Operational Guideline
Adolescent Health Day: Odisha

National Health Mission
Department of Health and Family Welfare
Government of Odisha

Table of Annexure:

Operational Guideline for Adolescent Health Day: Odisha

1. Introduction:

A key component of community level initiative of RKSK program is the Adolescent Health Day (AHD). It is independent of, and in addition to, all the activities carried out for adolescents under the RKSK program. It has four key objectives:

- Increase awareness among adolescents about the determinants of adolescent health such as (nutrition, sexual and reproductive health, mental health, injuries and violence including GBV, substance misuse and NCD)
- Improve coverage with preventive and promotive interventions on(nutrition, sexual and reproductive health, mental health, injuries and violence including GBV, substance misuse and NCD) for adolescents
- Increase awareness among parents and other key stakeholders on adolescents health needs
- Improve awareness of other adolescent health services in particular "shraddha clinic"

2. Operational Framework

2.1 About the Adolescent Health Day: The AHD need to be organized in every village once every quarter on a convenient day (preferably on a Sunday or second half of VHND day) using VHND platform. It will be organized at every **VHND site (but not to be clubbed with VHND).** For enhancing the participation of adolescent girls in Sabla districts effort to be made to coincide with the Kishori Diwas. AWCs or community spaces may be used as venues for organizing the AHD.

2.2 Target Group: During an AHD, services need to be offered to all the adolescent target groups (male/female; 10-14 and 15-19 age; school going, drop out; and married adolescents). Efforts need to be made to reach out to other stakeholders including parents, school teachers, GKS and PRI members to sensitize them on adolescent health needs. It is also important to have group/individual sessions with parents by ANM to sensitize them on adolescent health needs.

2.3 Publicity for AHD: Raising awareness about AHD is important for ensuring that the community, adolescents, parents and other key stakeholders are aware of services available through AHD. Following activities to be carried out for publicity of AHD:

- Use of Swathya Kantha for publicity of AHD
- PE, ASHA and AWW should circulate the message among the peers and their parents
- Wall painting and banners about AHD at VHND site (Fund can be utilized from GKS fund)
- Agenda item of AHD to be discussed during GKS meeting (about the event and date, place of organization of event with recorded proceedings)
- Discussion about the programme and venue at"Suna Bhauni" in SHG meeting.

- Raising awareness of AHD through community level institutional platforms for women such as "Shakti Varta"[1] (only in those RKSK districts where shakti varta is implemented)
- Raising mass awareness of AHD through cultural program such as folk dance/music/pala/daskatia with support from cultural institutions such as ZKSS[2] and BKSS. The Program Associate with DMRCH at the district need to coordinate and establish understanding with ZKSS members.

2.4 Services to be provided: On the appointed day, Peer Educators, ASHAs, AWWs, and others 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 may be organized, such as skits, plays, puppet shows etc with support from ZKSS/BKSS.

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 AHD the target group should be able to interact with the ANM and obtain basic services and information. They will also learn about preventive and promotive aspects of adolescent health care mentioned above, which will encourage them to seek health care at shraddha clinic. *{for detail implementation of AHD please refer the service delivery and implementation section of the guideline}.*
The following services need to be provided to adolescents on AHD:

Table 1 AHD services:

Information	Commodities	Services
Information Education and Communication (IEC) and Inter Personal Communication (IPC) ➢ Nutrition ➢ SRH ➢ Mental Health ➢ GBV ➢ NCD ➢ Substance misuse	➢ Sanitary Napkins ➢ IFA ➢ Albendazole ➢ anti-spasmodic tablets ➢ contraceptives	➢ Registration ➢ General health check-up, (BMI, anemia and diabetes), Referral to AFHCs/SHRADDHA clinics (for counseling and clinical services)

The IEC/IPC topics during AHD ***need to be age specific and to be conducted independently with each specific group*** (refer **annexure 2).** The infotainment channels such as skits and plays can be used for communicating key messages to the target groups.

[1] Shakti varta is a flagship program of women and child development department, health and family welfare department and rural development department of the government of Odisha with financial assistance from DFID, implemented in 15 high burden districts of Odisha with high IMR and MMR. It is a process on empowering women through PLA on health nutrion and WASH.

