dr. Zoya Ali Rizvi	Deputy Commissioner - Adolescent Health
Dr. Ashish B Chakraborty	Asst. Commissioner (MH)
Dr. Neeta Singh	Sr. Consultant - Child Health Nutrition
Dr. Vishal Kumar	Sr. Consultant - Child Health Nutrition
Dr. Nisha Singh	Sr. Consultant - Child Health Nutrition
Dr. Disha Agarwal	Sr. Consultant, Immunization
Ms. Amita Chauhan	Sr. Consultant, NHM
Mr. Deepak Kumar	Consultant- Adolescent Health
Development Partners	
Dr. Renu Srivastava	Strategy Director, Newborn Child Health, UPTSU, IHAT
Dr. Deepti Agarwal	National Professional officer, WHO
Dr. Pragati Singh	National Program Officer, SRHR, WHO Country of India
Dr. Nidhi Bhatt	National Consultant-FP, WHO Country of India
Ms. Shikha Bansal	National Consultant-AH, WHO Country of India
Dr. Prairna Koul	National Consultant-AH, UNICEF India
Dr. Rakshita Khanijou	Consultant, WHO Country of India
Jhpiego team	
National Health Systems Resource Centre (NHSRC)	
Maj Gen (Prof) Atul Kotwal	Executive Director
Dr. M A Balasubramanya	Advisor, Community Processes and Comprehensive Primary Health Care
Dr. Ashoke Roy	Director, Regional Resource Centre for North-East States
Dr. Rajani R Ved	Former- Executive Director
Dr. Suman	Senior Consultant, Community Processes and Comprehensive Primary Health Care
Dr. Devajit Bora	Senior Consultant, Community Processes and Comprehensive Primary Health Care, Regional Resource Centre for North-East States
Dr. Neha Dumka	Senior Consultant, Knowledge Management Division
Dr. Shalini Singh	Former- Senior Consultant, Community Processes and Comprehensive Primary Health Care
Dr. Rupsa Banerjee	Former- Senior Consultant, Community Processes and Comprehensive Primary Health Care
Ms. Ima Chopra	Consultant, Community Processes and Comprehensive Primary Health Care
Ms. Haifa Thaha	Consultant, Community Processes and Comprehensive Primary Health Care
Ms. Pumani Kalita	Consultant, Community Processes and Comprehensive Primary Health Care, Regional Resource Centre for North-East States
Ms. Sandhani Gogoi	Consultant, Community Processes and Comprehensive Primary Health Care, Regional Resource Centre for North-East States
Dr. Vijaya Shekhar Salkar	External Consultant, Community Processes and Comprehensive Primary Health Care

Namaste!

You are a valuable member of the Ayushman Bharat – Health and Wellness Centre (AB-HWC) team committed to delivering quality comprehensive primary healthcare services to the people of the country.
To reach out to community members about the services at AB- HWCs, do connect to the following social media handles-

https://instagram.com/ayushmanhwcs

https://twitter.com/AyushmanHWCs

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National Health Systems Resource Centre