Dr. RAKESH KUMAR, I.A.S
JOINT SECRETARY
Telefax : 23061723
E-mail : rk1992uk@gmail.com
E-mail : rkumar92@hotmail.com

भारत सरकार
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
निर्माण भवन, नई दिल्ली – 110011
Government of India
Ministry of Health & Family Welfare
Nirman Bhavan, New Delhi - 110011

D.O No.- M-12015/312/2014.MCH.DC(AH)
Date:05/03/2015

Dear All,

As you may be aware that Rashtriya Kishor Swasthya Karyakram (RKSK) was launched in 2014 with the vision of providing comprehensive services to adolescents in the country. Following this, State Orientations have also been conducted in many of States.

RKSK Operational Framework and Strategy Handbook have been shared with all of you and you must be well versed with the basic components of the programme. To provide a robust start to the programme, it has been decided that in the first phase the programme would be implemented in 231 Districts across the country. In these 231 RKSK Districts, community and facility based interventions would be implemented in select CHC/PHCs.

An Operational Guideline detailing the implementation framework has been developed and enclosed with this letter. You are requested to use these guidelines for implementation of RKSK in your State/UT and also for the purpose of preparation of State PIP 2015-16.

warm regards

Yours sincerely

Dr. Rakesh Kumar

Mission Directors all States/UTs

Copy to:
Nodal Officers (RKSK) all States/UTs

Guidelines for implementation of RKSK

Adolescent Health Division
Ministry of Health and Family Welfare
New Delhi

RKSK Rashtriya Kishor Swasthya Karyakram

Background:

At 253 million, India has the largest share of the adolescent population in the world. With a view to address the health and development needs of this age group which is 21percent of India's population, Ministry of Health and Family Welfare launched the **Rashtriya Kishor Swasthya Karyakram (RKSK)** on the 7th of January 2014.

RKSK has been developed to strengthen the adolescent component of the RMNCH+A strategy which, as we are all aware, is one of the weakest and a sub-critical programme area. Whilst core programming principles for RKSK are health promotion and a community based approach expanded scope of the programme includes nutrition, sexual & reproductive health, injuries and violence (including gender based violence), non-communicable diseases, mental health and substance misuse.

Implementation plan: selection of districts/ CHCs/ PHCs/ Sub-Centres:

Given the scope of the programme, an executive decision has been taken to implement RKSK in a **phased manner**. During the first phase, 231 districts as selected by the states have been identified for implementation. Within, these 231 districts 50% blocks will be covered. Thus, if there are 10 blocks in a district (normatively speaking) we are looking at covering 5 blocks/ 5 CHCs.

Further, out of 5/6 normative PHCs under one block CHC, two PHCs will be identified (basis ability and wherewithal to implement RKSK viz trained service provider, existing Adolescent Health programme with reasonable footfall and good infrastructure with dedicated space for AFHS etc.) All sub-centres under these PHCs and, all villages under these sub-centres will be selected for provision of all interventions and services envisaged under RKSK. Annex 1

(A) Management Capacities:

States are expected to augment AH management capacity commensurate to the workload and allocated budget of the new programme. In order to ensure a smooth and seamless rollout of RKSK the following steps need to be taken at the earliest:

- Set up a RKSK Unit at the State level with a dedicated full time Joint/ Deputy Director who is made in-charge of RKSK
- Ensure that the RKSK Unit comprises the following Programme Officers each responsible for a specific intervention or theme:
    - WIFS
    - Facility based RKSK Services (clinics and counselling),
    - Community based RKSK Services (Peer Educator & Adolescent Health Day)
    - Menstrual Hygiene Scheme
- At the district level a full time Program Officer for Adolescent Health should be appointed to coordinate all RKSK activities and ensure convergence

- A dedicated Adolescent Health counsellors is placed in AFHCs at the CHC level . Once in place, these counsellors should be designated as Block Nodal Officer for RKSK and will be responsible for all RKSK related activities in the block. Detailed job descriptions have already been shared.