[2] ZKSS/BKSS: they carry out IEC activities under different government schemes exclusively for propagation of government policies and programs through their cultural performances.

As said above ZKSS/BKSS are ideal cultural institutions for IEC purpose available at districts and sub districts.

Specific emphasis required to communicate with parents during AHD. The content to be offered to parents during AHD should include information, skills and support such as:

- information on addressing concerns of Adolescents; engage with families, parents; dialogues with gatekeepers, influencer, involving PRI, VHND, local bodies/clubs
- effort should be made to help parents develop/enhance skills on communicating with adolescents
- parents should be educated and sensitized on resource available for assisting them in managing adolescents

2.5 Identification of Cases for Referral: During AHD efforts should be made to identify adolescents with following issues for referral to sharddha clinic for clinical services or counseling: (for detail plz **refer annex 8**)

- adolescents with high or low BMI
- severe and moderate cases of anemia
- 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

2.6 Data Collection and Compilation:

- ANM need to prepare sub centre level AHD microplan (refer **annex 3)** ahead of conducting AHD and share the same to BPM and MO/IC CHC for information and approval.
- Refer **annex 4** for AHD reporting format to be completed by ANM
- Refer **annex 5** for monthly reporting format to be completed by ANM at sub centre level and submitted to BPM CHC.
- Refer **annex 6** for monthly reporting format to be complied by BPM at CHC level and submitted to program associate of RKSK program at district.
- Refer **annex 7** for monthly reporting format to be complied by program associate at district level and submitted to state RKSK team.

Further AHD being one of the key strategies of the adolescent health program, hence all programme meetings at district and block levels it needs to be reviewed. Each district and block should keep a record of number of AHDs planned and held.
In addition NHM Odisha will conduct rapid assessment surveys to assess the impact of AHD (refer **annex 1 AHD log frame for detail indicators**).

3. Service Delivery and Implementation

3.1 The following personal play key role for organizing AHD such as

- ANM
- ASHA
- AWW
- Peer Educators
- Medical Officer (IC) (At selected places)
- Counselors (At selected places)

3.2 Preparatory activities of AHD: It includes the following points:

- ANM will prepare a micro plan during monthly meeting by discussion with Medical Officer In-Charge **(micro plan format is attached in annex 3)**
- The Block micro plan should compiled by BPM at block level and shared with district for monitoring the activity.
- ANM to ensure that all instruments, drugs and other materials (e.g weighing scale, hemoglobin meter, Stethoscope, BP apparatus, IFA, albendazole, anti-spasmodic tablets, sanitary napkins and contraceptives) are available in place.
- ANM to provide communication materials including IEC pamphlets(DPMU/BPM to arrange IEC materials for the programme).
- AWW to help ASHA and PEs to mobilize adolescents and other stakeholders in the village to attend AHD.
- The VHND site used for AHD should be clean, availability of clean drinking water, provision for privacy for health check-up etc. It should be ensure before organization of AHD.

3. 3 Activities to be carried out during AHD: It includes the following

- Mobilization of beneficiaries and their parents: On AHD, Peer Educators, ASHAs, AWWs will mobilize adolescents, parents and other stakeholders, to assemble at the VHND site (e.g. AWC/ School/ community centre etc.)
- To gain attention of the target group and to transfer knowledge on adolescent health, various "infotainment" activities can be organized, such as skits, plays, puppet shows etc in coordination with ZKSS/BKSS.
- ANM and other health personnel need to be present during the AHD to provide services and educate/orient the target groups.

3.4 Activities to be carried out post AHD: It includes the following

- ANM to keep records and documents (GKS proceedings, registration sheet, referral sheet, reporting format and line listing copy of ASHA of each AHD separately).
- ANM to prepare report and submit to BPMU for onward transmission of report **(reporting format attached in annex 5).**

3.5 Checklists to Facilitate Implementation Activities for Organizing AHD: 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.

