

**MATERNAL AND
ADOLESCENT
HEALTHCARE**

Chapter

3

3.1 MATERNAL HEALTH

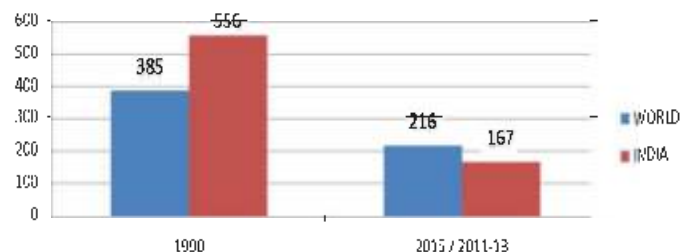
Women are strong pillars of any vibrant society. Sustained development of the country can thus be achieved only if we take holistic care of the women and children. Massive and strategic investments have been made under the National Health Mission for improvement of Maternal Health. The survival and well-being of mothers is not only important in their own right but are also central to solve large broader-economic, social and developmental challenges.

3.2 MATERNAL MORTALITY RATIO (MMR)

Maternal Mortality Ratio (MMR) in India was exceptionally high in 1990 with 556 women dying during child birth per hundred thousand live births. Approximately 1.38 lakh women were dying every year on account of complications related to pregnancy and child birth. The global MMR at the time was much lower at 385. However, there has been an accelerated decline in MMR in India. MMR in the country has declined to 167(2011-13) against a global MMR of 216 (2015). The number of maternal deaths stands reduced by 70%. India's share among global maternal deaths has declined significantly to about 15% as per the MMEIG report.

- Millennium Development Goal (MDG)-5 pertains to Maternal Health where target is to reduce the Maternal Mortality Ratio (MMR) by three quarters between 1990 & 2015. Based on the UN Inter-Agency Expert Group's MMR estimates in the publication "Trends in Maternal Mortality: 1990 to 2015", the target for MMR is estimated to be 139 per 1,00,000 live births by the year 2015 taking a baseline of 556 per 100,000 live births in 1990.
- However, as per the estimates in above publication, the MMR in India has declined by 68.7% and has come down from 556 in 1990 to 174 in 2015 at an average annual decline of 4.6%. The same report has classified India among countries "Making Progress".
- Globally, the World's MMR has fallen nearly by 44% over the past 25 years, to an estimated 216 maternal deaths per 100 000 live births in 2015,

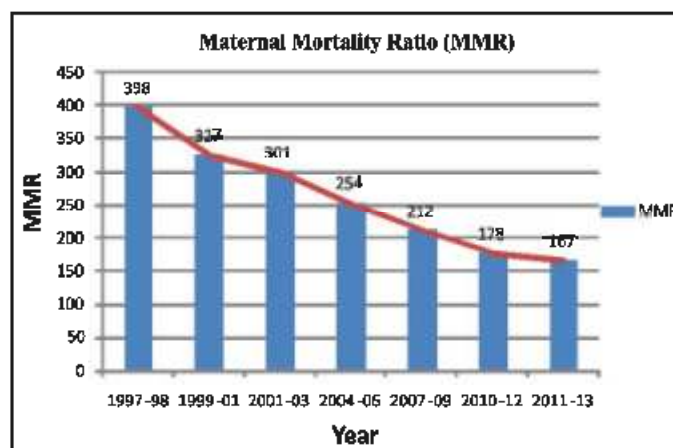
from an MMR of 385 in 1990 at an average annual decline of 2.3%.



3.3 DECLINING MATERNAL MORTALITY RATIO (MMR)

- The data on maternity related deaths is made available by Registrar General of India (RGI) through its Sample Registration System(SRS) in the form of Maternal Mortality Ratio (MMR). As per the latest report of the Registrar General of India, Sample Registration System (RGI-SRS), MMR of India has shown a decline from 212 per 100,000 live births in the period 2007- 09 to 167 per 100,000 live births in the period 2011-13.

Accelerated pace of decline in MMR for India



- Out of the 15 States for which comparative data are available, 9 States have registered higher (or equal) rate of compound annual decline during 2011-13 than the all-India decline of 2.1%.
- The percentage compound rate of decline in MMR during (2010-12) to (2011-13) has been higher in the State of Maharashtra (21.8%), followed by Andhra Pradesh (16.4%), Haryana (13.0%), Tamil Nadu (12.2%), Punjab (9.0%), Assam (8.5%), Gujarat (8.2%), Karnataka and Kerala (7.6%), Odisha (5.5%) as compared to the decline in other

States.

