

Institutionalizing Bi-Monthly Adolescent Health Governance: An Evaluation of Peer Educator and Master Trainer Networks in Rural Madhya Pradesh

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ABSTRACT

Adolescents aged 10–19 years account for roughly one-fifth of India's population, yet in several states their health needs remain poorly served [1,17]. Madhya Pradesh continues to report high rates of adolescent anaemia, early marriage, limited menstrual hygiene practices, and under-utilisation of mental health and reproductive health services [17,18]. Against this backdrop, the National Health Mission (NHM) Madhya Pradesh operationalised a structured bi-monthly contact system under the Rashtriya Kishor Swasthya Karyakram (RKSK) [1,2]. Village-level Saathiya peer educators convene sessions on the second and fourth Saturdays of every month, while Block-level Master Trainers provide supportive supervision and quality assurance.

This paper presents a retrospective analysis of routinely collected programme data from the RKSK Activity Tracking Portal (November 2025 – August 2026). The dataset comprises 63,710 Master Trainer supervisory records generated by 399 trainers across 115 blocks, and 30,234 peer-educator session logs from 14,747 active Saathiyas working in 6,223 villages, documenting 263,101 direct adolescent contacts. We examine operational fidelity, geographic and temporal reach, and patterns of module delivery. The analysis is situated within an implementation-science lens that emphasises the role of continuous supportive supervision in sustaining peer-education programmes [16,21,22].

Results show that fixed Saturday contact points produced high volumes of structured activity. Supportive supervision accounted for 89.5% of Master Trainer effort. Biological and nutritional modules were delivered far more frequently than sessions on sexual and reproductive health, mental health, or substance use. GPS-enabled clock-in rates averaged only 42% statewide, with marked shortfalls in tribal and forested blocks. Because the study relies on administrative logs, claims about community-level behavioural change remain suggestive rather than causal. The findings nonetheless identify clear operational priorities: offline-first digital tools, targeted capacity building for sensitive modules, and more equitable trainer deployment. Policy implications for adolescent health systems in similar rural settings are discussed.

Keywords: Rashtriya Kishor Swasthya Karyakram; Saathiya peer educators; Master Trainer cadre; bi-monthly Saturday contact; adolescent health governance; supportive supervision; implementation science; Madhya Pradesh

INTRODUCTION

The second decade of life is a period of rapid biological, cognitive and social change. Decisions made and habits formed during these years influence health trajectories well into adulthood [3,4]. India is home to more than 250 million adolescents—the largest such cohort in the world [1,17]. Recognising both the opportunity and the risk

this demographic presents, the Ministry of Health and Family Welfare launched the Rashtriya Kishor Swasthya Karyakram (RKSK) in January 2014 [1,2]. Unlike earlier programmes that focused narrowly on reproductive health, RKSK adopted a broader socio-ecological framing organised around six priority domains: nutrition, sexual and reproductive health, non-communicable diseases, substance use, injuries and gender-based violence, and mental health [1,2].

Subsequent revisions expanded the curriculum to ten modules, incorporating disability inclusion, climate-related health risks, and digital safety. Yet the translation of national guidelines into reliable village-level practice has been uneven [6,10]. In Madhya Pradesh—a state with substantial tribal populations, dispersed settlements, and persistent patriarchal norms—implementation faced particular obstacles. Shame surrounding menstruation, silence around sexual harassment, limited mobility of adolescent girls, and the competing demands of agricultural labour all constrained participation in health sessions [17,18,25].

Peer education has long been recognised as a promising modality for reaching adolescents, precisely because peers shape norms and behaviour during this developmental window [5,6,25]. Implementation-science literature, however, consistently shows that peer programmes without sustained mentorship tend to lose intensity and credibility over time [16,21,22]. Continuous supportive supervision emerges as a critical determinant of both facilitator retention and message fidelity. NHM Madhya Pradesh therefore coupled the Saathiya peer-educator model with a dedicated cadre of Block-level Master Trainers drawn from public health staff and clinic counsellors. These trainers were tasked with on-site coaching, quality audits, and coordination with frontline workers (ASHAs, ANMs, Anganwadi workers, and Community Health Officers at Ayushman Arogya Mandirs) [14,16].