A step by step guide for operationalizing the both the community and facility based interventions of RKSK is as below:

(B) Community based services:

Peer Educator

The PE programme aims to ensure that adolescents or young people between the ages of 10-19 years benefit from regular and sustained peer education covering nutrition, sexual and reproductive health, conditions for NCDs, substance misuse, injuries and violence (including GBV) and mental health. This is eventually expected to improve life skills, knowledge and aptitude of adolescents. **Peer Educator's role is to serve as source of sensitization and referral to experts and services**

In every village (1000 population/ASHA habitation) four peer educators i.e. two male and two female peer educators will be selected based on the recommendation/ nomination of ASHA and the school teacher. To ensure coverage of adolescents in both schools and out of school, two peer educators (i.e., one male and one female) will be selected to work with adolescents in school, and similarly, two peer educators will be selected to work with adolescents out of school.

Each male and female peer educator will be expected to:

- Form a group of 15-20 boys and girls respectively from their community and conduct weekly one to two hour participatory sessions using PE kits
- Participate in Adolescent Health Day to inform and educate young people and involve parents.
- Refer young people to AFHCs and/or Adolescent Helpline; and the Adolescent Health Day for health check-ups.
- PEs will constitute Adolescent Health Club at sub-centre level, under the overall guidance of ANM. These clubs will meet monthly to discuss issues of PEs and get support from ANM.
- In order to ensure the sustainability of the PEs, PEs will be linked to ASHAs who will play a facilitator role and create an enabling environment for the PEs.

Detailed note on training of Peer Educators is placed at Annex-I

ANM and ASHAs:

Field-level functionaries will be providers of information, services and commodities at the community level and make appropriate referrals to Adolescent Friendly Health Clinics (AFHCs) as and when required. They will serve as the first point of contact for the adolescents. These service providers will be instrumental in creating an enabling environment at the community

level for adolescent health and development activities through existing platforms such as AWCs, Sabla Kishori-Samooh, Teen Clubs and Village Health, Nutrition and Sanitation Committees (VHNSCs), and creating new platforms for service delivery such as organising Adolescent Health Days (AHDs) every quarter. Community-based workers and volunteers will engage with parents and families of adolescents to increase awareness about the unique needs of this dynamic group

Adolescent Health Day:

- Increase awareness among adolescents, parents, families and stakeholders about the determinants of adolescent health such as nutrition, SRH, mental health, injuries and violence (including GBV), substance misuse and NCDs.
- Improve awareness of other AH related services, in particular Adolescent Friendly Health Clinics (AFHCs)/helplines.
- In addition, during Adolescent Health Day the Counsellor or the trained MO/ ANM will hold group sessions with parents to provide:
  - Information on topics related to adolescent health. In addition feedback should be collected on the area specific adolescent and parenting problems, and efforts should be made to help parents get information on resolving these issues.
  - Skills: Efforts should be made to help parents develop/enhance skills on communicating with adolescents, such as talking with adolescents about sex, listening to adolescents' concerns, or talking without shouting.
  - Support: Parents should be educated and sensitized on the resources available for assisting them in managing adolescent issues.

AHD will be organized in every village once every quarter on a convenient day (preferably on a Sunday) following the VHND; in Sabla districts, this day should coincide with the existing Kishori Diwas. AWCs or community spaces may be used as venues for organizing the AHD. During an AHD, The following services will be provided:

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

(C) Facility based services:

Guidelines for operationalizing the Model AFHCs

Infrastructure:

- There has to be a separate room for AFHC. In case of non-availability of the separate room the available room should be sub divided to create space/room for the AFHC.
- The physical appearance of AFHCs is important for creating an environment where adolescents feel comfortable.
- A typical health set up might not attract adolescents, but a simple makeover with wall paint, colourful furniture, bright posters, LCD screens with appropriate health messages etc. can all transform the facility.
- Basic amenities like sitting arrangement, clean drinking water, and clean toilets should be made available for the adolescents visiting the clinic.
- The following instruments, equipment & furniture are to be ensured in the AFHCs

Sr. No.	Items	Quantity
Furniture		
1	Chairs	3
2	Table	1
3	Curtains on doors and windows	As per need
4	Bedside Screen	1
5	Examination Table	1
6	Almirah	1
7	Step Tool	1
8	Bench / Chair for waiting area	As per need
Equipment s and Instruments		
1	Weighing Machine	1
2	BP Apparatus	1
3	Stethoscope	1
4	Thermometer	1
5	Measuring Tape	1
6	Torch / Flashlight	1
7	Snellen’s Chart	1
8	Height Chart	1

Minimum Human Resource Required for the AFHCs:

- Full time placement of One AFHS trained MO and ANM/ LHV should be ensured by the facility in charge.
- It is advisable that two MOs are trained for the facility with preferable inclusion of the Female MO.
- In absence of the service providers at the weekly AFHCs at the PHCs the MOs, ANMs and Counsellor from the nearby CHCs should be deputed to those PHCs on service days.