- Average decline in MMR between 2007-09 and 2011-13 has been 11.3 points per year, i.e. 5.8% compound rate of annual decline. Assuming that the annual compound rate of decline observed during 2007-09 and 2011-13 continues, India's MMR is likely to reach the MDG -5 target of 139.
- India's MMR has fallen nearly by 70% over the past 25 years, to an estimated 167 maternal deaths per 100 000 live births in 2011-13, from an MMR of 556 in 1990.
- India, has also committed, to the latest UN target for the Sustainable Development Goals for MMR to less than 70 per 100,000 live births by 2030.
- Despite significant improvements in maternal health over the last decade or so, which is evident in the reductions in maternal mortality in the country, an estimated 44,000 mothers continue to die every year due to causes related to pregnancy, childbirth and the post-partum period. The major medical causes of these deaths are hemorrhage, sepsis, abortion, hypertensive disorders, obstructed labor and 'other' causes including anaemia. A host of socio-economic-cultural determinants like illiteracy, low socio-economic status, early age of marriage, low women's empowerment, traditional preference for home deliveries & other factors contribute to the delays leading to these deaths.

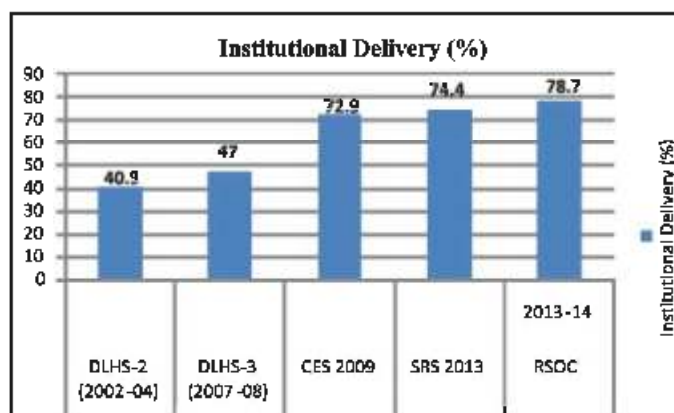
3.3.1 State's progress on MMR

- The annual rate of decline of MMR during the period 2010-12 and 2011-13 is 6.2%.
- Assam continues to be the state with the highest MMR (300) followed by Uttar Pradesh/ Uttarakhand (285) and Rajasthan (244).
- States of Maharashtra (21.8%), Andhra Pradesh (16.4%), Haryana (13%), Tamil Nadu (12.2%), Assam (8.5%), Gujarat (8.2%), Punjab (9.0%), Karnataka (7.6%) and Kerala (7.6%) have registered equal or higher decline as compared to the national decline.

- States which have achieved an MMR of 100 per 100,000 live-births in 2011-13 are Kerala, Tamil Nadu, Maharashtra and Andhra Pradesh. The States of Gujarat, Haryana, Karnataka, West Bengal have also reached the MDG-5 target.
- Additional efforts will be required for lowering the MMR, especially, in the States of Assam (300), Uttar Pradesh (285), Rajasthan (244), Odisha (222), Madhya Pradesh / Chhattisgarh (221) and Bihar/Jharkhand (208), which have quite high MMR as compared to the national level, if the MDG target is to be achieved in an equitable manner.

3.4 INSTITUTIONAL DELIVERY

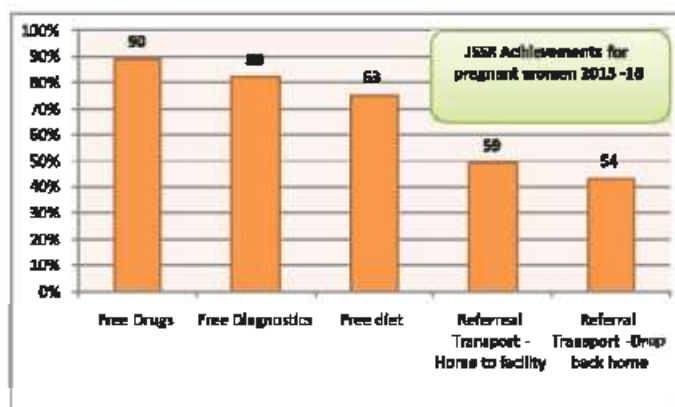
Institutional deliveries in India have risen sharply from 47% in 2007-8 to over 78.7% in 2013-14 while Safe delivery has simultaneously climbed from 52.7% to 81.1% in the same period.



3.4.1 Key strategies to reduce MMR

- For bringing pregnant women to health facilities to ensure safe delivery and emergency obstetric care, Janani Suraksha Yojana (JSY), a demand promotion scheme was launched in April 2005. The number of JSY beneficiaries has risen from 7.39 lakhs in 2005-06 to more than 104.16 lakhs in 2015-16, with the expenditure on this scheme increasing from Rs. 38.29 crores to Rs. 1649.12 crores in 2015-16. It is well established that JSY has succeeded in promoting institutional delivery. Under NHM, institutional delivery has increased from 40.8% in 2005-06 (NFHS-3) to 78.7% (Rapid Survey of Children 2013-14).