A further innovation was the institutionalisation of fixed contact days. By directing that adolescent cohort meetings and supportive supervision visits occur on the second and fourth Saturdays of each month, the state sought to create predictable, school-compatible and agriculturally feasible windows for engagement [2,23]. The present study evaluates how this combined architecture—peer educators, Master Trainers, and a bi-monthly calendar—has performed across 21 priority districts. We treat the analysis as an operational evaluation of implementation intensity and fidelity, not as a causal impact assessment of community-level outcomes.

Policy Context and Programme Architecture

The Second- and Fourth-Saturday Mandate

Earlier attempts at adolescent outreach in the state had relied on sporadic meetings, often scheduled around the convenience of supervisors rather than the availability of young people. Attendance fluctuated and behavioural messages rarely accumulated into sustained practice [6,10]. In response, the Department of Public Health and Family Welfare issued operational directives establishing a fixed bi-monthly calendar [2,23]:

Second Saturday — Adolescent Health, Nutrition and Life-Skills Day. Sessions emphasise Modules 1–4 and 6. Typical activities include BMI measurement, review of mid-day meal quality (in convergence with PM POSHAN), distribution and compliance tracking of Weekly Iron and Folic Acid Supplementation (WIFS) [19], Albendazole administration under National Deworming Day, and practical discussions of personal and menstrual hygiene.

Fourth Saturday — Psychosocial Empowerment, Safety and Mental Well-being Day. Sessions centre on Modules 5, 7–10. Content covers mental health literacy and stigma reduction (with linkage to Tele-MANAS and Manodarpan) [20], substance-use refusal skills, gender-based violence awareness and POCSO provisions, child and women's helplines (1098, 181), and cyber-safety practices [24].

Four-Tier Supervisory Cascade

Programme sustainability rests on a deliberately layered support structure consistent with implementation frameworks that emphasise multi-level facilitation [16,21]. At the apex, a State Resource Group, working with UNFPA and UNICEF technical partners, adapts curriculum materials and monitors statewide indicators [8,9].

Block-level Master Trainers form the operational spine: they visit villages, observe Saathiya facilitation, coach frontline workers, and enter activity data into the RSKS Activity Tracking Portal [13,14]. Below them, ASHAs, ANMs, Anganwadi workers and Community Health Officers mobilise adolescents, secure meeting venues, and manage the anonymous Question Box (Prashna Peti). At the base, male–female pairs of Saathiya peer educators conduct participatory discussions with cohorts of roughly 15–20 adolescents [2,6].

Table 1. Four-tier governance cascade under RSKS Madhya Pradesh

Tier	Actors and core functions
State	NHM Adolescent Health Division; State Resource Group; UNFPA/UNICEF technical oversight — curriculum adaptation, policy monitoring
Block	Master Trainers — supportive supervision, quality audits, ATP digital entry, coordination with frontline cadres
Sector / Village	ASHA, ANM, AWW, CHO — mobilisation, venue logistics, clinical linkage, management of Prashna Peti
Community cohort	Saathiya peer educators (male–female pairs) — bi-monthly facilitation of 15–20 peer cohorts using activity books and diaries

METHODS

Design and Setting

We conducted a retrospective observational analysis of routinely collected administrative data. The geographic scope covered 21 priority districts of Madhya Pradesh spanning 115 administrative blocks, including predominantly tribal districts (Alirajpur, Jhabua, Mandla, Dindori), Bundelkhand districts (Chhatarpur, Damoh, Panna, Tikamgarh), and districts of the central plains (Vidisha, Dewas). The diversity of agro-climatic zones and social structures allows cautious generalisation within the state, though findings should not be extrapolated uncritically to other regions of India [17,18].

Data Sources

Two primary datasets were extracted from the password-protected RSKS Activity Tracking Portal for the period November 2025 through August 2026.

Master Trainer Supervision Dataset (N = 63,710). Generated by 399 unique Master Trainers. Variables included activity type, geographic coordinates at clock-in, timestamps, and district identifiers.

Peer Educator Activity Dataset (N = 30,234). Session logs submitted by 14,747 unique Saathiyas across 6,223 villages. Variables captured thematic modules covered, pedagogical methods, presence of supervisors or frontline workers, participant counts, and free-text feedback notes. Aggregate adolescent contacts totalled 263,101 (mean 8.7 participants per session).