- Dedicated AH Counsellor is to be placed at the AFHCs (DH,SDH and CHC) for counselling services. If the recruitment of the Counsellor is to be done, it has to be completed at the earliest.
- All the clinical services must be provided by the clinical staff of the AFHC and counselling services must be provided by the trained counsellors/ MO/ANM.
- Service providers should be non- judgmental and competent.

Privacy of the Clients

- Efforts should be made to maintain privacy and confidentiality, to ensure that adolescents are comfortable attending clinics.
- Adolescents must be treated with dignity and respect.
- Place of physical examination must have screens.
- While examination of the adolescent girls ANMs/ LHVs must remain present.
- All the doors and windows of the Clinic must have curtains.

Timing of the Clinic

Sub Centre	PHC	CHC	DH	Medical College
Walk in Clinics through ANMs.	Weekly AFHCs from 2 to 4 p.m. by ANMs and MOs	Daily AFHCs from 9 a.m. to 4 p.m Two hour daily clinic from 2pm-4pm by MOs, with support from ANMs	Daily AFHCs from 9 a.m. to 4 p.m Two hour daily clinic from 2pm-4pm by MOs, with support from ANMs	Daily AFHCs from 9 a.m. to 4 p.m SpecialityAFHC with different specialties from 9 a.m. to 1 p.m.

The above are only the suggested timings and facilities can modify the timings based on local circumstances

Registration of the Clients:

- All the adolescents visiting the AFHCs must be registered and record must be maintained in the Client Registration Register.
- Referring all the adolescents coming to the General OPD to the AFHC must be avoided. Only those Adolescents who require counselling on specific AH issues should be referred to the AFHC. Adolescents requiring clinical services for general ailments or other diseases should be treated at the General OPD only.

Package of AFHC Services:

Please refer to the table below to understand the scope of services that will be offered at each level of facility.

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

IEC:

- The signboard of the clinic should be placed at a prominent place and it must have the logo of RKSK. AFHC services should be made a part of Citizen Charter of the facility.
- IEC material relevant to the Adolescent needs should be strategically displayed in AFHCs.
- Filip books, Pocket books, Pamphlet, posters to be utilized for communication.
- AFHC services should be widely publicized through Mid media and Mass media so that the beneficiaries and other stakeholders are aware of the services provided and understand the need for the same.

Outreach Sessions:

- Counsellor at AFHCs should prepare a tour plan for visiting Schools, Colleges, Youth Clubs, Major Health events, Adolescent Health Day etc. twice a week to sensitize the adolescents and the stakeholders.
- Major topics which can be covered during the outreach sessions are nutrition, puberty related concerns, Premarital Counselling, Sexual Problems, Contraceptive, Abortion, RTI/STI, Substance abuse, Learning problems, Stress, Depression, Suicidal Tendency, Violence, Sexual Abuse, Other Mental Health Issues, health lifestyle, risky behaviour etc.

Record Keeping:

As per the guidelines of the GoI four types of registers to be maintained in the AFHC

1. **Client Registration Register:** This register is to be used to record details of all clients visiting the Adolescent Friendly Health Clinics (AFHC) prior to consultation with Doctor/ Counsellor. This register must be marked confidential since it has the contact information of all clients visiting the clinic. The clients must be assured of confidentiality while collecting this information so that their contact details –address and phone number may be recorded for follow-up.
2. **Service Provision Register:** This register is for recording the services provided to adolescent clients at the clinic
3. **Stock Register:** This register is to be used to maintain the daily record of stocks for drugs and supplies at the AFHC
4. **Outreach Sessions Register:** This register is to be maintained at the AFHC to record the outreach services.