- Building on the phenomenal progress of the JSY scheme, Government of India has launched Janani Shishu Suraksha Karyakaram (JSSK) on 1st June, 2011. The initiative entitles all pregnant women delivering in public health institutions to absolutely free and no expense delivery, including caesarean section. The entitlements include free drugs and consumables, free diet during stay at normal delivery as well as C-section, free diagnostics, and free blood wherever required. This initiative also provides for free transport from home to institution, between facilities in case of a referral and drop back home. Similar entitlements were put in place for all sick infants accessing public health institutions for treatment upto 1 year of age. The scheme has also been expanded to cover antenatal & post-natal complications of pregnancy
- Prior to the launch of NHM, Call Centre based ambulance network was virtually non-existent. Now most States have the facility where people can dial 108 or 102 or 104 telephone number for calling an ambulance. A total of over 21,000 ambulances/patient transport vehicles are now operational across states.
- Utilization of public health infrastructure by pregnant women has increased significantly as a result of JSY & JSSK. As many as 1.30 crore women delivered in Government health facilities last year (2015-16).



- **Mother and Child Tracking System (MCTS)** is a name based web based service that captures the details of pregnant women and children up to 5 years and aims to ensure that every pregnant

woman gets complete and quality ANC and PNC and every child receives complete range of immunization services.

- **Web Enabled Mother and Child Tracking System (MCTS)** is being implemented to register and track every pregnant woman, neonate, infant and child by name for quality ANC, INC, PNC, FP, Immunization services. More than 11.79 crore pregnant women and 10.11 crore children have been registered under MCTS till 4th Dec, 2016.
- **Establishing Maternal and Child Health (MCH) Wings** at high caseload facilities to improve the quality of care provided to mothers and children.
- **State of the art Maternal and Child Health Wings (MCH wings)** have been sanctioned at District Hospitals/ District Women's Hospitals and other high case load facilities at sub-district level, to provide quality obstetric and neonatal care. More than 30,000 beds for women & children were added across 492 health facilities in 21 States.
- **The process of Maternal Death Review (MDR)** has been institutionalized across the country in both facilities and in the community to identify, not only the medical causes, but also some of the socio-economic cultural determinants as well as the gaps in the system which contribute to the delays causing such deaths. This is with the objective of taking corrective action at appropriate levels and improving the quality of obstetric care. The States are being monitored closely on the progress made in the implementation of MDR.
- **Comprehensive abortion care, Sexually Transmitted Infections (STIs) and Reproductive Tract Infections (RTIs)** diagnostics and treatment is being provided at primary and secondary care levels. Syndromic case management for RTI/STI is being provided at the appropriate level delivery points. A policy decision has been taken for universal testing of HIV and syphilis in a pregnant women.
- **Monthly Village Health and Nutrition Days (VHND)** as an outreach activity at Anganwadi centers for provision of maternal and child care

including nutrition in convergence with the ICDS. In 2015-16 nearly 80 lakhs VHNDs were conducted in the States & UTs.

- For prevention and control of Anaemia, under the National Iron+ Initiative, Iron and Folic Acid (IFA) supplementation is provided at health facilities and during outreach activities. IFA is now being given for six months during the antenatal period and for six months during the postnatal period. Line listing and tracking of severely anaemic pregnant women for timely management is encouraged.
- **A Mother and Child Protection Card** developed jointly by the Ministry of Health & Family Welfare and the Ministry of Women and Child Development is being used by all States as a tool for monitoring and improving the quality of MCH and Nutrition interventions.
- Engagement of approximately 9.15 lakh Accredited Social Health Activists (ASHAs) to facilitate accessing of health care services by the community, particularly pregnant women.
- MBBS doctors have been trained in Anaesthesia (Life Saving Anaesthesia Skills - LSAS) and Emergency Obstetric Care including C-section (EmOC) skills to overcome the shortage of specialists in these disciplines, particularly in the rural areas. Staff Nurses/Auxiliary Nurse Midwives/Lady Health Visitors have been trained as Skilled Birth Attendants to improve quality of care during pregnancy and childbirth. So far, around 1600 doctors have been trained in Emergency Obstetric Care including C-sections and 2000 doctors in LSAS. Over 70,000 SNs/LHVs/ANMs have been trained as SBAs as per State reports.
- **Prevention of Postpartum Haemorrhage (PPH)** through Community based advance distribution of Misoprostol by ASHAs/ANMs has been launched for >20% home delivery districts. Operational



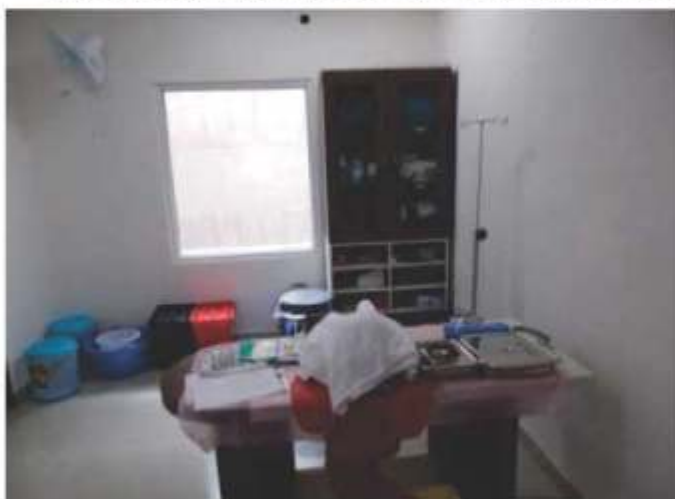
Guidelines and Reference Manual have been disseminated to the States. However, guidelines on the above are explicit in saying that during the counselling sessions with the pregnant women conducted by ASHAs and ANMs, emphasis is laid on the need to register for ante-natal care and delivery at institutions.