Analytic Approach and Epistemic Limits of Administrative Data

Records were cleaned in Python and R. Validation routines flagged duplicate identifiers, out-of-boundary GPS coordinates, and systematically missing fields. Descriptive statistics—frequencies, proportions, per-trainer productivity ratios, and monthly time series—form the core of the analysis. Because the data represent a near-complete census of logged programme activity rather than a probability sample, we present absolute counts and percentages without formal inferential tests.

It is essential to state clearly what these data can and cannot demonstrate. Administrative logs are well suited to describing implementation intensity, geographic coverage, temporal trends, and the relative emphasis placed on different curriculum modules. They are poorly suited to establishing causal links between programme exposure and individual- or community-level behavioural change. Self-reported logs also carry risks of over-reporting, incomplete capture, and social-desirability bias [13]. Qualitative notes embedded in the portal offer suggestive signals of emerging practice but cannot substitute for independently measured outcome indicators (for example, school attendance registers, WIFS consumption audits, or helpline call volumes). Where we discuss community-level change, we therefore use cautious language and treat such observations as hypothesis-generating rather than confirmatory.

Ethical Considerations

The analysis draws exclusively on de-identified administrative records generated for programme monitoring. No individual adolescent identifiers were accessed. The study was undertaken as part of institutional programme documentation under NHM Madhya Pradesh; no external commercial funding was received.

RESULTS

Master Trainer Output and Geographic Distribution

Across the evaluation period, 399 Master Trainers recorded 63,710 supervisory and mobilisation events. Absolute volume was highest in Mandla (7,456), Vidisha (6,216), Alirajpur (6,059), Chhatarpur (5,770) and Khandwa (4,906). Statewide mean productivity stood at 159.7 activities per trainer, with peaks in Dewas (256.5), Alirajpur (252.5) and Mandla (240.5). Several districts—Tikamgarh (65.6), Shahdol (62.6) and Ashok Nagar (10.0)—registered markedly lower output, reflecting trainer vacancies, larger geographic catchments, and weaker digital reporting infrastructure [13,14].

Figure 1. District-wise Master Trainer Activity Volume
(Top 12 districts, Nov 2025 – Aug 2026)

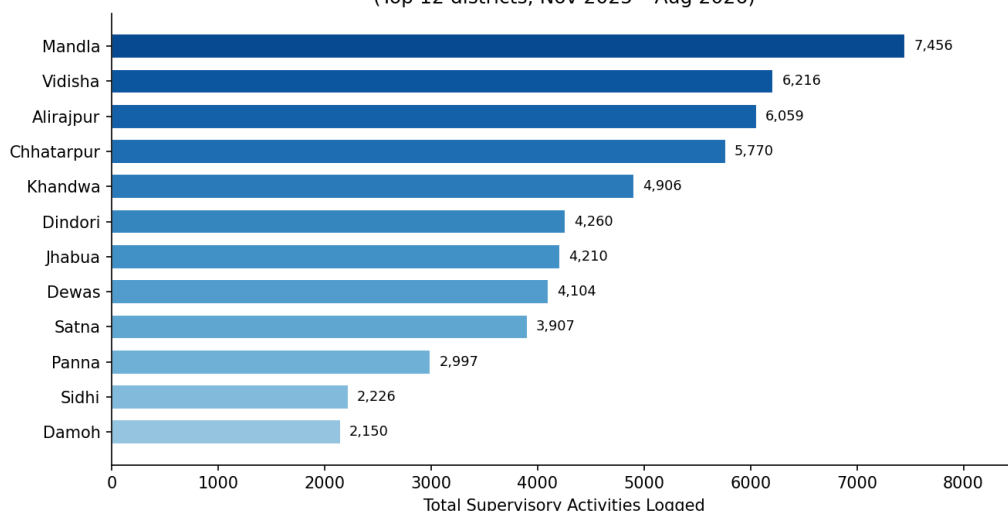


Figure 1. District-wise Master Trainer activity volume (top 12 districts, November 2025 – August 2026)

Table 2. District-wise Master Trainer cadre, activity volume and GPS compliance

District	Blocks	Trainers	Activities	Acts/Trainer	GPS %	Category
Mandla	9	31	7,456	240.5	33.1	High vol.
Vidisha	7	28	6,216	222.0	66.9	High vol.

