

Adolescent Health Survey

Findings from School-based Survey in Himachal Pradesh

Topline findings



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Suggested Citation: Mohanty S, Das SS, Bahl D, Mehra D, Sethi G, Garg R, Patel N, Mehta R, Beri G, Gupta A, Chauhan A, Mehra S. (2024). Adolescent Health Survey Findings from School-based Survey in Himachal Pradesh: Topline findings. New Delhi: Mamta Health Institute for Mother and Child.

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Chapter 1

Introduction

Adolescence, age between 10 to 19 years, is a crucial period for human development. This is a transition from childhood to adulthood that lays the foundation of the future of an individual¹. Health needs during adolescence, when unmet, can adversely impact immediate growth and development, and throughout the life course which potentially can result in lasting effects on the health of the next generations. However, investment in this stage of life will yield a triple dividend².

India has the largest adolescent population in the world, with 253 million individuals in this age group³. The distribution of adolescents in India highlights the importance of prioritising policies and programmes that promote their well-being, harness their potential, and ensure a sustainable and equitable future.

Acknowledging the vulnerability and significance of safeguarding and promoting the health and well-being of adolescents, the Ministry of Health and Family, Government of India in January 2014, launched the Rashtriya Kishor Swasthya Karyakram⁴.

For achieving the targets under the Sustainable Development Goals 2030, both health and education, are fundamental as schools create a unique opportunity to improve the formal education and health critical for the adolescents. The Government of India also initiated the Ayushman Bharat - School Health and Wellness Programme⁵ in 2020, in a joint collaboration between the Ministry of Health and Family Welfare and the Ministry of Human Resource and Development to strengthen the preventive and promotive health through activities for adolescents.

For decades now, several surveys have been carried out in India including the National Family Health Survey⁶⁻¹⁰, the Global Adult Tobacco Survey^{11,12}, the Global Youth Tobacco Survey¹³⁻¹⁷, the Global School-based Student Health Survey¹⁸, the National Mental Health Survey¹⁹, and the Comprehensive National Nutrition Survey²⁰ highlighting the vulnerability of adolescents in different health domains. Although the aforementioned surveys clearly indicate the vulnerability of adolescents, still there is no comprehensive survey conceptualised or implemented to evaluate the adolescent health holistically and subsequently strengthen the ongoing programmes.

Mamta Health Institute for Mother and Child is actively supporting the Himachal Pradesh Government in implementing many government programmes to address various aspects of healthcare, from adolescent health to maternal and child health, through comprehensive and community-centered approaches. And as part of furthering support to adolescent health implementation in the State, Mamta undertook this State-level School-based Adolescent (13-17 years) Health Survey with the approval and guidance of Government of Himachal Pradesh in the year 2023.



Launch of Adolescent Health Survey on November 9, 2023 at Shimla, Himachal Pradesh

Chapter 2

Methodology

2.1 Survey setting

Himachal Pradesh is administratively divided into 12 districts, 73 sub-divisions, 78 blocks and 172 tehsils. The State had an enabling environment for rolling-out the school-based Adolescent health survey. For instance, the school infrastructure in the State comprises 928 government high schools, 1,869 government senior secondary schools, and 130 governments colleges. The total number of students enrolled between class 8 and class 12 was 7,82,941²¹. There is almost universal enrolment, with the Net Enrolment Ratio at 99.7 in primary level²¹ and the retention rate was 96.42 in class 11. Himachal Pradesh became the first State in India to make elementary education accessible to every child²², and is an exception in upholding gender access in education²³. School enrolment and participation rates for girls are almost universal at the primary level. Higher levels of education, however, do reflect a gender-disparity²⁴.

2.2 Survey objectives

1. To understand the types and prevalence of adolescent health-related issues, including health behaviours in Himachal Pradesh.
2. To understand, access to and utilisation of services and commodities by adolescents according to Ayushman Bharat School Health and Wellness Programme and Rashtriya Kishor Swasthya Karyakram in Himachal Pradesh.
3. To understand the status of school policy environment and practices towards promoting health and well-being of adolescents in schools.
4. To provide recommendations to strengthen the ongoing adolescent health programme in the state of Himachal Pradesh.

2.3 Study design

1. **Advisory committees:** Two advisory committees were formed for the survey - one at a national level and another at the State level. Both advisory committees played a crucial role in advising the study design, development of survey tools, sampling methodology, implementation plan, data quality assurance, data analysis and report writing.
2. **Study design and participants:** A cross-sectional study design was used to recruit adolescents (13 to 17 years), both boys and girls, currently attending government schools for a one-point health survey. Additionally, school principals were included in the survey.

3. **Sampling:** Sample size was determined by using the Cochran Sampling technique of finite population²⁵ and arrived at 7,563 adolescents. The sample was distributed among all 12 districts by using the Probability-proportional-to-size by considering the location of schools (rural and urban), the sex of the students (boy and girl) and age of adolescents (13-15 years and 16-17 years). Further, exclusive boy's or girl's schools were also considered for sample distribution at the first instance. It was ensured that at least one school from a school cluster was included in the sampling.
4. **Research instruments:** Three research instruments were developed:
 - i. Students survey (self-administered): 'Global School-based Student Health Survey'²⁶ questions were adopted and adapted for the survey covering the domains including dietary behaviour, physical activity, hygiene, digital device use, connecting to parents/guardians, health-seeking behaviour, health screening, violence, substance use, reproductive and sexual health, menstrual hygiene, access to government schemes and mental health to assess the prevalence of adolescent health-related issues. The questions were aligned with the Global Action for Measurement of Adolescent Health²⁷.
 - ii. Principal survey (self-administered): 'Global School Health Policies and Practices Survey'²⁸ tool was customised covering the domains of school health coordination, healthy and safe school environment, violence and bullying, substance use prevention, implementation of government schemes, and physical education and activity.
 - iii. Observation (Data collectors checklist): The tool was developed with the aim to triangulate the self-reported data of adolescents and principals (as mentioned above) by observing the school environment (in and around) on cleanliness, substance use, availability of vendors selling junk food, adherence to the Tobacco Free Education Institution guidelines and school attendance.

All these survey tools were created electronically in KoBo collect²⁹.
5. **Pilot testing of research instruments:** Pilot testing was conducted in two districts, with representation from both rural and urban areas, and included both boys and girls enrolled in classes 7th to 12th.
6. **Ethical approval:** Ethical approval was obtained from the Institutional Review Board of Mamta Health Institute for Mother and Child, New Delhi (MIRB/September – 2023/009).
7. **Training of data collectors:** A two-day interactive residential training was organised in Shimla, during which 24 data collectors were trained on the research tools, field operational plan, data quality assurance, and anticipated challenges and probable solutions.
8. **Data quality assurance:** Logical sequencing, question skip pattern, default global position system locations, and the date and time of data gathering were all included in the online data collection interface. For the identification of student respondents in each school, an automated calculating mechanism was also integrated into the interface. To double-check and validate the data collection in the individual schools, principals of the sampled schools were telephonically back-checked. For 25% of the sampled schools, the data quality management team with experience in data quality parameters accompanied the data collectors during the data gathering process. Back checks and spot checks were undertaken by this team.