- Setting up of **Skill Labs** with earmarked skill stations for different training programs to enhance the quality of training and strengthen the quality of capacity building of different cadres of service providers in the States. Guidelines and training modules of skill labs have been disseminated to the States. National Skills labs are now operational for conducting training of trainers.
- To accomplish the above objective of setting up model standalone skills lab at State level also to handhold and guide the States in creating model skills lab and train State level Master trainers, Government of India has established five National Skills lab "Daksh" at Delhi and in NCR region with support from Maternal health division, Government of India and Liverpool school of tropical Medicine(LSTM). These National Skills labs have been attached to all the States and UTs so that there is an optimum utilization of the National Skills Lab. 1250 health personnel have been trained at the skills labs till date.
- 30 stand-alone skills lab have been established at different States such as Gujarat, Haryana, Bihar, Maharashtra, MP, West Bengal, Odisha, Tamil Nadu and Telangana. Additionally 186 MCH wings have been approved across the country which has in built skills lab.
- RMNCH+A approach emphasizes the role of highly skilled & empowered nurses in Maternal and Child Health. To improve the quality of training of nurses, training institutions for nursing –midwifery are being strengthened.
- **Pre-service Education for strengthening Nursing Midwifery Cadre:**
- Five colleges of nursing namely Govt. College of Nursing Vadodara, Wardha, Guwahati, Kanpur and MMC Chennai are being upgraded into National Nodal Centre (NNC) of excellence. By strengthening above >70% performance standards

has been achieved and 6 weeks training of ANM/GNM faculties have been initiated.



- Around 42% of the targeted ANM & GNM Nursing institutions in the high focus States have fully equipped mini-skill labs and 71% of these institutions have a well equipped library and around 73% have IT labs.
- Capacity building of faculty of nursing in the country through a six week customized Training has been conducted in National and State Nodal



centers. To improve the teaching and clinical skills, a 6 days training for 250 nursing faculty has also been conducted at National Skills lab "Daksh".

- Over 18,000 'Delivery Points' across the country have been strengthened in terms of infrastructure, equipment and trained manpower for the provision of comprehensive RMNCHA services.
- Behaviour change Communication efforts for early registration for ANC, regular ANC, institutional delivery, nutrition, care during pregnancy etc. are supported in States through the PIPs. Standardised IEC/BCC packages have been prepared at National level and disseminated to the States.

- **Kilkari weekly audio messages** to pregnant women and parents of infants, besides SMS messages, through MCTS are being sent to educate and update them on stage/ age specific recommended practices/requirements from the pregnancy till infancy.
- To sharpen the focus on the low performing districts, 184 High Priority Districts (HPDs) have been identified. These districts should receive 30% higher per capita funding, relaxed norms, enhanced monitoring and focused supportive supervision, and encouraged to adopt innovative approaches to address their peculiar health challenges.
- Operational guidelines for new initiatives have been prepared for Screening of Gestational Diabetes Mellitus, screening of Hypothyroidism for high risk group during pregnancy, Training of General Surgeons for performing Caesarean Section, Calcium supplementation during pregnancy, De-worming during pregnancy, Medical Methods of Abortion, Ensuring Access to safe Abortion and Addressing Gender Biased Sex Selection, birth companion during delivery, Maternal Near Miss programme and Technical and operational Guideline for screening for Syphilis during pregnancy. All the new guidelines have been disseminated to the States for implementation. These new initiatives will lead to decline in Maternal Mortality Ratio (MMR) and better health outcome in pregnant women and newborns.
- Guidelines on Standardization of Labour room at Delivery Point for establishing uniform protocols at all Labour rooms and Guidelines on Obstetric ICU/HDU to handle complicated pregnancies have been disseminated to the States.
- Moreover, Guidance Note on Use of Uterotonics during labour, Guidance Note on Prevention and management of Postpartum Haemorrhage have also been disseminated to the States for orienting service providers on use of uterotonics during labor and managing PPH cases.
- Dakshata- 3 day intrapartum training for doctors and SNs has been implemented in the States of MP,

Rajasthan, Odisha, Maharashtra, Andhra Pradesh, Telangana and Assam. 5256 participants (doctors and staff nurses) from DHs and CHCs have been trained in Dakshata.