Table 2 Checklist for Service Providers on AHD:

Service Provider	Checklist
ANM	**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 pamphlet Ensure reporting of AHD to the MO in charge.
PE (male/female)	**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. **Actions to be taken on the day of AHD:** 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	**Actions to be taken before the AHD:** Co-ordinate with PEs, FNGO (if present), ANM and AWW. **Actions to be taken on the day:** Guide PEs to mobilize all the adolescents to attend the AHD.

	Assist ANM and AWW.
AWW	**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 PEs, ASHA and ANM.
PRI	**Actions to be taken:** Coordinate to invite all members of GKS 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.

4. Operational cost for AHD :

- Food provision for the participants – Rs.1000
- Infotainment program using ZKSS/BKSS: Rs. 500
- Mobility cost to ANM / Health worker Male: 200
- Award & Recognition : Rs.200
- ASHA incentive: Rs.150

Annexure 1 Logic Model for AHD Program

Program Outcome: A Community Level Comprehensive Adolescent Health Service Program for Improving Health and Well Being of Adolescents aged 10-19years (from 15RKSK Identified Operational Districts) in making a healthy transition to adult.			
Over all Program Objective	**Outcome Indicators**	**Program Service Delivery Indicator**	**Means of Verification**
1. Promote counselling and treatment service on health issues (as mentioned under key objectives) among adolescents aged 10-19years in 15RKSK operational districts	1.1) increase the % of adolescents aged 10-19years who seek counselling and treatment service from ANM on AHD	1.1) number and % of AHD planned and held 1.2) total number of adolescents visiting AHD 1.3) number of adolescents aware of shraddha clinic and its services offered for adolescents 1.4)total number of adolescents referred to shraddha clinic during AHD 1.5) total number of parents attending AHD 1.6) % of parents who are sensitized throughZKSS[1]/BKSS[2]/IPC/orientation discussion during AHD (out of total number of parents who attended the AHD)	AHD report State PIP
Key Objective	**Outcome Indicators**	**Output Indicators**	**Means of Verification**
Improve Nutrition			
1. Increase adolescents awareness of the adverse effects and consequences of malnutrition among adolescents girls and boys (10-19years of age), and promote knowledge of balanced diet	1.1) reduction in % of adolescents who are thin (BMI<18.5kg/m^2) 1.2) reduction in % of adolescents who are over weight/obese (BMI>25.0kg/m^2)	1.3) % of adolescents with correct knowledge on balanced diet and nutritional deficiencies(out of total number of adolescents who attended AHD) 1.4) number of adolescents participated on AHD and referred to shraddha clinic with high or low BMI (out of total number of adolescents who attended AHD) 1.5) % of care givers such as ANM, AWW,ASHA, teachers, having correct knowledge on balanced diet and nutritional deficiency	Ongoing rapid assessment of nutritional and health outcomes among adolescents Periodic surveys (AHS, DLHS, NFHS) measuring knowledge attitude and practise AFHC MIS AHD report

[1] ZKSS:Zilla Kala Sanskruti Sangha

[2] BKSS:Block Kala Sanskruti Sangha

2. Increase adolescents awareness of the adverse effects and consequences of Iron Deficiency Anemia among adolescence boys and girls (10-19years)	2.1) reduction in % of adolescents with any anaemia (<12.0g/dl) 2.2) reduction in % of adolescents with severe anaemia (<7.0 g/dl)	2.3) % of care givers such as ANM, ASHA, AWW, teachers, PE and parents having correct knowledge on iron rich foods 2.4) number of adolescents participated on AHD and referred to shraddha clinic with severe and moderate cases of anaemia 2.5) % of adolescents having correct knowledge on iron rich foods(out of total number of adolescents who attended AHD) 2.6) % of adolescents given 4 -5 IFA tablets per month (out of total number of adolescents who attended AHD)	Ongoing rapid assessment of nutritional and health outcomes among adolescents Periodic surveys (AHS, DLHS, NFHS) measuring knowledge attitude and practise WIFS MIS AHD report AFHC MIS
Enable SRH			
3. Improve knowledge attitude and behaviour in relation to Sexual Reproductive Health (SRH)	3.1) increase in % of married adolescents reporting unmet need for contraceptives (separately for spacing, limiting and total) {15-19years} 3.2) increase in % of contraceptive prevalence rate among married adolescents {15-19years} 3.3) increase in % of adolescents who used condom during first sexual intercourse {15-19years} 3.4) reduction in % of adolescents aged 15-19 who had sexual debut before age 18	3.6) % of adolescents correctly reporting that a woman can get pregnant at first sex if not used any contraception (out of total number of adolescents who attended AHD) 3.7) % of adolescents aged 15–19 with knowledge of at least one modern method of contraception (out of total number of adolescents who attended AHD) 3.8) % of adolescents with comprehensive knowledge about HIV/AIDS(out of total number of adolescents who attended AHD) 3.9) % of adolescents aware of at least one symptom of RTI/STI (out of total number of adolescents who attended AHD) 3.10) Total number and % of AHDs providing contraceptives	Ongoing rapid assessments of nutritional and health outcomes among adolescents Periodic surveys (AHS, DLHS, NFHS) measuring knowledge, attitudes and practices