9. **Student participation consent:** Consent was taken from the sampled school authorities for surveying students. The parents or legal guardians of the pupils gave passive consent³⁰. Electronic student assent was taken from each survey participant as per the direction of the Institutional Ethics Committee.
10. **Data collection:** As many as 7,563 students along with 204 principals from 204 schools participated in the survey in the month of November, 2023.
11. **Data analysis:** The collected data was cleaned for inconsistencies. Descriptive statistics across all modules and variables were used. Univariate analysis was performed to describe the general characteristics of the survey population. This was followed by Pearson's Chi-square test to measure the statistical relationship / association between two categorical variables at a significant level of $p < 0.05$.



Chapter 3

Result

3.1 District-wise schools covered for data collection

Data for the adolescent health survey was collected from 204 schools across all the 12 districts of Himachal Pradesh based on student enrolment in government schools. A total of 7,563 students in the adolescent age and 204 principals participated in the survey (table 3.1).

Table 3.1: Distribution of sampled schools across districts

District	School	Boys	Girls	Total
Bilaspur	17	321	328	649
Chamba	16	351	305	656
Hamirpur	17	336	311	647
Kangra	17	332	325	657
Kinnaur	15	282	293	575
Kullu	17	302	351	653
Lahul & Spiti	16	203	250	453
Mandi	17	327	330	657
Shimla	21	378	277	655
Sirmour	19	340	314	654
Solan	14	324	331	655
Una	18	337	315	652
Total	204	3833	3730	7563

3.2 Background details

The majority of the surveyed schools (85.8%) were co-educational, with 89.2% were of higher secondary level, and 86.8% being situated in rural areas (table 3.2).

Table 3.2: Student characteristics who participated in the survey

Variable	Number	Percentage
Type of school		
Only boy's school	13	6.4
Only girl's school	16	7.8
Coeducational school	175	85.8
Grades taught in school		
Upper Primary School	4	2.0
High School	18	8.8
Higher Secondary School	182	89.2
Location of School		
Rural	177	86.8
Urban	27	13.2
Students Profile		
Location		
Rural	6687	88.4
Urban	874	11.6
Sex		
Boy	3833	50.7
Girl	3730	49.3
Age		
13 to 15 years	5073	67.1
16 and 17 years	2490	32.9

The survey included almost equal proportions of boys and girls, with a higher percentage of younger adolescents (67.1%), residing in rural areas (88.4%).

Chapter 4

Findings

This survey presents the findings of a comprehensive assessment of adolescent health in 12 districts of Himachal Pradesh by following thematic areas:

Module A	<u>Pre-Survey (background characteristics)</u>
Module B	<u>Food Preferences and Choices</u>
Module C	<u>Physical Activity</u>
Module D	<u>Personal Hygiene</u>
Module E	<u>Digital Device Use and Cyber-Bullying</u>
Module F	<u>Connect to Parents and/or Guardian</u>
Module G	<u>Health Seeking Behaviour</u>
Module H	<u>Access to Government Schemes</u>
Module I	<u>Violence and Road Safety</u>
Module J	<u>Substance Use</u>
Module K	<u>Reproductive and Sexual Health</u>
Module L	<u>Menstrual Hygiene</u>
Module L	<u>Mental Health</u>

Vulnerability assessment of adolescent population in every thematic area has been derived based on the overall finding and not based on the tables presented in each section.

4.1 Food Preferences and Choices

The Indian Council of Medical Research's, 'My Plate for the Day'³¹ recommends sourcing of micro and macronutrients from a minimum of eight food groups with vegetables, fruits, green leafy vegetables, roots and tubers forming essentially half of the recommended plate of foods per day. The other major portion is from cereals, and millets followed by pulses, flesh foods, eggs, pulses, nuts, oil/seeds, curd/milk.

Table 4.1: Percentage of Students Self-Reported Food Preference

Indicator	Sex		Age		Residence		Total
	Boy	Girl	13-15	16-17	Urban	Rural	
Healthy food habit							
Fruit >= 4-6 times ^a	52.54*	56.38	53.99	55.34	55.59	54.28	54.44
Milk/milk product >= 4-6 times ^a	71.56	68.42*	70.00	70.04	70.21	68.49	70.01
Egg >= 4-6 times ^a	27.18	23.40*	26.61	22.69*	18.38*	26.23	25.32
Unhealthy food habit							
Junk food >= 2 days ^{a,c}	97.94	97.59	97.67	97.95	97.37	97.82	97.77
Skipped breakfast ^b	22.33	24.08	22.27	25.06*	23.12	23.74	23.19
Skipped lunch ^b	31.10	30.08	27.52	36.87*	26.14	31.18*	30.60

a. During the past 7 days

b. During the past 30 days

c. Consumption of fried food, and/or soda beverage, and/or high salt food, and/or high sugar food during the past 7 days

* Differences across groups are statistically significant at 95% confidence level

More than half of adolescents (54.4%) ate fruits 4-6 times or more during the last 7 days. There was a statistically significant difference between boys (52.5%) and girls (56.4%) (table 4.1). However, no significant difference by age and place of residence was observed.

Almost 70% of the adolescents reported consuming milk/milk products 4-6 times or more in the past 7 days. More boys (71.6%) as compared to girls (68.4%) reported consuming milk/milk products and the difference was statistically significant. While, no statistically significant difference by age and place of residence was observed.

Almost 98% of the adolescents reported eating junk food in the past 7 days. However, there were no statistically significant differences by sex, age, and place of residence in consumption of junk food.

More than 23% of adolescents skipped breakfast in the past 30 days. There was no statistically significant difference observed between boys and girls in skipping breakfast. When comparing age, the proportion of adolescents who skipped breakfast was higher among those aged 16-17 than aged 13-15 (25.1% and 22.3%). However, no significant difference was observed between adolescents from rural areas and urban areas in skipping breakfast.

The result underscores a significant concern regarding the vulnerability of **adolescent girls in the older age group (16 and 17 years)** residing in **rural areas**, particularly about their adoption of unhealthy dietary behaviours.

4.2 Physical Activity

The World Health Organization, recommends individuals to engage in an average of 60 minutes per day of moderate-to-vigorous intensity, mostly aerobic, physical activity throughout the week³² whereas, in training and resource material of Ayushman Bharat School Health and Wellness Programme, the appropriate amount of physical activity, specifically 30 minutes a day for children has been recommended⁵.