- For placing emergency obstetric care services at the health facilities, once the women have come into the institutional fold, more than 18,000 'Delivery Points' fulfilling certain bench marks of performance have been identified across the country. These are being strengthened in terms of infrastructure, equipments, trained manpower for provision of comprehensive Reproductive, Maternal, Newborn Child health services along-with services for Adolescents and Family Planning etc. These are being monitored for service delivery.
- Maternal Health Tool Kit has been developed as a ready reckoner/handbook for programme managers to plan, implement and monitor services at health facilities, with a focus on the Delivery Points, which includes setting up adequate physical infrastructure, ensuring logistics and supplies, recording/reporting and monitoring



systems with the objective of providing good quality comprehensive RMNCH services.

- Regular IEC/BCC is done including messages on early registration for ANC, regular ANC, institutional delivery, nutrition, care during pregnancy etc. Funds are being provided to the States through PIPs for comprehensive IEC/ BCC

on Maternal and New Born health. Standardised IEC/BCC packages have been prepared at National level and have been disseminated to the States.

- Further, to sharpen the focus on the low performing districts, 184 High Priority Districts (HPDs) have been identified. These districts would receive 30% higher per capita funding, relaxed norms, enhanced monitoring and focused supportive supervision and encouraged to adopt innovative approaches to address their peculiar health challenges. Harmonized technical assistance to States by Development Partners to strengthen implementation of Interventions under RMNCH+A with a focus on High Priority Districts.

3.5 JANANI SURAKSHAYOJANA (JSY)

- Janani Suraksha Yojana (JSY) is a safe motherhood intervention under the National Health Mission (NRHM). It is being implemented with the objective of reducing maternal and neonatal mortality by promoting institutional delivery among poor pregnant women. The scheme, launched on 12 April 2005 by the Hon'ble Prime Minister, is under implementation in all the States and Union Territories (UTs), with a special focus on Low Performing States (LPS).
- JSY is a centrally sponsored scheme, which integrates cash assistance with delivery and post-delivery care. The Yojana has identified Accredited Social Health Activist (ASHA) as an effective link between the government and pregnant women.

3.5.1 Important Features of JSY

The scheme focuses on poor pregnant woman with a special dispensation for States that have low institutional delivery rates, namely, the States of Uttar Pradesh, Uttarakhand, Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Assam, Rajasthan, Orissa, and Jammu and Kashmir. While these States have been named Low Performing States (LPS), the remaining States have been named High Performing States (HPS).

3.5.2 Eligibility for Cash Assistance

The eligibility for cash assistance under the JSY is as shown below:

LPS	All pregnant women delivering in government health centres, such as Sub Centers (SCs)/Primary Health Centers (PHCs)/Community Health Centers (CHCs)/First Referral Units (FRUs)/general wards of district or State hospitals
HPS	All BPL/Scheduled Caste/Scheduled Tribe (SC/ST) women delivering in a government health centre, such as SC/PHC/CHC/FRU/general wards of district or State hospital
LPS & HPS	BPL/SC/ST women in accredited private institutions

3.5.3 Cash Assistance for Institutional Delivery

The cash entitlement for different categories of mothers is as follows:

Category	Rural area		Total	Urban area		Total
	Mother's package	ASHA's package*		Mother's package	ASHA's package**	
LPS	1400	600	2000	1000	400	1400
HPS	700	600	1300	600	400	1000

*ASHA package of Rs. 600 in rural areas include Rs. 300 for ANC component and Rs. 300 for facilitating institutional delivery.

**ASHA package of Rs. 400 in urban areas include Rs. 200 for ANC component and Rs. 200 for facilitating institutional delivery.

3.5.4 Subsidizing cost of Caesarean Section

The Yojana has a provision to hire the services of a private specialist to conduct Caesarean Section or for

the management of Obstetric complications, in the Government Institutions, where Government specialists are not in position.

3.5.5 Cash assistance for home delivery

BPL pregnant women, who prefer to deliver at home, are entitled to a cash assistance of Rs 500 per delivery. The conditionalities of age of pregnant women i.e. 19 years or above and only up to two children have been removed w.e.f. 08.05.2013.

3.5.6 Accrediting private health institutions

In order to increase the choice of delivery care institutions, States are encouraged to accredit at least two willing private institutions per block to provide delivery services. The State and District authorities should draw up a list of criteria/protocols for such accreditation.