	3.5) decrease in the % of adolescents girls having menstrual related problems (10-19years)	3.11) number of adolescents who are confident to say no to sex(out of total number of adolescents who attended AHD) 3.12) % of adolescents accessing AHD for RTI/ STI, abortion and puberty related problems (out of total number of adolescents who attended AHD) 3.13) % of adolescent girls aware of benefits of menstrual hygiene(out of total number of adolescents who attended AHD) 3.14)% of adolescent girls using disposable sanitary napkins or washed and sun-dried cloth(out of total number of adolescents who attended AHD) 3.15) number of adolescents participated on AHD and referred by PE to AFHC for menstrual, RTI/STI related problem	State MHS monthly report AHD report AFHC MIS
4. Increase adolescents awareness of the adverse effects and consequences of teenage pregnancies	4.1) reduction in % of adolescents marriage in age group 15–19 4.2) reduction in % of married adolescents aged 15-19 who have begun childbearing (either had a live births or pregnant with first child) 4.3) increase in median Age at first Marriage 4.4) increase in % of married adolescents aged 15-19 years using any modern method of contraception	4.5) % of adolescents indicating positive attitude about delaying first conception after marriage(out of total number of adolescents who attended AHD) 4.6) % of married adolescent couples having comprehensive knowledge on risks of early pregnancy(out of total number of married adolescents who attended AHD) 4.7) % of parents/community leaders having correct knowledge of legal age at marriage and disadvantages of early child bearing 4.8) % of married adolescent couples accessing AHD for contraceptives or counseling on family planning services by ANM in a confidential manner	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 AHD report

5.Improve birth preparedness, complication readiness and provide early parenting support for adolescent parents (15-19years)	5.1) increase in % of pregnant adolescents who received at least three antenatal care checkups 5.2) increase in % of adolescent mothers who delivered in a health facility during last one year	5.3) % of adolescents reporting correct knowledge of care during pregnancy(out of total number of adolescents who attended AHD) 5.4) % of service providers (such as, ASHAs, ANMs, AWWs, PE etc.) reporting correct knowledge of care during pregnancy 5.5)% of adolescents referred by ANM on AHD, accessing adolescent clinics for counseling 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 AHD report
Enhance Mental Health			
6. Address mental health concerns of adolescents	6.1) decrease in % of adolescents (10-14 and 15-19 years) who reported feeling of sad/ hopeless/depressed almost every day at least for two weeks during last one year	6.2) % of adolescents, who have correct knowledge of early warning signals of common mental health problems(out of total number of adolescents who attended AHD) 6.3) % of teachers, parents and ANMs, PE who have correct knowledge on early warning signals of common mental health problems 6.4) % of adolescents accessing shraddha clinics for counseling on mental health referred by ANM on AHD	Ongoing rapid assessments of nutritional and health outcomes among adolescents AFHC MIS AHD report
7. Promote favorable attitudes for preventing injuries and violence (including GBV) among adolescents (10-19years)	7.1) decrease in % of adolescents who have experienced physical, emotional or sexual violence (10-19years) 7.2) decrease in the proportion of adolescents aged 10-19 years, who suffered from major injuries (accident, fall or any other which restricted their locomotors function), during past 12 months	7.3) % of adolescents reporting correct knowledge on their rights and entitlements as well as legal provisions against sexual abuse/harassment/injuries (out of total number of adolescents who attended AHD) 7.4) % of ANM and care givers (such as partners, husbands, mothers-in-law, teachers) reporting correct understanding of GBV 7.5) number of adolescents referred to shraddha clinic in GBV related cases by ANM during AHD	Periodic surveys (AHS, DLHS, NFHS) measuring knowledge, attitudes and practices Ongoing rapid assessments of nutritional and health outcomes among adolescents AFHC MIS AHD report