Alirajpur	6	24	6,059	252.5	50.6	High vol.
Chhatarpur	8	30	5,770	192.3	42.8	High vol.
Khandwa	7	27	4,906	181.7	47.6	Mid
Dindori	7	28	4,260	152.1	9.1	Mid
Jhabua	6	23	4,210	183.0	63.6	Mid
Dewas	6	16	4,104	256.5	53.9	High prod.
Satna	8	30	3,907	130.2	27.2	Mid
Panna	5	20	2,997	149.8	69.7	High GPS
Sidhi	5	18	2,226	123.7	23.5	Low-mid
Damoh	7	27	2,150	79.6	14.0	Low
Guna	5	19	2,089	109.9	43.1	Low-mid
Singrauli	3	12	1,747	145.6	43.6	Low-mid
Sheopur	3	11	1,682	152.9	3.6	Low GPS
Umaria	3	11	1,585	144.1	34.3	Low-mid
Tikamgarh	6	23	1,509	65.6	32.4	Low
Shahdol	5	10	626	62.6	7.5	Low
Rajgarh	5	1	111	111.0	1.8	Sparse
Ashok Nagar	4	10	100	10.0	9.0	Sparse
State total / mean	115	399	63,710	159.7	42.1	—

Composition of Field Activities

Supportive supervision dominated the Master Trainer portfolio (57,011 of 63,710 events; 89.5%). Coordination meetings and Saathiya Brigade sittings contributed 4.6%, Kishor ka Shor mobilisation 1.9%, and formal peer-educator induction trainings 1.2%. Residual categories together comprised less than one percent. This distribution indicates that Master Trainers function primarily as field mentors rather than as mass mobilisers, consistent with implementation evidence that continuous coaching is a key determinant of peer-education quality [14,16,21].

Figure 2. Composition of Master Trainer Field Activities
(N = 63,710 logged events)

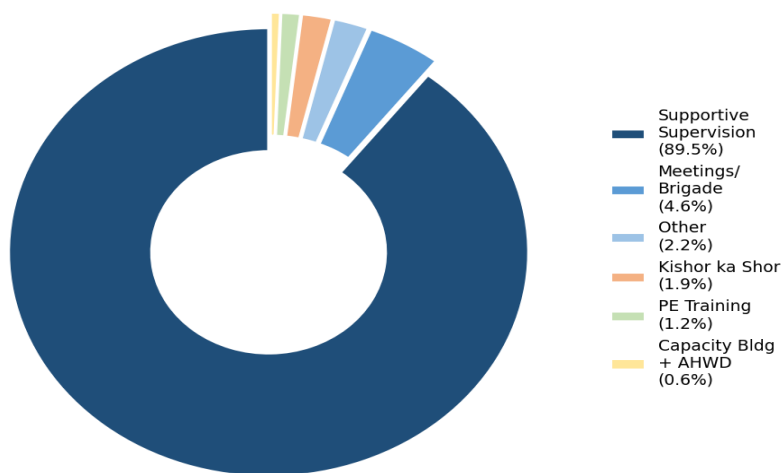


Figure 2. Composition of Master Trainer field activities (N = 63,710)

Peer-Educator Footprint and Module Delivery

The 30,234 Saathiya session logs spanned 6,223 villages and reached 263,101 adolescents (mean 8.7 participants per session). Module coverage was markedly uneven. Sessions on puberty and physical changes (Module 2) and nutrition/anaemia (Module 3) far outnumbered those on sexual and reproductive health (Module 5), substance misuse (Module 7) or climate-related health (Module 6). Mental health sessions (Module 8) occupied an intermediate position.