3.5.7 Direct Benefits Transfer under JSY

Direct Benefit Transfer (DBT) mode of payment was initially rolled out in 43 districts w.e.f. 1.1.2013 and in 78 districts from 1.7.2013. Now, this initiative has been expanded across the country over all the districts. Under this initiative, eligible pregnant women are entitled to get JSY benefit directly into their bank accounts through Aadhaar/Core Banking Solution. Details of payments made through DBT mechanism in FY 2016-17 till 30.09.2016 are as under:

Period : from	Numbers	Amount (in Rs.)
01.04.2016 to 30.09.2016		
Aadhaar based payments	84,461	112,146,682.00
Payments through Core Banking Solution (CBS)	3,933,765	5,336,197,805
Total	4,018,226	5,448,344,487

3.5.8 Physical & Financial progress

JSY has been a phenomenal success both in terms of number of mothers covered and expenditure incurred on the scheme. From a modest figure of 7.39 lakhs beneficiaries in 2005-06, the scheme currently provides benefit to more than one crore beneficiaries every year. Also the expenditure of the scheme has increased from 38 crores in 2005-06 to 1668 crores in 2014-15.

In terms of achievement, the JSY is considered to be one of the important factors in increased utilization of public health facilities by the pregnant women for delivery care services which are reflected in the following:

- Increase in institutional deliveries which have gone up from 47% (District Level Household Survey-III, 2007-08) to 78.7% (RSOC:2013-14);
- Maternal Mortality Rate (MMR) which have declined from 254 maternal deaths per 1,00,000 live births in 2004-06 to 167 maternal deaths per 1,00,000 live births during 2011-13;
- IMR has declined from 58 per 1000 live births in 2005 to 39 per 1000 live births in 2014;
- The Neo-Natal Mortality Rate (NMR) has declined from 37 per 1000 live births in 2006 to 26 per 1000 live births in 2014.

Year-wise physical and financial progress of JSY is as under:

Year	No. of beneficiaries (in lakhs)	Expenditure (in crores)
2005-06	7.39	38.29
2006-07	31.58	258.22
2007-08	73.29	880.17
2008-09	90.37	1241.33
2009-10	100.78	1473.76
2010-11	106.97	1618.39
2011-12	109.37	1606.18
2012-13	106.57	1640.00
2013-14	106.48	1762.82
2014-15	104.38	1668.39
2015-16	104.16	1649.17
2016-17*	46.15	671.70

* Reported Data for the period April-September 2016. Figures are provisional

3.6 PRADHAN MANTRI SURAKSHIT MATRITVA ABHIYAN (PMSMA)

- The Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA) has been launched to provide fixed-day assured, comprehensive and quality antenatal care universally to all pregnant women on the 9th of every month.
- As part of the campaign, a minimum package of antenatal care services would be provided to pregnant women in their 2nd/3rd trimesters, by OBGY specialists/Radiologist/Physicians at Government health facilities, with the support from private sector doctors to supplement the efforts of the Government.
- These services will be provided in addition to the routine ANC at the health facility/outreach at identified public health facilities (PHCs/CHCs, DHs/urban health facilities etc.) in both urban and rural areas
- One of the critical components of the Abhiyan is identification and follow-up of high risk pregnancies and red stickers would be added on to the Mother and Child Protection cards of women with high risk pregnancies.
- Engagement with Private Sector
 - Hon'ble Prime Minister of India highlighted the aim and purpose of introduction of the Pradhan Mantri Surakshit Matritva Abhiyan in the 31st July 2016 episode of Mann Ki Baat and requested doctors to dedicate 12 days in a year to this initiative.



- A National Portal for PMSMA and a Mobile application have been developed to facilitate the engagement of doctors from private/voluntary sector.

- –OBGY specialists / Radiologist/ Physicians working in the private sector are encouraged to volunteer for the campaign and can register for the campaign through any of the following mechanisms:

- Toll Free Number - Doctors can call 18001801104 to register
- SMS- Doctors can SMS 'PMSMA <Name> to 5616115
- PMSMA Portal- Register at www.pmsma.nhp.gov.in
- Register using the 'Volunteer Registration' Section of the Mobile Application

- **Comprehensive Communication Strategy:** A comprehensive communication campaign targeting both beneficiaries and the doctors has been developed. This includes a gamut of media materials including TV and radio spots, print advertisements and posters.
- **National Launch of PMSMA:** A National Launch of the Pradhan Mantri Surakshit Matritva Abhiyan was organized on 4th November, 2016 and the comprehensive, PMSMA Communication Campaign, PMSMA portal and Mobile Application were launched at the event.

3.7 RASHTRIYA KISHOR SWASTHYA KARYAKRAM (RKSK)

Rashtriya Kishor Swasthya Karyakram aims to implement plans and programmes in order to ensure holistic health and development of 253 million adolescents, by addressing needs related to sexual and reproductive health, nutrition, injuries and violence (including gender based violence), prevention of non-communicable diseases, mental health and substance misuse among adolescents. Key drivers of the program are community based interventions; facility based interventions; social and behavior change communication; and inter-sectoral convergence.