Prevent Substance Misuse			
8. Increase adolescents awareness of the adverse effects and consequences of substance misuse (10-19years)	8.1) decrease in % of adolescents who drink alcohol at least once a week 8.2) decrease in % of adolescents who are daily tobacco users (smoking) 8.3) decrease in Proportion of adolescents aged 13-15 years who have smoked one or more cigarettes in the past 30 days 8.4) decrease in % of adolescents who are daily smokeless tobacco users	8.5) % of adolescents who believe smoking causes serious illnesses (out of total number of adolescents who attended AHD) 8.6) % of adolescents who believe smokeless tobacco causes serious illnesses(out of total number of adolescents who attended AHD) 8.7) % of ANM and care givers (such as partners, husbands, mothers-in-law, teachers) reporting correct understanding of adverse effects and consequences of substance misuse 8.8) number of adolescents counseled by ANM duringAHD on tobacco/alcohol related cases referred to shraddha clinic	Periodic surveys (AHS, DLHS, NFHS) measuring knowledge, attitudes and practices Ongoing rapid assessments of nutritional and health outcomes among adolescent AHD report AFHC MIS
Address NCDs			
9. Promote behavior change in adolescents to prevent NCDs such as hypertension, stroke, cardiovascular diseases and diabetes (10-19years)	9.1) decrease in % of adolescent with diagnosed diabetes 9.2) decrease in % of adolescents with diagnosed hypertension 9.3) prevalence of current tobacco use (smoking and smokeless)among adolescents	9.4) % of adolescents counseled by ANM during AHD, reporting correct knowledge of early warning signals of NCD (diabetes and hypertension) {out of total number of adolescents who attended AHD} 9.5) % of adolescents counseled by ANM during AHD reporting correct knowledge of healthy lifestyle(out of total number of adolescents who attended AHD) 9.6) number of adolescents referred by ANM during AHD to shraddha clinic and diagnosed in diabetes 9.7) number of adolescents referred by ANM during AHD to shraddha clinic and diagnosed in hypertension 9.8) % of ANM and care givers (such as partners, husbands, mothers-in-law, teachers) reporting correct understanding of early warning signals of NCDs and 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 AFHC MIS reports AHD report
Activities: (plz refer Table 3 of AHD guideline for activities)			

Annex-2

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	✓	✓	✓	✓	✓	✓

Annexure-3

SUB CENTRE Micro plan of AHD (Adolescent Health Day)																	
District:					Block:						Sub Centre:						
Sl. No.	Name of VHND site	Name of the tagged Villages	Place of AHD Community center/ AWC /school	Total Adolescent Population	Male				Female				Married Adolescents (14-19 years)	Q1	Q2	Q3	Q4
					10-14 years		15-19 years		10-14 years		15-19 years						
					in school	out of school	in school	out of school	in school	out of school	in school	out of school		Jun	Sept	Dec	Mar
Total																	

Annex 4

Format for Basic Data Collection and Reporting During AHD (to be completed by ANM)

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 GKS members: Yes/No

B: Coverage

1. Total Village Population:

2. Total Adolescent Population in the Village and attendance in the AHD:

		Total Population	Attendance at AHD
Female 10-14years	In-school		
	Drop out		
Male 10-14years	In-school		
	Drop out		
Female 15-19years	In-school		
	Drop out		
Male 15-19years	In-school		
	Drop out		