Figure 3. RKSK Module Delivery: Standalone vs Total Inclusions
(Saathiya Peer Educator Sessions)

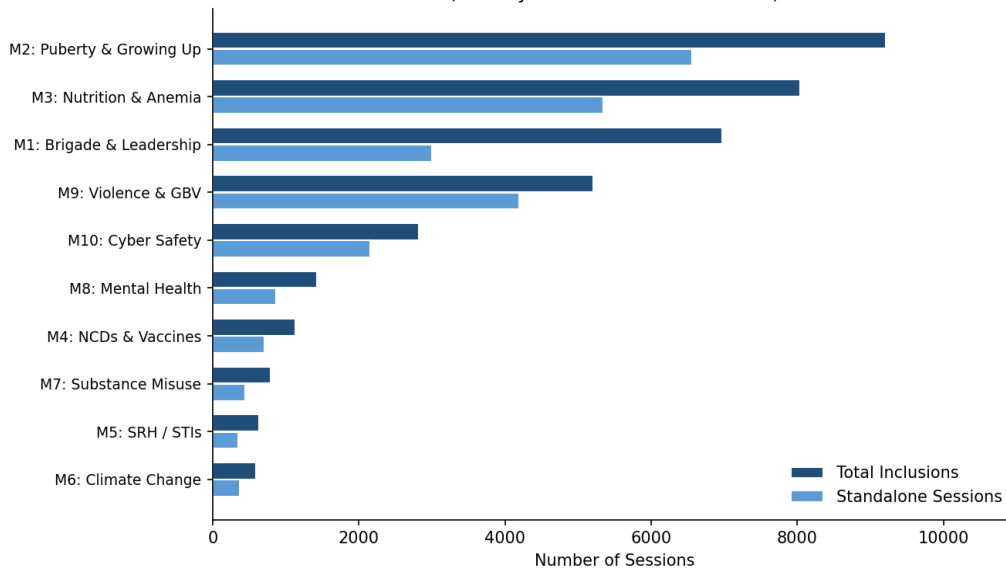


Figure 3. RKSK module delivery: standalone sessions versus total inclusions

Table 3. Saathiya module utilisation and session delivery

RKSK Module Theme	Standalone	Total Inclusions*
M2: Growing Up & Physical Changes (Puberty)	6,559	9,214

M3: Nutrition, Anaemia Prevention & IFA/WIFS	5,344	8,041
M9: Violence & Injury Prevention (Road Safety & GBV)	4,193	5,208
M1: Saathiya Brigade & Leadership	3,002	6,974
M10: Safe Use of Social Media & Cyber Security	2,149	2,821
M8: Mental Health, Resilience & Anti-Stigma	869	1,421
M4: Common Diseases, NCDs & Adolescent Immunisation	712	1,126
M7: Substance Misuse Prevention & De-addiction	438	789
M6: Climate Change, Environment & Health Impacts	374	592
M5: Sexual & Reproductive Health, RTI/STIs & HIV	348	631

*Total inclusions count both standalone deliveries and integrated multi-module sittings.

Temporal Patterns and Digital Compliance

Monthly logging rose from 1,524 records in November 2025 to a peak of 8,554 in May 2026, remaining high through the monsoon months. GPS clock-in capture averaged 42.1% statewide. Districts with stronger digital infrastructure (Panna 69.7%, Vidisha 66.9%, Jhabua 63.6%) performed better; remote tribal and forested districts lagged sharply (Sheopur 3.6%, Shahdol 7.5%, Dindori 9.1%) [13,24].

Figure 4. Temporal Trajectory of Master Trainer Reporting
(November 2025 – August 2026)