Table 4.2: Percentage of Students Self-Reported Physical Activity

Indicator	Sex		Age		Residence		Total
	Boy	Girl	13-15	16-17	Urban	Rural	
Physical activity							
Mild exercise 3-7 days ^a	58.81	59.22	56.51*	64.10	59.13	59.00	59.01
Moderate exercise 3-7 days ^a	60.29	57.88*	59.00	59.32	58.74	61.87	59.10
Strenuous exercise 3-7 days ^a	62.74	50.91*	57.48	55.74	57.08	56.89	56.91
Sedentary activity							
Spent time on reading, and doing academic work, including tution >= 3hr ^a	41.48	51.21*	45.14	48.69*	49.43	45.87	46.28

a. During the past 7 days

* Differences across groups are statistically significant at 95% confidence level

Almost 59% and 57% of the adolescents reported that they had engaged in moderate and strenuous physical activities respectively in the past seven days (table 4.2). The frequency of adolescents who reported to have been engaged in moderate and strenuous physical activities in the past 7 days was higher among boys, as compared to girls (60.3% vs 57.9%) and (62.7% vs 50.9%) respectively. However, no statistically significant difference was observed for age, and place of residence of adolescents in self-reporting of engagement in moderate and strenuous physical activity.

On the other hand, 46.3% of the adolescents self-reported that they spent time on reading, and doing academic work, including tutions on an average of more than 3 hour in the past 7 days. The frequency was differed by sex, boys (41.5%) vs girls (51.2%). There was statistically significant difference between younger adolescents (45.1%) and older adolescents (48.7%), while there was no statistically significant difference by place of residence.

The interpretation highlights a significant concern related to the vulnerability of **adolescent boys** in the **younger age group (13 to 15 years)** who reside in **urban areas** due to their low engagement in physical activity in their daily schedules.

4.3 Personal Hygiene

In Low- and Middle-Income Countries, the importance of hygiene practices such as handwashing and tooth brushing has been relatively overlooked. However, these practices are crucial, as inadequate sanitation and poor personal hygiene significantly contribute to the spread of diseases, particularly gastrointestinal and respiratory illnesses³³⁻³⁶. The World Health Organization recommends washing hands with soap and water when visibly dirty or visibly soiled with body fluids or after using the toilet³⁷.

Table 4.3: Percentage of Students Self-Reported Personal Hygiene Practices

Indicator	Sex		Age		Residence		Total
	Boy	Girl	13-15	16-17	Urban	Rural	
Personal hygiene practices							
Not washing hand after using rest room ^a	4.49*	2.60	3.78	3.09	2.97	3.63	3.56
Not washing hand before eating food ^a	4.41*	2.23	3.45	3.09	2.97	3.38	3.33
Not washing hand before handing food ^a	7.62*	4.05	5.80	5.98	4.22	6.07*	5.86
Hygiene in school							
Not having separate toilets or latrines for boys and girls ^b	-	-	-	-	16.79*	2.28	3.93
Toilets or latrines were not clean	15.59*	10.51	10.83	17.70*	26.37*	11.36	13.07
Unavailability of running water in school toilets	-	-	-	-	17.29	17.85	17.79
Not having handwashing area inside school toilets	-	-	-	-	6.09	6.46	6.42
Dustbin not cleaned every day in the classroom	-	-	-	-	16.55*	9.09	9.96

^a The response to the question was either never, or rarely, or sometimes during the past 30 days

^b Analysis excluding exclusive boys' and exclusive girls' school

* Differences across groups are statistically significant at 95% confidence level

Around 13.0% reported toilets were not clean at school with statistically significant differences (15.5% among boys vs 10.5% among girls), (10.8% among 13-15 aged vs 17.7% among 16-17 aged) and (26.4% in urban areas vs 11.4% in rural areas) (table 4.3). However, all principals self-reported cleaned toilets in their respective schools.

About 17.8% of the adolescents reported unavailability of running water in school toilets whereas, 6.5% self-reported not having a handwashing area inside school toilets; 10.0% of adolescents self-reported dustbins were not cleaned every day in the classroom with statistically significant difference between 16.6% in urban areas and 9.1% in rural areas.

To Promote hygiene among school students, the Government of India had launched the Swachh Vidyalaya Initiative to provide separate toilets for girls and boys in all Government schools³⁸. Additionally, the standard operating procedure of Swachh Vidyalaya, mandates schools to clean dustbin on a daily basis³⁹.

However, the interpretation highlights a significant concern related to the vulnerability of **younger age (13 to 15 years)**, and **rural adolescents** being susceptible to infection due to inconsistent personal hygiene practices.

4.4 Digital Device Use and Cyber-Bullying

The Annual Status of Education Report, 2023⁴⁰ findings reflect that while there is a wider access, as 95% of males and 90% of females reported knowing how to use a smartphone, the technical nuance of “know-how to use a smartphone” looks different for men and women. For instance, boys between the 14- and 18-year age group were more than twice as likely to own their own smartphone than girls, and, therefore, were likely to spend far more time using the device for a wider variety of tasks. With this earlier age of mobile maturity, children in India also reported experiencing online risks at a higher rate.

Table 4.4: Percentage of Students Self-reported Digital Device Use and Bullying

Indicator	Sex		Age		Residence		Total
	Boy	Girl	13-15	16-17	Urban	Rural	
Digital devices use more for than 8 hours/ per day ^a	2.37*	1.58	1.62	2.73*	1.83	2.00	2.00
Bullied someone online ^b	12.47*	6.73	8.65	11.65*	12.44*	9.27	9.64
Bullied by someone online ^b	9.94*	5.76	7.19	9.28*	10.96*	7.48	7.88

a in the past 7 days

b in the past 12 months

* Differences across groups are statistically significant at 95% confidence level.

In the past 12 months, 9.6% of adolescents reported bullying someone online, while 7.9% reported having been bullied by someone online (table 4.4). Boys reported higher proportion of both being bullied others (9.9%) and bullied by others (12.5%) compared to girls (5.8% bullied, 6.7% bullied by others).

There were significant differences in the prevalence of bullying someone online by age (8.7% in adolescents aged 13-15 years and 11.7% in 16–17-years old) and residence (12.4% in urban and 9.3% in rural areas). Similarly, in the prevalence of being bullied by someone by age was (7.2% in adolescents aged 13- 15 years and 9.3% in 16–17-years old) and residence (11.0% in urban areas and 7.5% in rural areas).

The findings highlight a significant concern related to the vulnerability of students - **older adolescents (16-17 years), boys**, and those who reside in **urban** areas being more vulnerable. Specifically, their regular usage of digital devices in their daily routines is noteworthy.

4.5 Violence and Road Safety

Adolescents are more prone to be involved in violence and physical attacks and fights and are more prone to injury, intentional or unintentional, than their older counterparts⁴¹. India bears the highest burden of child road traffic fatalities globally, with an estimated 1.5 million cases reported annually⁴².