3. Total Number of parents who attended the AHD:……

Continued……

C. Services								
Services	**Female**		**Male**		**Married Adolescents**	**Parents**	**Other Stake Holders[3]**	**Total**
	10-14	15-19	10-14	15-19				
	IS[4]	DO[5]	IS	DO				
1. BMI Screening						X[6]	X	
2. Anaemia						X	X	
3. Number of adolescents provided IFA tablets						X	X	
4. Number of adolescents provided albendazole tablet						X	X	
5. Number of adolescents provided contraceptives	X		X			X	X	
a) condom	X		X			X	X	
b) OCP	X		X			X	X	
e) ECP	X		X			X	X	
6. RTI/STI Screening and clinical services						X	X	
7. Number of adolescents provided sanitary napkins			X	X		X	X	
8.IPC/Orientation/Discussion:								
a) Nutrition								
b) SRH								
c) Mental Health								
d) GBV								
e) NCD								
f) Substance Misuse								
9. Total number of adolescents referred:							X	
a) To shraddha clinic for clinical services							X	
b) To shraddha clinic for counselling services							X	
c) To other health service							X	

[3] Stakeholders includes parents, school teachers, PRI etc
[4] IS= In school
[5] DO=Drop out
[6] X = service not available

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

Annex 5

Sub Centre Level Format for Basic Data Collection and Reporting During AHD (to be compiled by ANM)

A: Coverage

1. Total number of Village : _____2.Total number of AHD planned_____
3. Total number of AHD conducted _____
4.Total number of Village covered through AHD_____

5. Total Adolescent Population in the Village and attendance in the AHD:

		Total Population	**Attendance at AHD**
Female 10-14years	In-school		
	Drop out		
Male 10-14years	In-school		
	Drop out		
Female 15-19years	In-school		
	Drop out		
Male 15-19years	In-school		
	Drop out		

6. Total Number of parents who attended the AHD:……

B. Services

Services	**Female**		**Male**		**Married Adolescents**	**Parents**	**Other Stake Holders**[7]	**Total**
	10-14	15-19	10-14	15-19				
	IS[8]	DO[9]	IS	DO				
1. BMI Screening						X[10]	X	
2. Anaemia						X	X	
3. Number of adolescents provided IFA tablets						X	X	

[7] Stakeholders includes parents, school teachers, PRI etc
[8] IS= In school
[9] DO=Drop out
[10] X = service not available

4. Number of adolescents provided albendazole tablet						X	X	
5. Number of adolescents provided contraceptives	X		X			X	X	
a) condom	X		X			X	X	
b) OCP	X		X			X	X	
e) ECP	X		X			X	X	
6. RTI/STI Screening and clinical services						X	X	
7. Number of adolescents provided sanitary napkins			X	X		X	X	
8.IPC/Orientation/Discussion:								
a) Nutrition								
b) SRH								
c) Mental Health								
d) GBV								
e) NCD								
f) Substance Misuse								
9. Total number of adolescents referred:							X	
a) To shraddha clinic for clinical services							X	
b) To shraddha clinic for counselling services							X	
c) To other health service							X	

D. Remarks (include performance, challenges etc)	
Signature	
ANM	

Annex 6 :
CHC Level Monthly Format for Basic Data Collection and Reporting during AHD (to be completed at BPMSU)

A. Basic Information

Total number of AHD Planned:…… Total Number of AHD Conducted:……
Name of the CHC:…… District:…….....

B: Coverage			
1. Total CHC Population:			
2. Total Adolescent Population in the CHC and attendance in the AHD:			
		Total Population	Attendance at AHD
Female 10-14years	In-school		
	Drop out		
Male 10-14years	In-school		
	Drop out		
Female 15-19years	In-school		
	Drop out		
Male 15-19years	In-school		
	Drop out		
3. Total Number of parents who attended the AHD:……			

C. Services

Services	**Female**		**Male**		**Married Adolescents**	**Parents**	**Other Stake Holders[11]**	**Total**
	10-14	15-19	10-14	15-19				
	IS[12]	DO[13]	IS	DO				
1. BMI Screening						X[14]	X	
2. Anaemia						X	X	
3. Number of adolescents provided IFA tablets						X	X	
4. Number of adolescents provided albendazole tablet						X	X	
5. Number of adolescents provided contraceptives	X		X			X	X	
a) Condom	X		X			X	X	

[11] Stakeholders includes parents, school teachers, PRI etc
[12] IS= In school
[13] DO=Drop out
[14] X = service not available