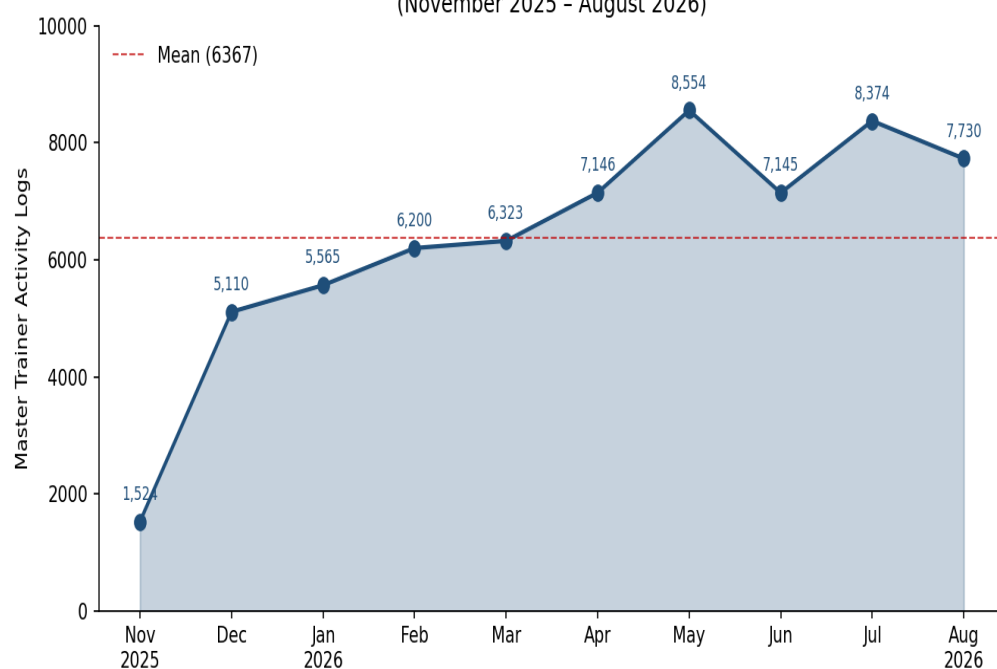


Figure 4. Temporal trajectory of Master Trainer reporting (November 2025 – August 2026)

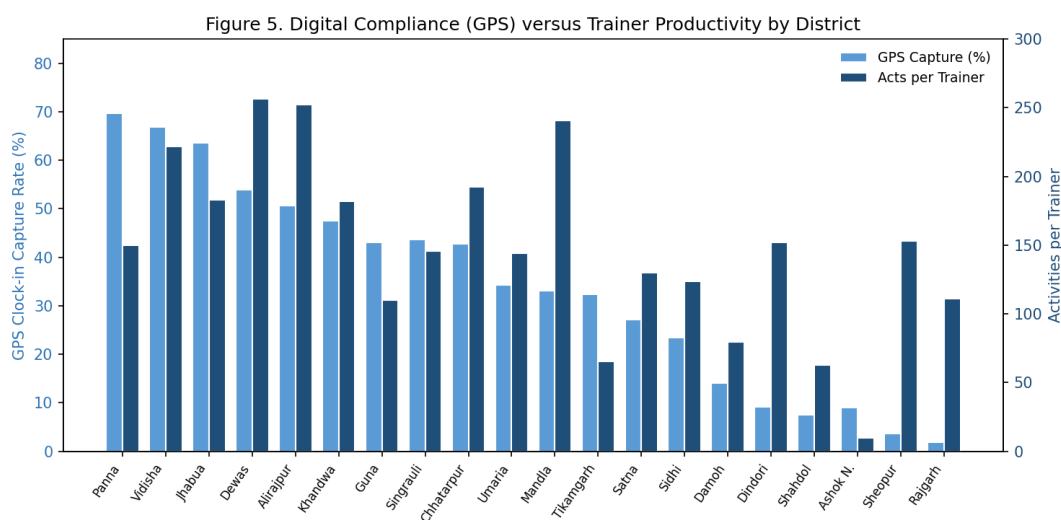


Figure 5. Digital compliance (GPS capture) versus trainer productivity by district

Contrasting High- and Low-Performing Districts

High-volume districts (Mandla, Vidisha, Alirajpur, Chhatarpur, Khandwa) accounted for nearly half of all Master Trainer activity despite comprising fewer than one-third of trainers, and tended to show higher GPS compliance. Low-volume districts were characterised by thinner trainer deployment, weaker digital reporting, and larger average block sizes that stretched supervisory capacity [13,14].

Table 4. Operational contrast between high-volume and low-volume districts

Indicator	Top-5 volume districts*	Bottom-5 volume districts†
Combined activities	30,407 (47.7%)	2,931 (4.6%)
Combined trainers	140 (35.1%)	55 (13.8%)
Mean acts per trainer	217.2	53.3
Mean GPS capture (%)	48.2	10.9
Mean blocks per district	7.4	4.6
Predominant geography	Mixed plains / tribal	Bundelkhand / tribal fringe

*Mandla, Vidisha, Alirajpur, Chhatarpur, Khandwa. †Tikamgarh, Shahdol, Rajgarh, Ashok Nagar and residual low-activity blocks aggregated for comparison.