Table 4.5: Percentage of Students Self-reported Violence and Road Safety

Indicator	Sex		Age		Residence		Total
	Boy	Girl	13-15	16-17	Urban	Rural	
Violence							
Engaged in physical fight ^a	28.62*	17.51	23.56	22.29	27.63*	22.55	23.14
Bullied someone physically ^a	17.77*	10.05	13.64	14.62	17.92*	13.44	13.96
Bullied by someone physically ^a	15.34*	7.35	11.39	11.41	15.98*	10.80	11.40
Feeling unsafe while going, coming, and inside school \geq 1 days ^b	26.51*	18.61	22.73	22.37	25.57*	22.22	22.61
Road safety							
Do not wear a helmet when pillion riding or driving a motorcycle/scooty ^{b√}	48.25	46.12	47.84	46.18	46.26	47.45	47.31
Do not wear a seat belt when driving a car or other motor vehicle ^{b√}	42.18	40.24	41.32	41.32	40.08	41.44	41.28
Do not wear a seat belt when riding a car or other motor vehicle ^{b√}	42.86	40.4	41.29	42.62	40.14	41.92	41.71

a During the past 12 months

b During the past 30 days

√ Excluding those respondents who neither drive or pillion ride

* Differences across groups are statistically significant at 95% confidence level

Over 23% of adolescents self-reported indulging in physical fights in the past 12 months (table 4.5). The percentage of adolescents who reported indulging in physical fights is higher among boys, as compared to girls (28.6% vs 17.5%). The percentage of adolescents who reported of getting into physical fights in last 12 months was higher in urban areas compared to rural (27.6% vs 22.6%). However, no statistically significant difference was observed by age.

Almost 14% of the adolescents reported having bullied physically someone in the past 12 months. The frequency of adolescents who reported having bullied someone was higher among boys, as compared to girls (17.8% vs 10.0%). The prevalence of getting into physical fights in last 12 months was higher in urban areas compared to rural (17.9% vs 13.4%). However, was no statistically significant difference was observed by age.

In the past 12 months, 11.4% of adolescents self-reported having been bullied by someone physically. Boys reported a higher proportion of being bullied by someone compared to girls (15.3% vs 7.4%). There were significant differences in the prevalence of bullied by someone physically by residence (16.0% in urban areas and 10.8% in rural areas). However, no statistically significant difference was observed by age.

In the past 12 months, 22.6% of respondents self-reported feeling unsafe while going or coming back from school. Boys reported a higher proportion of reporting of feeling unsafe compared to girls (26.5% vs 18.6%). There were significant differences in the prevalence of feeling unsafe by residents (25.6% in urban areas and 22.2% in rural areas). However, no statistically significant difference was observed by age.

Almost 47%, 41% and 42% of the adolescents self-reported not wearing a helmet when pillion riding or driving a motorcycle or scooty, not wearing a seat belt when driving a car or other motor vehicle, and not wearing a seat belt when riding a car or other motor vehicle respectively. However, no statistically significant difference was observed by age, sex, and place of residence.

According to the responses gathered from the survey, principals reported that policies prohibiting fighting and other forms of violence were in place in 96.1% of schools. Additionally, the data indicated that policies against the physical abuse of students by teachers were reported in 98.5% of schools.

The analysis highlights a concern about the vulnerability of **young (13 to 15 years) adolescent boys in rural areas** primarily attributed to their indulgence in violence and unsafe road use behaviours.

4.6 Substance Use

Adolescents are the group of people most prone to substance addiction⁴³. The critical age of initiation of drug use is the adolescent period⁴⁴, and the maximum usage of drugs occurs during among adolescence age.

Table 4.6: Percentage of Students Self-reported Substance Use

Indicator	Sex		Age		Residence		Total
	Boy	Girl	13-15	16-17	Urban	Rural	
Substance used							
Smoked or chewed tobacco ^a	5.24*	2.31	3.47	4.46*	3.08	3.89	3.79
E – cigarette ^a	4.72*	2.31	3.43	3.73	2.63	3.65	3.53
Alcohol ^a	4.41*	2.12	2.96	3.94*	3.08	3.30	3.28
Marijuana ^b	4.85*	2.73	3.92	3.57	2.74	3.95	3.81
Cocaine/heroin/opium ^b	4.04*	2.25	3.29	2.89	2.05	3.30	3.16
Hallucinogens ^a	4.75*	3.35	4.12	3.94	2.74	4.23*	4.06
Needle to inject any illegal drug ^c	9.24	8.79	10.19*	6.63	6.96	9.29*	9.02
Inhalants ^b	5.22*	3.70	4.51	4.38	4.00	4.53	4.47
Cough syrup without prescription ^b	22.15	23.49	23.67*	21.04	20.78	23.07	22.81
Sleeping pills ^b	5.19*	3.51	4.65	3.78	3.77	4.44	4.36

a in the past 30 days

b in the past 12 months

c during life time

*Differences across groups are statistically significant at 95% confidence level

Adolescents self-reported substance use over the past 30 day period. As many as 3.8% used tobacco, 3.5% e-cigarettes, 3.3% alcohol, 3.8% marijuana, 3.2% cocaine/heroin/opium, 4.0% hallucinogens, 4.5% inhalants, 9.0% injectable drugs, 22.8% cough syrup without prescription and 4.3% sleeping pills (table 4.6).

In comparison to girls, a higher percentage of boys indulged in various substance use, tobacco (5.2% in boys vs 2.3% in girls), e-cigarette (4.7% in boys vs 2.3% in girls) and alcohol (4.4% in boys vs 2.1% in girls), marijuana (4.9% in boys vs 2.7% in girls), cocaine/heroin/opium (4.0% in boys vs 2.3% in girls) and hallucinogens (4.8% in boys vs 3.4% in girls), inhalants (5.2% in boys vs 3.7% in girls), and sleeping pills (5.2% in boys vs 3.5% in girls). However, no statistically significant difference was observed by sex with consumption of cough syrup without prescription and injectable drug use.

Adolescents aged between 16- to 17-year-olds have self-reported a higher proportion of smoking or chewing tobacco (3.5% among 13–15-year vs 4.5% among 16–17-year adolescents), and consuming alcohol (3.0% among 13–15-year vs 3.9% among 16–17-year adolescents). Adolescents aged between 13- to 15-year-old reported a higher proportion of injecting drug (10.2% among 13–15-year vs 6.6% among 16–17-year), and cough syrup without prescription (23.7% among 13–15-year vs 21.0% among 16–17-year).

The statistically significant difference was observed in hallucinogens (4.2% in urban areas and 2.7% in rural areas) and injectable drugs (9.3% in urban areas and 7.0% in rural areas) by residence.

Ninety-eight percent of school principals have self-reported implementing measures to prohibit substance use among faculty, staff members, and visitors. Adhering to the Tobacco-Free Education Institution Guidelines 2020⁴⁵, all school principals confirmed the existence of policies preventing tobacco use by students. Seventy percent of schools displayed the “Tobacco Free Education Institution” signage at the entrance/ boundary wall of the school, display board, specifying the ‘Tobacco Free Area’ signage inside the school. The surveyors, however, observed that 83.3% of schools had pan shop or *ghumti* within 100 yards from the school premises selling tobacco products in violation of section 6b of The Cigarettes and Other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution) Act, 2003.