   Link:http://nhm.gov.in/nrhm-components/rmnch-a/adolescent-health/adolescent-reproductive-sexual-health-arsh/manualformats.html

   Formats are available at the National Health Mission website to download the same the above link may be followed.

Reporting:

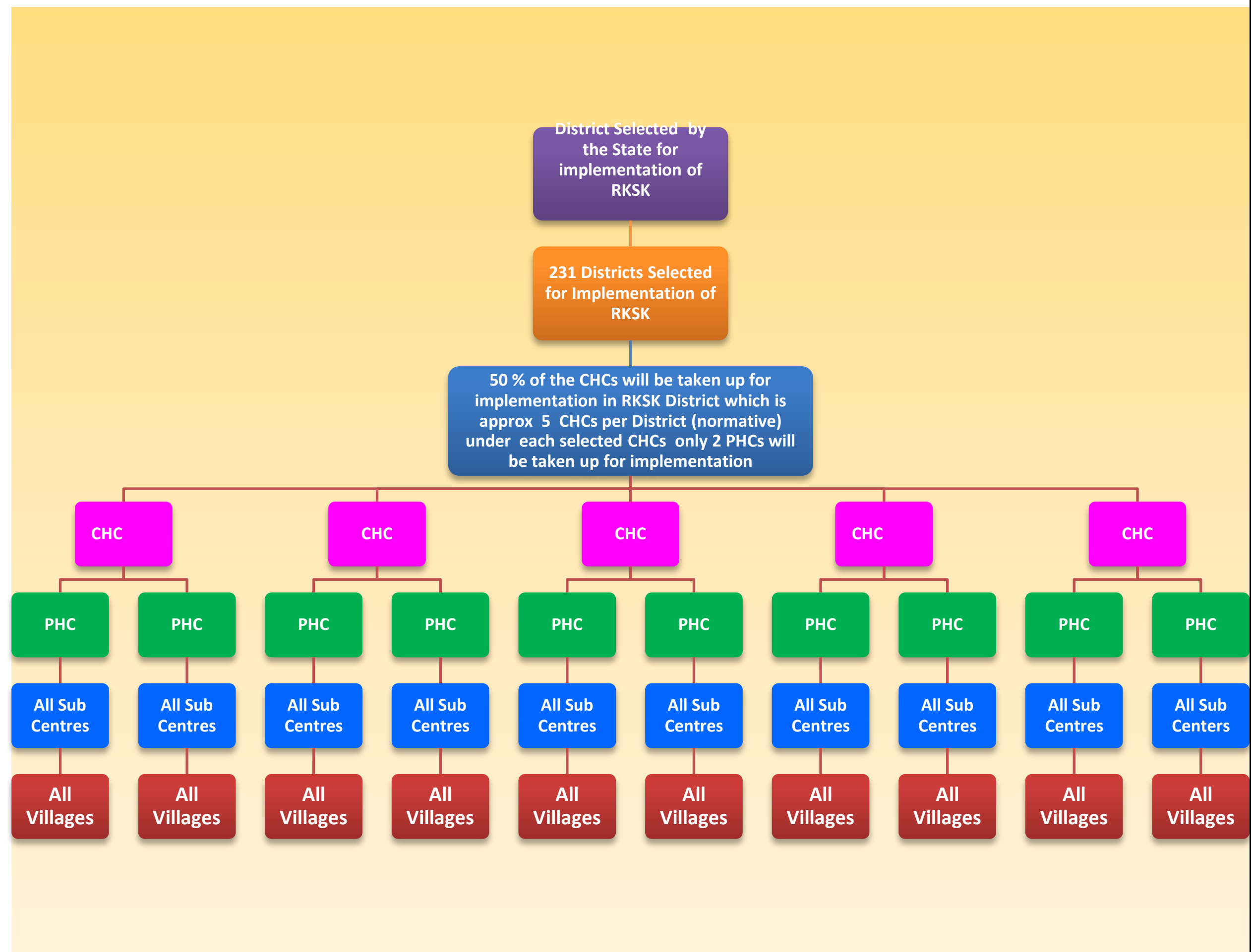
- It is important for States/UTs to be able to report accurate, timely and comparable data to MoHFW for monitoring and supportive supervision of the existing programme and scale up.
- In order to ensure accurate and timely submission of data, specific date(s) for submission of consolidated reports on AFHCs need to be followed as mentioned below:
- Adolescent Friendly Health Clinics (AFHCs) to send monthly consolidated reports to the districts by 5th of the following month. This report must be submitted on the Facility Level Consolidated Monthly Format. This report has to be compiled from the Service Delivery Registers and the Outreach service Delivery Register used at AFHCs.
- District Level Consolidated Monthly Report to be compiled for each district in the States/UTs. This District Level Consolidated Monthly Report has to be generated by 10th of