Interpretive Signals from Portal Narratives

Administrative logs cannot establish causal links between programme exposure and community-level change. Qualitative notes embedded in the portal, however, offer early, hypothesis-generating signals of emerging practice. We present these signals cautiously and note that independent triangulation with school attendance registers, WIFS consumption audits, or helpline utilisation data was not feasible within the present dataset.

Menstrual Hygiene and Puberty Literacy

With more than nine thousand session inclusions, Module 2 created repeated opportunities to discuss physiological change. Portal narratives describe displacement of cloth rags by cotton or sanitary pads, more frequent pad changes, and safer disposal practices. Several villages reported declines in menstruation-related school absenteeism among girls in active Saathiya cohorts. These observations remain anecdotal; linkage to school registers would be required for confirmation [12,17].

Nutrition, Dietary Equity and Anaemia Control

Module 3 sessions used the Tiranga Thali visual aid and locally available foods to illustrate balanced plates. Peer educators also tracked WIFS compliance and National Deworming Day coverage [19]. Common misconceptions about iron-folic acid tablets were addressed through repeated messaging. Whether peer sessions can shift deeper gendered patterns of intra-household food allocation remains an open empirical question [12,17].

Gender Norms, Violence Prevention and Legal Literacy

Module 9 and gender-equality exercises engaged both boys and girls in deconstructing rigid role expectations and introduced the FRIES consent model alongside POCSO provisions and helpline information (1098, 181) [25]. Villages with consistent Master Trainer presence reported increased utilisation of Childline and Sakhi One-Stop Centres, though formal referral tracking remains incomplete.

Mental Health, Substance Use and Digital Safety

Modules 7, 8 and 10 were delivered less frequently. Role-plays on peer-pressure refusal, personal safety-net mapping, and practical cyber-safety instruction represent concrete skill-building content [7,20,24]. The lower delivery volume of these modules is itself an important finding: it signals where facilitator confidence and community readiness remain limited.

Table 5. Illustrative signals of emerging practice (synthesised from portal narratives; not independently verified outcomes)

Domain	Prevailing practice (reported baseline)	Emerging signals (portal notes)
Menstrual hygiene	Cloth reuse; limited sun-drying; ritual isolation	Cotton/sanitary pad use; hygienic washing; reduced isolation
Dietary equity	Girls eat last and least; low iron-rich intake	Balanced-plate awareness; improved WIFS/NDD discussion
Gender & marriage	Early marriage normalised; rigid role scripts	Education retention valued; delayed marriage discussed
Safety & reporting	Silence on harassment; fear of formal channels	Helpline awareness (1098, 181); POCSO literacy
Mental health & substances	Distress stigmatised; limited refusal skills	Tele-MANAS awareness; peer refusal strategies practised

DISCUSSION

Three operational observations emerge. First, the combination of a fixed bi-monthly calendar and a dedicated Master Trainer cadre produced high volumes of structured adolescent contact across diverse rural and tribal geographies. Second, the overwhelming share of Master Trainer time devoted to supportive supervision (89.5%) aligns with implementation-science evidence that continuous field mentorship is a critical determinant of peer-education quality and sustainability [16,21,22]. Third, thematic delivery remains skewed toward biological and nutritional modules, with markedly lower coverage of mental health, substance use and sexual/reproductive health.

Why Sensitive Modules Lag: An Implementation Analysis

The under-delivery of Modules 5, 7 and 8 is not merely a statistical imbalance; it reflects well-documented barriers in peer-education implementation. Several interacting factors appear relevant:

Facilitator confidence and skill. Adolescent peer educators and even many frontline workers report greater ease discussing puberty and diet than facilitating conversations about sexuality, contraception, psychological distress or substance use. Without structured practice, role-play scripts and ongoing coaching, facilitators default to safer content [5,7].

Community readiness and social risk. In rural and tribal settings, open discussion of SRH or mental distress can expose facilitators and participants to stigma or family sanction. Peer educators may rationally avoid topics that threaten their own social standing [5,25].

Supervision focus. If Master Trainer feedback concentrates on session logistics and attendance rather than on facilitation quality for sensitive content, the incentive structure reinforces existing module preferences [14,16].

Curriculum density and time. A ten-module package delivered in bi-monthly slots creates pressure to cover "core" biological content first; psychosocial modules are more easily deferred.