3.7.1 Community based interventions:

Weekly Iron Folic Acid Supplementation Programme (WIFS):

- The prevalence of anaemia in adolescent girls (Hb<12 g%) and in boys (Hb< 13g%) is high as per the reports of NFHS-3. According to NFHS-3 almost 56% of adolescent girls and 30% adolescent boys aged 15-19 years suffer from some form of anaemia.
- During adolescence, iron deficiency anaemia can result in impaired physical growth, poor cognitive development, reduced physical fitness and work performance and lower concentration on daily tasks. Iron deficiency in adolescent girls influences the entire life cycle. Anaemic girls have lower pre-pregnancy stores of iron and pregnancy is too short a period to build iron stores to meet the requirements of the growing foetus.
- Taking cognizance of the matter, the Ministry of Health and Family Welfare, Government of India has launched the Weekly Iron and Folic Acid Supplementation (WIFS) Programme in 2012 to reduce the prevalence and severity of nutritional anaemia in adolescent population (10-19 years).
- **Target Groups:** Weekly Iron folic Acid supplementation programme is being implemented for the following two target groups in both rural and urban areas:
 - A. Adolescent girls and boys who are school going and are in Government/Government aided/ municipal schools from 6th -12th classes.
 - B. Adolescent Girls who are not in school or out of school.
- The programme aims to cover 10.8 Crore adolescents through 3.5 lakh schools and 8.7 lakh anganwadi centres across the country.

3.7.2 Strategy for Reducing Anaemia in Adolescents

- Under the WIFS programme for adolescents, IFA supplements are to be distributed free on weekly basis to the target groups in Categories A and B.
- Administration of weekly Iron-Folic Acid Supplements (WIFS).
- Screening of target groups for moderate/severe anaemia and referring these cases to an appropriate health facility.

- Biannual de-worming (Albendazole 400mg), six months apart, for control of worm infestation.
- Information and counselling for improving dietary intake and for taking actions for prevention of intestinal worm infestation.

3.7.3 Management Structure

The Ministry of Health and Family Welfare (MoHFW) is the nodal Ministry for the Weekly Iron Folic-Acid Supplementation Programme. MoHFW is responsible for policy formulation, technical support, yearly planning of the WIFS programme, including the allocation of resources for supply of IFA supplements and deworming tablets, developing resource material for IEC/BCC, establishing monitoring systems and reviewing the programme progress.

The WIFS programme is implemented in both the urban and rural areas among both adolescent boys and girls in school; and only out of school adolescent girls (both married and unmarried). The WIFS strategy involves a “fixed day” approach for WIFS distribution. It is recommended that Monday should be the day on which all schools undertake the programme, with one additional designated day for absentees. To ensure high compliance in IFA supplementation supervised consumption of the IFA tablets is recommended. The programme also encourages and provides for the consumption of IFA tablets by the frontline workers such as AWW, ASHA and teachers to enhance the value of WIFS among adolescents and community members. The programme aims to cover a total of 10.8 crore beneficiaries including 8.3 crore in-school and 2.5 crore out-of-school beneficiaries.

3.7.4 Current status

Till March 2016, the average monthly coverage of adolescents under the WIFS programme was 27.5%, with 31% in-school and 15.3% out of school coverage.

3.7.5 Peer Education (PE) Programme

It is proposed to enrol and train four peer educators i.e. two male and two female per village or 1000 population in all villages under two PHC selected for RKSK roll-out.

These peer educators will form groups of 15-20 boys and girls and will conduct weekly one to two hour participatory sessions on adolescent health, facilitate organization of Adolescent Health Day and will signpost adolescents to Adolescent Friendly Health Clinics (AFHCs) or Adolescent Helpline and Adolescent Health Day.

During the first phase of implementation of PE programme, 50% Blocks in 214 RKSK districts have been selected. Further to this, two PHC under each of these selected CHCs have been identified for roll-out of PE programme. PE selection and training are being conducted in all villages under the two identified PHCs.

Till March 2016, around one lakh PEs have been selected across 25 States/UTs and their six days trainings along with ASHA workers of the village are being conducted in the States.

3.7.6 Scheme for Promotion of Menstrual Hygiene among Adolescent Girls in Rural India

- The Ministry of Health and Family Welfare has launched Scheme for Promotion of Menstrual Hygiene among adolescent girls in the age group of 10-19 years in rural areas as part of the Adolescent Reproductive Sexual Health (ARSH) in RCH II, with specific reference to ensuring health for adolescent girls.
- The major objectives of the scheme are:
 - i. To increase awareness among adolescent girls on Menstrual Hygiene
 - ii. To increase access to and use of high quality sanitary napkins to adolescent girls in rural areas.
 - iii. To ensure safe disposal of Sanitary Napkins in an environmentally friendly manner.
- Under the scheme a pack of 6 sanitary napkins is provided under the NRHM's brand 'Freedays'. These napkins are sold to the adolescent girls at Rs. 6 for a pack of 6 napkins in the village by the Accredited Social Health Activist (ASHA). On sale of each pack, the ASHA gets an incentive of Rs. 1 per pack besides a free pack of sanitary napkins per month. This initial model of the

scheme was rolled out in 112 selected districts in 17 States through central supply of sanitary napkin packs.