The concern regarding **young (13 to 15 years) adolescent boys in rural areas**, being more vulnerable to various substance misuse.

4.7 Reproductive and Sexual Health

Adolescence is a time of personal experience and choice, when personal and sexual identities are formed⁴⁶. Becoming a sexually healthy adult is one of the key developments during adolescence.

Adolescents in India are vulnerable to sexual and reproductive health risks due to their developing and young age, particularly due to their solitude in matters related to sexuality and reproductive health, their lack of accurate and complete knowledge and their inability or unwillingness to use most contraceptive methods and health services⁴⁷.

Table 4.7: Percentage of Students Self-reported Sexual Health

Indicator	Sex		Age		Residence		Total
	Boy	Girl	13-15	16-17	Urban	Rural	
Sexual Behaviour							
Ever had sexual intercourse	7.72*	4.13	5.95	5.94	6.62	5.86	5.95
Age at first sexual intercourse <14 years	56.42	74.03*	-	-	55.17	63.52	62.44
Contraceptive use at last sexual intercourse	49.32*	59.74	56.95	44.59*	44.83	54.08	47.11

* Differences across groups are statistically significant at 95% confidence level

Almost 6% of the adolescents self-reported to have ever had sex. The frequency of adolescents who reported having ever had sexual intercourse is higher in boys, as compared to girls (7.7% vs 4.1%) (table 4.7). However, no statistically significant difference was observed by age and residence.

Among the adolescents who have ever had sex, 62.4% self-reported having sexual intercourse before reaching the age of 14 years. The frequency was higher among girls, compared to boys (74.0% vs 56.4%). No statistically significant difference was observed by residence. In comparison to adolescents from urban, higher percentage of adolescents from rural areas reported having had sexual intercourse before reaching age 14 years but the difference was, however, statistically insignificant.

Nearly half of the respondents (47.1%) who ever had sex, reported using modern contraception for protection during their recent sexual encounter. The proportion of girls to have had unprotected sex was higher as compared to boys (59.7% vs 49.3%). Similarly, the percentage of respondents who had unprotected sex was higher among adolescents aged between 13 to 15 years as compared to adolescents aged between 16 to 17 years (57.0% vs 44.6%). No statistically significant difference was observed by residence.

The interpretation of the data underscores a concern regarding **young adolescents (13 to 15 years), boys**, and students in **rural areas**, being particularly vulnerable especially for early initiation of sexual activity which mostly are unprotected.

4.8 Menstrual Hygiene

Menstrual Hygiene Management to ensure healthy and dignified menstruation has received particular attention⁴⁸⁻⁵⁰ from the World Health Organization and the United Nations Children's Fund. The inability to manage menstrual hygiene can have serious consequences for adolescent girls' physical, mental, and emotional health, as well as their social development and educational attainment⁴⁹. Millions of adolescent girls in India drop out of school every year due to restrictions on mobility, a lack of gender-specific restrooms and disposal facilities in schools, and fear or shame of the odor and stains of menstrual blood⁵¹. Under the Ayushman Bharat School Health and Wellness Programme⁵ package, school students are provided with sanitary napkins.

Table 4.8: Percentage of Students Self-reported Menstrual Hygiene

Indicator	Sex		Age		Residence		Total
	Boy	Girl	13-15	16-17	Urban	Rural	
Menstrual Hygiene							
Menstrual cycle started	-	-	-	-	-	-	73.91
Menstrual hygiene practice	-	-	98.85	99.19	99.29	98.95	98.98
Experienced menstrual problem ^a	-	-	30.87	29.68	32.03	30.21	30.40

a during the past 30 days.

* Differences across groups are statistically significant at 95% confidence level.

Almost universal (99.0%) use of hygienic menstrual practices such as sanitary pads, tampons, or menstrual cups was reported (table 4.8). The high reporting of hygienic menstrual practices among adolescents could also be attributed to the provision of these products in schools as self-reported by principals with 66.5% of schools providing sanitary napkins to adolescent girls. Schools are actively involved in creating an enabling environment by promoting the use of hygienic products, as indicated by the principals (86.4%), and are facilitating this initiative by providing a secure place for the disposal of sanitary napkins. However, the observation checklist captured that 58.3% of schools had dustbins in the toilets.

Nearly one-third (30.4%) adolescent girls self-reported of having menstrual cycle problems during the past 30 days. There were no statistically significant differences observed by age, and residence.

Diverse strategies were adopted by adolescents in dealing with menstrual challenges. The majority, 55.97%, opted not to act or relied on home remedies, and 32.5% of girls sought treatment from formal health care services such as government health facilities, private hospitals, private doctors, ANM Sub-Centers, and Adolescent Friendly Health Clinics. Additionally, 8.9% of students obtained medication from a chemist, while 2.5% sought treatment from the health room at school or from teachers.

Rural adolescent girls are particularly vulnerable to infections because of poor hygienic practices, and suboptimal health seeking related to menstruation.

4.9 Mental Health

During adolescence, many mental health issues emerge⁵², some of which persist into adulthood⁵³. Poor adolescent mental well-being increases poor school adjustment, reduced concentration, low achievement, problematic social relationships and a higher rate of health risk behaviours, such as substance use, school dropout and incurring expulsion⁵⁴. Additionally, bullying others and being bullied are common among adolescents with mental health problems.

Table 4.9: Percentage of Students Self-reported Mental Health

Indicator	Sex		Age		Residence		Total
	Boy	Girl	13-15	16-17	Urban	Rural	
Mental health							
Depressed ^a	7.72	10.29*	8.12	10.76*	10.62	8.78	8.99
Worried ^a	5.32	7.53*	5.80	7.67*	6.28	6.43	6.41
Anxious ^a	5.09	7.18*	5.38	7.63*	7.88*	5.89	6.12
Difficult to stay focused ^a	12.31*	9.89	9.93	13.53*	14.95*	10.62	11.12

a During the past 12 months

*Differences across groups are statistically significant at 95% confidence level.

In the past 12 months 9.0%, 6.4%, and 6.1% of students self-reported as always or most of the time felt depressed, worried and anxious, respectively.

In comparison to boys, more girls often felt depressed (7.72% in boys vs 10.3% in girls), worried (5.3% in boys vs 7.5% in girls) and anxious (5.1% in boys vs 7.2% in girls).

Adolescents aged between 16- to 17 -year-olds self-reported in higher proportion of feeling depressed (8.1% among 13–15 years vs 10.8% among 16–17 years), worried (5.8 % among 13–15 years vs 7.7% among 16–17 years), anxious (5.4% among 13–15 years vs 7.6% among 16–17 years), always or most of the time in the past 12 months compared to those aged between 13-15 years (table 4. 9).