These mechanisms are consistent with broader implementation literature on peer education sustainability: programmes that invest heavily in initial training but neglect continuous, topic-specific coaching frequently experience rapid dilution of sensitive messaging [6,10,21,22].

Concrete Capacity-Building Pathways

Addressing the module imbalance requires more than exhortation. We propose four concrete pathways:

Topic-specific refresher modules for Master Trainers. Structured 2–3 day residencies focused on SRH facilitation, mental-health first-aid language, and substance-use refusal skills, using culturally adapted role-plays and case vignettes drawn from Madhya Pradesh contexts [5,7,20].

Supervised practice cycles. Require that a defined proportion of Master Trainer observation visits focus on a sensitive module; provide structured feedback forms that score facilitation quality rather than only attendance and logistics [14,16].

Peer-educator micro-credentials. Issue simple recognition (certificates, public acknowledgment at block meetings) for Saathiyas who complete supervised delivery of Modules 5, 7 or 8, creating positive incentives for tackling harder content.

Safe-space protocols and adult backup. Ensure that sensitive sessions are co-facilitated or immediately backed by an ASHA, ANM or CHO, reducing the social risk borne by adolescent facilitators alone [2,6].

Geographic Inequity and Explanatory Factors

Variation in trainer productivity is not random. High-volume districts tended to combine adequate trainer density, better digital connectivity, and, in several cases, stronger pre-existing health-system infrastructure. Low-volume districts often faced vacancies, larger geographic catchments, and poor network coverage that discouraged real-time reporting [13,14]. These patterns underscore that implementation intensity is itself socially and infrastructurally patterned; equal policy intent does not automatically produce equal operational coverage.

Limitations

Several limitations must be kept in view. The data are administrative and self-reported; we cannot independently verify session quality or actual participant comprehension. GPS capture is incomplete, so spatial analyses are partial [13]. Claims about shifts in menstrual hygiene, dietary practice or help-seeking rest on qualitative portal notes rather than on linked outcome indicators (school registers, consumption audits, helpline volumes). No contemporaneous comparison group exists, precluding strong causal inference. The ten-month observation window is relatively short for assessing durable behavioural or normative change. Finally, the theoretical framing, while strengthened by engagement with implementation-science literature on supportive supervision, remains focused on operational rather than on deeper social-determinant analysis.

Comparison with Existing Literature

Our findings resonate with earlier evaluations of RKSK peer education in other Indian states, which have similarly noted the importance of supportive supervision and the difficulty of sustaining attention to sensitive modules [6,10]. The Madhya Pradesh experience adds a distinctive element: the deliberate institutionalisation of fixed weekend contact days. If subsequent evaluations confirm that this calendar improves attendance stability relative to ad-hoc scheduling, the approach may warrant consideration in other large rural states [2,23].

Policy Recommendations and Conclusion

On the basis of the operational patterns documented here, five priorities stand out.

Offline-first digital architecture. Full offline caching, background synchronisation and local timestamp validation would reduce under-reporting in low-connectivity zones without penalising trainers [13,24].

Targeted psychosocial capacity building. Topic-specific refresher training, supervised practice cycles and peer-educator micro-credentials focused on SRH, mental health and substance use [5,7,20].

Cadre completion and hardship incentives. Fill vacancies to the intended complement of four Master Trainers per block; introduce modest hardship allowances for remote and tribal postings [14,21,22].

Multi-sectoral convergence. Tighten operational links among Saathiya Brigades, Ayushman Arogya Mandirs, Adolescent Friendly Health Clinics, the School Health and Wellness Programme, and PM POSHAN so that peer sessions can be linked to measurable service uptake [11,15,19].

Institutionalised adolescent feedback and outcome triangulation. Standardise monthly aggregation of Prashna Peti queries and, where feasible, link programme data to school attendance, WIFS audits and helpline volumes to move beyond purely administrative indicators [2,23].

In sum, the institutionalisation of second- and fourth-Saturday adolescent health contact, executed by Saathiya peer educators and scaffolded by Block-level Master Trainers, has established a workable platform for adolescent health governance in rural Madhya Pradesh. The platform's reach is already substantial; its depth—particularly on psychosocial and sexual-health themes—remains a work in progress. Closing that gap through concrete capacity-building pathways and more rigorous outcome triangulation will determine whether the programme realises its full potential [3,4].

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