- Key activities under the proposal include:
 - i. Community based Health Education and outreach in the target population to promote menstrual health
 - ii. Ensuring regular availability of Sanitary napkins to the adolescents
 - iii. Sourcing and procurement of Sanitary napkins
 - iv. Storage and distribution of Sanitary napkins to the adolescent girls
 - v. Training of ASHA and nodal teachers in Menstrual Health
 - vi. Safe disposal of Sanitary napkins
- Since 2015-16, the scheme had been decentralized and funds were approved in the State Programme Implementation Plans for procurement of sanitary napkin packs, for safe storage and disposal, and for training of ASHA and nodal teachers. The States were instructed to undertake procurement of sanitary napkins packs at prices decided through competitive bidding. The funds were approved for State-level procurement of sanitary napkin packs in 162 districts across 20 States in 2015-16.
- **Current Status:** Uptill March 2016, a total of 8.2 crore packs of sanitary napkins supplied through central procurement have been utilized, with coverage of approximately 2.75 Crore rural adolescent girls.

3.7.7 Facility based interventions :

1. Strengthening of existing Adolescent Friendly Health Clinics (AFHC)
 2. Setting up of new AFHCs
 3. Ensuring availability of trained human resource at AFHCs- medical officer, ANM and counsellors
- Adolescent Friendly Health Clinics act as the first level of contact of primary health care services with adolescents. These clinics are being

developed across level of care to cater to diversified health and counselling need of adolescent girls and boys. These broad objectives will be achieved through establishment of optimally functional AFHCs at District Hospitals, Community Health Centres and Primary Health Care centres in prioritized districts.

- Trainings of medical officer, nurses and counsellors positioned in AFHCs are being ensured through development of a structured training plan for capacity building. The training of human resource positioned in AFHCs operationalized in RKSK districts is being prioritized. Adolescent Health Division of Ministry of Health and Family Welfare has initiated National Level Training of Trainers for Medical Officers, ANMs/LHVs and Counsellors. These master trainers will further provide State/District level training to service providers at designated district training sites.
- As on 31st March 2016, 7,481 AFHCs have been made functional across the country. Linkages have also been established with Integrated Counselling and Testing Centres (ICTC) for management of HIV/AIDS and treatment of RTI/STI cases. In addition to 1,431 AH counsellors working in the primary care health facilities, around 753 ICTC counsellors (in RKSK districts) are also providing Adolescent Health counselling services. Till March 2016, 6008 Medical Officers 15237 ANMs and 821 counsellors have been trained across primary health care facilities in Adolescent Friendly Health Services.

3.7.8 Convergence

- Within Health & Family Welfare - FP, MH , RBSK, NACP, National Tobacco Control Programme, National Mental Health Programme, NCDs and IEC.
- With other departments/ schemes - WCD (ICDS, KSY, BSY, SABLA), HRD (AEP, MDM), Youth Affairs and Sports (Adolescent Empowerment Scheme, National Service Scheme, NYKS, NPYA).

3.7.9 Social and Behaviour Change Communication with focus on Inter Personal Communication

After wide spread consultations, a comprehensive communication strategy has been developed by AH division in collaboration with the UNICEF country office. The strategy provides overall guidance to the State and District Programme managers on formulation of communication campaign for adolescents on six priority areas identified under RKSK. An implementation guideline has also been developed to supplement the communication strategy and to aid its roll-out. Both the strategy and implementation guideline were shared with State programme managers during the National Review of RKSK programme in June 2015. To further strengthen the understanding of communication for adolescent health, strategy has been shared with State and District level managers during RKSK regional reviews in November & December, 2015.

3.7.10 Recent initiative under RKSK

- National Adolescent Health Review Workshop was organized on 1st-2nd June 2015 with participation of six State Mission Directors and State Nodal officers for Adolescent Health from 34 States. States were reoriented on RKSK and State performances reviewed.
- RKSK Communication Strategy developed with technical support from UNICEF and disseminated to the States during National Workshop.
- Five Regional Review Workshops aimed at programme review and planning ahead were organized in Dehradun, Jaipur, Bhopal, Hyderabad and Guwahati in November & December, 2015
- Revised RKSK Implementation Guidelines for PE programme roll out shared with the States. 1000+ Master Trainers for PE Programme trained in 35 Regional level ToTs for PE programme.
- With focus on convergence in WIFS programme. Joint letter signed by Secretary MoHFW, MoHRD & MoWCD addressed to Chief Secretaries of States for better convergence for improved programme outcomes.
- Year long Awareness generation activities for Adolescent Nutrition and Anaemia were organized with support from UNICEF. This included articles in regional and national newspapers, Panel discussions on radio and TV channels, engagement of Ms. Priyanka Chopra, UNICEF goodwill ambassador as Brand Ambassador for WIFS. WIFS Media Campaign was launched along with dissemination of IEC material by Hon. HFM on 23rd December, 2015.