There was no statistically significant difference by residence in self-reporting of being depressed and worried. Predominantly more urban adolescents self-reported feeling anxious (7.9% in urban and 5.9% in rural areas).

The findings underscore a concern regarding the vulnerability of **urban**, and **older adolescent (15 to 17 years) girls** who are with poor mental health.

4.10 Access to Government Schemes

The Government of India, through the School Health and Wellness Programme, has introduced a package of services like School Health and Promotion⁵ activities (age-appropriate incremental learning delivered through Health and Wellness Ambassadors and Health and Wellness Messengers), health screening (through Rashtriya Baal Swasthya Karyakram mobile health teams), service provisions (provision of weekly iron-folic acid and deworming tablets, and sanitary napkins) for promoting adolescent health and well-being.

Moreover, Health and Wellness Ambassadors are tasked to deliver weekly health promotion and disease prevention information through engaging activities. In addition, two students from each class assist the Health and Wellness Ambassadors in facilitating initiatives and activities.

Table 4.10: Percentage of Students Self-reported Access to Government Schemes

Indicator	Sex		Age		Residence		Total
	Boy	Girl	13-15	16-17	Urban	Rural	
Government Schemes							
Any team visited school to conduct health check-up	-	-	-	-	68.38	71.56	71.19
Received one deworming tablet from the school ^a	76.94*	80.24	80.01	75.62*	66.21*	80.19	78.57
Received any weekly iron folic acid tablets from the school ^b	85.78*	89.65	89.26	84.50*	82.88*	88.32	87.69
Health related topics discussion in assembly sessions	-	-	-	-	87.21*	89.49	89.22
Discussion/lecture on health conducted in class ^c	-	-	-	-	59.82*	68.92	67.87
Health Mela organised in school ^d	-	-	-	-	35.73*	46.85	45.56
Knows Health Ambassador	57.92	59.76	58.33	59.84	57.88	58.95	58.83
Knows Health and Wellness Messenger	57.92	59.76	58.33	59.84	51.14*	59.29	58.35

a in last 6 months

b in last 1 month

c in last week

d in last 3 months

*Differences across groups are statistically significant at 95% confidence level.

More than 71% of the adolescents self-reported that a team visited their school to assess/screen their health status or conduct health check-ups within the school premise in the last six months before survey. However, no statistically significant difference was observed by residence.

Adolescents self-reported to a tune of 78.6% and 87.7% of receiving deworming tablets and weekly iron-folic acid tablets from school respectively. The proportion of reporting receiving deworming tablets (76.9% in boys vs 80.2% in girls) and weekly iron-folic acid tablets (85.8% in boys vs 89.7% in girls) was higher among girls compared to boys. Statistically significant lower proportion was observed in adolescents aged 16-17 years and from urban areas in reporting of receiving deworming tablets (80.0% in 13-15 vs 75.6% in 16-17), (66.2% from urban vs 80.2% from rural), and weekly iron-folic acid tablets (89.3% in 13-15 vs 84.5% in 16-17), (82.9% from urban vs 88.3% from rural) (table 4.10).

Adolescents self-reported health-related topics being discussed in assembly sessions (89.2%), discussion and/or lecture on health was conducted in the classrooms (67.9%) and organisation of Health Mela in school (45.6%). The percentage was however statistically lower in urban areas as compared to rural areas. Adolescents self-reported knowing the Health Ambassador of the school (58.8%) and the Health and Wellness Messenger of their class (58.4%).

The self-reported data from the respondents significantly differed from the self-reporting by school principals. As many as 95% of the principals reported that students undergo yearly health screening.

The findings underscore adolescents **older (16 and 17 years)** in age, **boys** and from **urban** areas are vulnerable because of their limited utilisation of existing government programmes and schemes

Chapter 5

Recommendations

We consolidated the recommendations under three themes for consideration and relevant actions. The first part is around strengthening the existing Ayushman Bharat School Health and Wellness Programme curriculum to enhance and prioritise communication within the school environment for the identified contextual issues, the second part includes recommendations on reinforcing the implementation of existing policy and programme components, and the third is focused on inter-departmental coordination.

5.1 Food Preferences and Choices

The Indian Academy of Pediatrics (2019) guidelines, recommend only one serving of 'junk food' per week. The survey findings, however, revealed that 98% of adolescents consumed junk food twice or more in the past week. Additionally, 23% reported skipping breakfast, and 30% skipped lunch. These highlight the need to initiate dialogue to foster healthier eating habits and options.

a) Ayushman Bharat School Health and Wellness Programme curriculum

To promote and engage children, initiatives such as the “Ghar Ka Khana” (home food) competition can be arranged. Involving the parents in this event may showcase innovative cooking techniques and ingredients, such as the consumption of millet, to transform unhealthy meals/food into nutritious and attractive alternatives.

Students may co-create a food label that is easy to understand and can be used to decide which food options are healthy vis-a-vis unhealthy.

b) Fostering policy reinforcement

Ensuring school canteens (wherever available) do not serve food high in fat, salt, and sugar.

To promote the consumption of healthy option, foods can be kept in coloured shelves such as red (to avoid consumption), green (can consume frequently) and yellow (to have in moderation) as recommended by the Food Safety and Standards Authority of India and Working Group of Women and Child Development^{55,56}.

c) **Strengthening Inter-departmental coordination**

District and block authorities, school management committees and local governance representatives may ensure coordination between Education Department, Health and Family Welfare Department, and law enforcement agencies to enforce the Food Safety and Standard Authority of India's safe food and healthy diets for School Children Regulations, 2020 which stipulates that no hawkers sell food high in fat, salt, or sugar within 50 meters around schools.

5.2 Physical Activity

Considering that many health habits start early, the World Health Organization (2020), recommend that adolescents should limit their sedentary time, particularly recreational screen time. However, the present data documented that half of the adolescents (46%) were engaged in sedentary activities during the past week, highlighting a concerning trend toward inactivity among this age group. To promote present and future well-being, the following are recommended to encourage physical activity.

a) **Ayushman Bharat School Health and Wellness Programme curriculum**

Integrating physical activity across the 11 themes of the School Health and Wellness Programme can contribute to fostering increased physical activity and discourage sedentary lifestyles among students.

Creative activities should be incorporated into the curriculum to involve parents and community members through activities such as the “*Parivar ki Bhagidari*” (Family partnership) race. The child's goal would be to recruit more team members and participate in the race.

In each physical education class, regular water breaks for students need to be encouraged for adequate fluid intake to prevent dehydration in the present changing climatic conditions.

Schools are to have bi-annual “*Khelo India*” fitness assessment⁵⁷ to assess the fitness of the students. Results may also be shared with parents.

b) **Fostering Policy reinforcement**

To ensure that every school has mandatory physical education teachers, playground, and daily physical education classes.

c) Strengthening Inter-departmental coordination

Block authorities, school management committees and local government representatives can earmark funds to develop and maintain physical activity infrastructures in schools.