the following month based on the Facility Level Consolidated Monthly Formats sent from each AFHC in the district.

- States/UTs to submit Consolidated Quarterly Report to the MoHFW by 20th of month following the respective quarter (e.g. 1st Quarter report submitted on 20th April). Quarterly report must bear the signature of the Nodal officer. Report to be compiled based on District Level Monthly Reports.

Annex 1

First phase of implementation of RKSK



RKSK

Annex 2

PEER EDUCATOR TRAINING STRATEGY

A summary of the training strategy as mentioned below:

National Level Orientation of Nodal Agencies:

- At the National Level Nodal agencies are being considered to facilitate the Peer Educator Training in response to the EoI floated by NHSRC to empanel agencies.
- 5 trainers from each of these agencies, i.e. total of 25 resource persons will be oriented in RKSK over a period of two days. AH Division and NHSRC will be responsible for organizing this sensitization / training.
- The expected outcome of this training is to create a Regional **Resource Persons Pool at the regional training sites** who will then train a cadre of District Trainers and create a standard training methodology and materials.

Level of training	Days of training	Participants	Responsibility
National level orientation of Nodal agencies	2 days	Nodal agencies identified by NHSRC	AH Division / NHSRC
Regional	5 days	Nominated MOs/representative of NGOs from social domain by the State	Training institutions empanelled by NHSRC and AH Division
Block	6 days	Peer Educator & ASHAs	District CMO/ Nodal officer RKSK/BMO

Regional Level Training:

- After the completion of the Orientation of Nodal agencies, they will further move to Regional Level Training Sites to train the Medical Officers / NGOs/ trainers from RKSK implementing districts. The names of the participants for the Regional Level Training would be decided by the State and further communicated to the AH division. ***It is suggested that in some of the implementing districts, Medical Officers are selected for this Regional Level Training so that these districts have a training cascade through Medical Officers & ANMs.***
- The duration of the Training of Trainers will be five days.
- The Regional sites of these Nodal Agencies may be utilized for these trainings.
- Four persons (Medical Officers or, alternatively NGOs with experience of having worked with UN /reputed International agencies) from RKSK implementing districts (231) will be called for the training at Regional Training sites. Total training load of these training will be 924 trainers basis assumption that four trainers each will attend the trainings.
- They will be trained in 31batches; each batch will comprise 30 participants.

Profile of Trainers

- District Trainers with substantial experience, commitment of work as full time trainers for at least one-two month for conducting Training of ANMs.
- The agencies involved in adolescent health programmes such as SABLA, SAKSHAM, WIFS, other community level interventions related to adolescent/youth will be given preference. However, Medical Officers must be selected from some districts.
- Trainers involved in training with ICDS, education, literacy, livelihood, water and sanitation projects or trainers working on gender issues, etc. may also be considered.

TRAINING OF PEs and ASHAs

- MOs/NGOs who receive training at the Regional level will train the Peer Educators and ASHAs forming a normative batch of 40 comprising of 32 PEs and 8 ASHAs.
- In each RKSK implementing District 50% of the CHCs will be covered and 2 PHC under each CHC will be taken up in the first phase of implementation of PE. Further, each PHC will have 6 sub-centres hence 2000 PHCs will cover 12000 sub centre (2000 PHCs x 6 Sub Centre). Each sub centre will have a catchment area of 5000 population.
- For every 1000 population 4 PEs and 1 ASHAs is to be trained and each SC will have 5000 population in its catchment area
- Therefore, for every 5000 population 20 peer educators and 5 ASHAs will be trained.
- Duration of the training will be 6 days.

Peer Educator Training Steps