	Female		Male		Married Adolescents	Parents	Other Stake Holders[15]	Total
	10-14	15-19	10-14	15-19				
b) OCP	X		X			X	X	
e) ECP	X		X			X	X	
6. RTI/STI Screening and clinical services						X	X	
7. Number of adolescents provided sanitary napkins			X	X		X	X	
8.IPC/Orientation/Discussion:								
a) Nutrition								
b) SRH								
c) Mental Health								
d) GBV								
e) NCD								
f) Substance Misuse								
9. Total number of adolescents referred:							X	
a) To shraddha clinic for clinical services							X	
b) To shraddha clinic for counselling services							X	
c) To other health service							X	

D. Remarks (include performance, challenges etc)			
Signature :			
MO/IC		BPM	

[15] Stakeholders includes parents, school teachers, PRI etc

Annex 7

District Level Monthly Format for Basic Data Collection and Reporting During AHD (Compiled at DPMU by DMRCH/Program Associate RKSK)

A. **Basic Information**			
Total number of AHD Planned:……..			
Total Number of AHD Conducted:……			
Name of the District:……..			
B: Coverage			
1. Total District Population:			
2. Total Adolescent Population in the district and attendance in the AHD:			
		Total Population	**Attendance at AHD**
Female 10-14years	In-school		
	Drop out		
Male 10-14years	In-school		
	Drop out		
Female 15-19years	In-school		
	Drop out		
Male 15-19years	In-school		
	Drop out		
3. Total Number of parents who attended the AHD:……			

C. Services								
Services	**Female**		**Male**		**Married Adolescents**	**Parents**	**Other Stake Holders[16]**	**Total**
	10-14	**15-19**	**10-14**	**15-19**				
	IS[17]	**DO[18]**	**IS**	**DO**				
1. BMI Screening						X[19]	X	
2. Anaemia						X	X	
3. Number of adolescents provided IFA tablets						X	X	
4. Number of adolescents provided Albendazole tablet						X	X	
5. Number of adolescents provided contraceptives	X		X			X	X	
a) condom	X		X			X	X	
b) OCP	X		X			X	X	
e) ECP	X		X			X	X	
6. RTI/STI Screening and						X	X	

[16] Stakeholders includes parents, school teachers, PRI etc
[17] IS= In school
[18] DO=Drop out
[19] X = service not available

clinical services								
7. Number of adolescents provided sanitary napkins			X	X		X	X	
8.IPC/Orientation/Discussion:								
a) Nutrition								
b) SRH								
c) Mental Health								
d) GBV								
e) NCD								
f) Substance Misuse								
9. Total number of adolescents referred:							**X**	
a) To shraddha clinic for clinical services							**X**	
b) To shraddha clinic for counselling services							**X**	
c) To other health service							**X**	

D. Remarks (include performance, challenges etc)			
Signature			
ADMO FW		**DPM**	
Program Associate (RKSK Program)		**DMRCH**	

Annex 8

AHD Service Basket

Nutrition • BMI Screening and recording in card • Anaemia testing • Provision of IFA tablet and albendazole • Discussion/IPC/orientation on nutrition and balanced diet • Addressing gender based food distribution in households • Referral and follow up
SRH • Conversations about harmful practise of child marriage • Information about adverse consequences of teenage pregnancy • Provision of sanitary napkin • Discussion/IPC/orientation on SRH including information on RTI/STI/HIV and AIDS, contraception's and choices, age of marriage, abortion, pre-marital counselling etc • Referral to shraddha clinic and follow up
Mental Health • Discussions/IPC/orientation on mental health including age specific mental issues among adolescents and ways to overcome them including stress, depression, suicidal tendency etc • Referral to shraddha clinic for regular counselling and follow up
GBV • Discussions/IPC/orientation on GBV
NCD • Discussions/IPC/orientation on NCD, exercise and healthy lifestyle and personal hygiene • Focuses discussions on prevention of NCD through exercise, healthy life style and avoidance of tobacco and alcohol • Referral to shraddha clinic and follow up
Substance misuse • Discussion/IPC/orientation on harmful effects and consequences of substance misuse