5.3 Personal Hygiene

The World Health Organization recommends washing hands with soap and water when visibly dirty, visibly soiled with blood or other body fluids, or after using the toilet. However, the survey findings revealed a concerning gap in hygiene practices among adolescents. Approximately 3% to 6% of adolescents were not washing their hands after using the toilet, before eating, or before handling food, and thus pose a potential risk for infectious diseases. Swachh Bharat Swachh Vidyalaya, part of the larger Swachh Bharat Mission, by the Government of India aimed at promoting cleanliness, hygiene, and sanitation in schools across the country. As observed, unclean toilets (13%), lack of running water (18%), and uncleaned dustbins (10%) can further exacerbate the problem. Addressing aforementioned hygiene and sanitation issues is crucial for improving hygiene practices among adolescents.

a) Ayushman Bharat School Health and Wellness Programme curriculum

As part of Module 6 “Nutrition, Health and Sanitation”, the students should be taught “How to Handwash” as suggested by the World Health Organization⁵⁸.

Global Handwashing Day (October 15th) should be celebrated by involving students, school administration, the parents and community members.

In the month of October, schools can organise educational games and interactive workshops on hand hygiene to reinforce the benefits of adequate handwashing and personal hygiene.

b) Fostering Policy reinforcement

Aligning with the Swachh Bharat Swachh Vidyalaya, a school maintenance schedule may be maintained and periodically checked by the School Management Committee and the designated teachers³⁸.

5.4 Digital Device Use and Cyber-Bullying

Nearly 2% of adolescents were spending more than 8 hours a day on digital devices. Additionally, the findings documented that 10% of adolescents were engaged in online bullying, while 8% have been victims of online bullying in the past 12 months. This current emerging trend highlights the growing concern of cyberbullying, which has been documented to lead to serious emotional and psychological consequences. These insights, even minuscule at present, underscore the need for interventions focused on promoting healthier digital habits and addressing cyberbullying.

a) Ayushman Bharat School Health and Wellness Programme curriculum

Comprehensive education can be introduced and emphasised within Module 3 “Interpersonal Relationship” while discussing the types and various forms of bullying, its impact on individuals and communities, and strategies for prevention and intervention that can contribute to a holistic understanding of the issue.

There is an opportunity to enhance Module 11 “Promotion of Safe Use of Internet, Gadgets, and Media” by documenting the adverse effects of cyber-bullying on physical, psychological, and academic performance.

As part of Module 11, students can be sensitised about ‘National Cyber Crime Reporting Portal’⁵⁹, Helplines Numbers (1800-180-5522)⁶⁰, Emergency Response Support System (112). All these numbers and websites can be permanently displayed in the designated ‘Health and Wellbeing Corner’ at schools.

5.5 Violence and Road Safety

The Motor Vehicle Act (1988) mandates using seat belts and helmets and prohibits underage driving. The National Crime Records Bureau report and Global Burden of Disease data highlight road injury as one of the principal causes of adolescent morbidity and mortality in the country. The survey results indicate that many adolescents frequently engage in unsafe road use behaviours. Specifically, 47.3% reported not wearing helmets while riding motorcycles, while 41.1% did not wear seat belts while driving cars. These findings underscore the need to promote, nurture, and reinforce safe road use practices among adolescents.

a) Ayushman Bharat School Health and Wellness Programme curriculum

Relevant content may be included in Module 10, “Safety and Security against Violence and Injuries,” to promote adherence to road safety measures among adolescents, and promote safer road use practices⁶¹ for self and other road users.

Activities can be included where school students can draw a map to locate the type of traffic signs and markings such as the center line, double white/yellow lines, various traffic signs, small broken white lines, parking prohibited lines, stop lines, and zebra crossing lines and non-violation of traffic rules.

Information, Education, and Communication materials for safety signals and road markings should be permanently displayed in the designated corner inside the school to reinforce the messages^{61,62}.

b) Strengthening Inter-departmental coordination

Regular virtual awareness campaigns emphasising on road safety can be initiated in schools in collaboration with the Transport Department, through various mediums to promote safe road use.

5.6 Substance Use

A small yet notable percentage of adolescents (3% to 5%) used substances. The diverse nature of substance use by adolescents, includes – tobacco, e-cigarettes, alcohol, marijuana, cocaine, hallucinogens, injectable drugs, inhalants, cough syrups, and sleeping pills. These findings emphasise the critical need to reduce substance access and promote the health and well-being of adolescents within the existing robust policy framework aimed at preventing substance use. Enforcement of laws and regulations like the Comprehensive Dangerous Act (2002); the Narcotic Drugs and Psychotropic Substances Acts (1985, 1989); the Juvenile Justice Act (2015); the Cigarettes and Other Tobacco Products Act (2003); and the Prohibition of Electronic Cigarettes Act (2019) would address the access. The Ayushman Bharat – School Health and Wellness Programme curriculum needs to emphasise the rationale and benefits of avoiding substances in the first place including addressing peer pressure.

a) Ayushman Bharat School Health and Wellness Programme curriculum

To enhance the prevention and management of substance misuse, the existing information in Module 7 “Prevention and management of substance misuse” should be contextualised by incorporating additional content on e-cigarette, Marijuana, and hallucinogens.

Activities for discouraging substance misuse can be conducted including taking a pledge against substance use in assemblies, organising competitions (poster, slogan, essay, quiz, debates, community walks, signature campaigns and street plays). Additionally, how to avoid peer pressure and lured to addiction can be co-created by students themselves under the mentorship of Ayushman Bharat Health and Wellness Ambassadors.

Organise visits by the Adolescent Friendly Health Clinic counsellor/ Medical Officer. During such visits, adolescents can be sensitised to the long-term risks associated with substance abuse and provided with information on available for support and assistance. This can include sharing details about the tobacco quit line number (1800 112 356)⁶³, m-cessation (011-22901701)⁶⁴, nearest Adolescent Friendly Health Clinic, Health and Wellness Centers, and de-addiction center (Deaddiction and Rehabilitation Centre, Bhuntar, Kullu).

b) Strengthening inter-departmental coordination

The school authorities can organise virtual interactions with local law enforcement and health authorities to deliver substance abuse messages. This will facilitate in advocating the policy makers regarding substances.

c) Fostering policy reinforcement

School authorities should follow the Tobacco Free Educational Guidelines to prevent tobacco use among school students, teachers, and staff.

5.7 Reproductive and Sexual Health

Nearly 6% of adolescents were engaged in sexual intercourse. Among those who have been sexually active, almost half used contraception during their last sexual encounter. A critical need is to help adolescents make informed and healthy decisions about their sexual health through the early beginning of culturally sensitive, age-appropriate, and contextual sexual and reproductive health education, improved access to resources, and supportive environments.

a) Ayushman Bharat School Health and Wellness Programme curriculum

Core concepts suggested by International Technical Guidance⁶⁵ on Sexual Education can be integrated into Module 9 “Reproductive Health and HIV Prevention”.

Another key component on the role of contraception in the prevention of sexually transmitted infections and reproductive tract infections can also be included in the Module.

Key concepts such as condom use and abortion can be contextualised as topics under Module 9 “Reproductive Health and HIV Prevention”.

Visit of Adolescent Friendly Health Clinic Counsellor or Medical Officer can be a valuable initiative for education on adolescent reproductive anatomy and processes. Information about adolescent reproductive anatomy and processes and available helplines 7827-170-170⁶⁶ for violence against women or CHILDLINE on 1098⁶⁷ or women in distress on 1091⁶⁸.

b) Strengthening inter-departmental coordination

The school authorities can invite the local law enforcement and health authorities to be the part of school assembly and deliver a session on laws and policies such as the Protection of Children from Sexual Offences Act and Medical Termination of Pregnancy Amendment Rules, 2021⁶⁹.

5.8 Menstrual Hygiene

Around 30% of adolescent girls reported experiencing menstruation-related challenges. Among them, more than half (56%), however, resorted to home remedies or opted not to act on menstrual challenges. The relatively low percentage of adolescent girls seeking medical help for menstrual issues indicates a need also to be addressed as the demand side approach, access to healthcare, and supportive environments may better address menstrual health challenges.

a) Ayushman Bharat School Health and Wellness Programme curriculum

Within Module 1 “Growing up Healthy” there is an opportunity to emphasise on menstrual health issues aiming to increase awareness. This would ensure that adolescent girls are equipped with knowledge of normal menstrual experiences and when they should seek guidance from healthcare professionals.

Adolescent Friendly Health Clinic Counsellor/ Medical Officer visits to the school on annual days can sensitise parents, students, teachers, and school management regarding menstrual hygienic products.

To ensure the successful implementation of the Ayushman Bharat School Health and Wellness Programme, it is crucial to enhance the supply side and expand reach covering all beneficiaries.

To promote the use of menstrual hygiene products, it is essential to create an enabling environment that includes the availability of safe disposal and facilities for handwashing.

5.9 Mental Health

Adolescent mental health is indeed a critical issue that needs attention. The prevalence of mental health issues among adolescents, ranged from 6% to 11%, highlighted the importance of addressing these challenges early on. Effective support and intervention are crucial in improving the quality of life for adolescents.

a) Ayushman Bharat School Health and Wellness Programme curriculum

Health and Wellness Ambassadors can be sensitised on ‘Red Flag Signs’ introduced by the Ministry of Education in 2022 with an aim for early identification of signs of thirteen Adolescent Mental Health Issues and concerns⁷⁰.

In Module 2 “Emotional Well-Being and Mental Health”, activities such as ‘*khoj*’ (discover) can be incorporated where students can be tasked with researching available services and helplines for adolescent mental health issues and concerns.

During the annual school events, inviting Adolescent Friendly Health Clinic counsellors, or Medical Officers can help raise awareness about adolescent mental health issues. They can sensitise parents, students, teachers, and school management about the importance of connectedness between parents and children, as well as between students and teachers, in preventing mental health issues. These sessions can also educate attendees about available mental health services such as those offered in Adolescent Friendly Health Clinics, Health and Wellness Centres, and helplines including Tele Manas (14416)⁷¹.

5.10 Government Schemes

Implementation of various health-related activities within schools is crucial for promoting adolescent well-being, especially under the Ayushman Bharat – School Health and Wellness Programme. As 46% of schools organised health melas, the awareness of health ambassadors and health and wellness messengers was relatively modest, at 59% and 58%, respectively.

a) Ayushman Bharat School Health and Wellness Programme curriculum

The *Rashtriya Bal Swasthya Karyakram* mobile health team's visit to the school needs to be informed well in advance so that students and their parents can be encouraged to avail the early identification and early management facilities.

A robust digital mechanism for tracking the estimation, supply, distribution, and consumption of iron folic acid and deworming tablets by respective schools and teachers can ensure timely and uninterrupted supply and stock of commodities and consumption reporting. This can be integrated within the Education Department reporting system with lateral linkages with the Health Department.

A digital recording platform comprising all the reporting and compliance may enhance implementation of different programmatic activities including those by the Health and Wellness Ambassadors as per the guidelines.

b) Strengthening inter-departmental coordination

Coordination between school authorities with the Health Department may be strengthened for an uninterrupted supply of iron folic acid tablets, deworming tablets, and sanitary napkins as well as for health screening and organising the Health Mela.

c) Fostering policy reinforcement

School authorities, Health and Wellness Ambassadors, and other authorities concerned may follow the coordination and supportive supervision mandates of *Rashtriya Kishor Swasthya Karyakram* and *Rashtriya Bal Swasthya Karyakram* for the holistic health of adolescents.

5.11 Overarching

The school inspectors are mandated to inspect schools on a regular basis to ensure the academic achievements of students. Communication with school children on various themes of the Ayushman Bharat School Health and Wellness Programme may be embedded into the inspection process.

‘Health and Well-being Corner’ - a physical space can be dedicated in every school, where monthly articles by students relevant to the ongoing topics of the Ayushman Bharat School Health and Wellness Programme schedule and Information, Education and Communication materials can be used to promote participation and increase health and well-being outlook among students. Every month, the corner can be linked with a specific Ayushman Bharat School Health and Wellness Programme module so that all the modules are covered within the academic session.

Decentralising the process for ongoing support, identified Cluster Resource Centre and Block Resource Centre Coordinators may also handhold implementation concurrently.

The existing platforms in schools such as school assemblies, parent-teacher meetings, annual functions, and School Management Committees may be effectively used to sensitise school students, parents and management about themes, available services and commodities under Ayushman Bharat School Health and Wellness Programme and Rashtriya Kishor Swasthya Karyakram for adolescents, and the existence of Health and Wellness Ambassadors as well as Health and Wellness Messengers in schools and classes respectively.

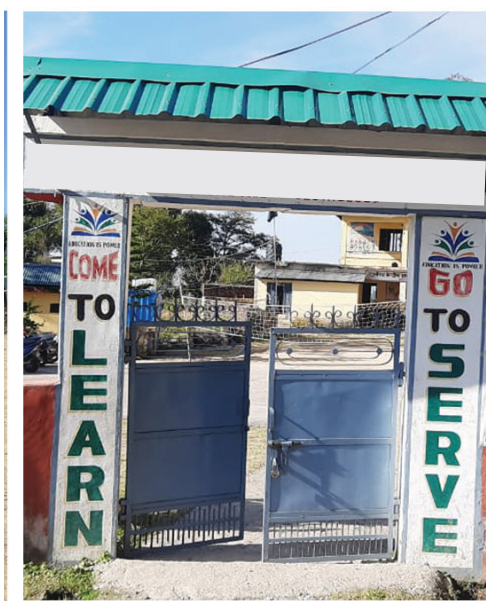
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