3 Chapter

MATERNAL AND ADOLESCENT HEALTHCARE

3.1 MATERNAL HEALTH

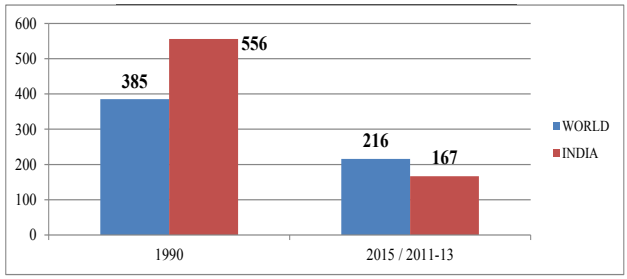
Sustained development of the country can be achieved only if we take holistic care of our women and children. Massive and strategic investments have been made under the National Health Mission (NHM) for improvement of Maternal Health. The survival and well-being of mothers is not only important in their own right but are also central to solving 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. There has however, 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 68.7%. India's share among global maternal deaths has declined significantly to about 15% as per the Maternal Mortality Estimation Index Agency Group (MMEIG) report. Millennium Development Goal (MDG) 5 pertains to Maternal Health, where target is to reduce the 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 was 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 fell by nearly 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%.

India's progress on MDG -5 in the global context



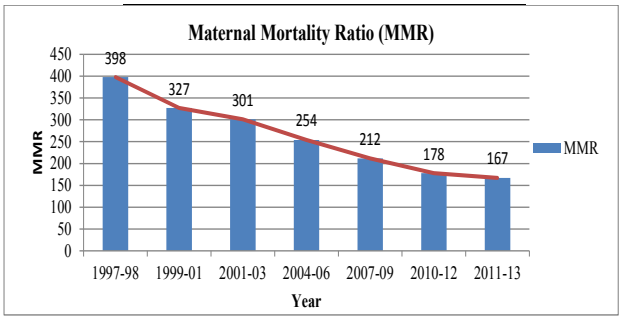
Source "Trends in Maternal Mortality: 1990 to 2015" - UN Inter–Agency Expert Gro up's & RGI - SRS

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



Source: RGI –SRS

- 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 highest in 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%).
- 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 fell by nearly 68.7% 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 at 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 level of women's empowerment, traditional preference for home deliveries and other factors contribute to the delays leading to these deaths.

3.3.1 State's progress on MMR

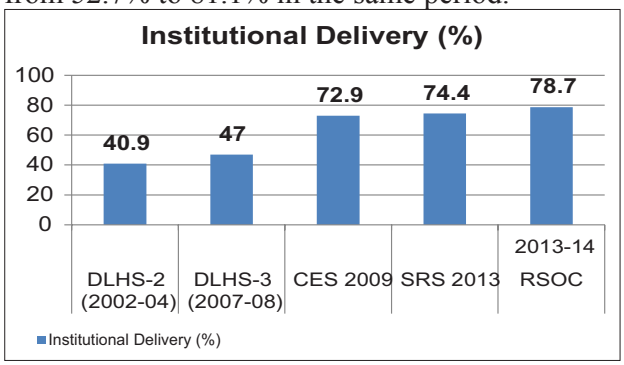
- The annual rate of decline of MMR during the period 2010-12 and 2011-13 is 6.2%.
- Assam continues to be the State with the highest MMR (300) followed by Uttar Pradesh/ Uttarakhand (285) and Rajasthan (244).
- States of Maharashtra (21.8%), Andhra Pradesh (16.4%), Haryana (13%), Tamil Nadu (12.2%), Assam (8.5%), Gujarat (8.2%), Punjab (9.0%), Karnataka (7.6%), Kerala (7.6%) and 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 2007-08 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 The key strategies for accelerating the pace of decline in MMR:

- For bringing pregnant women to health facilities, for ensuring 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 104.38 lakhs in 2014-15, with the expenditure on this scheme increasing from Rs. 38.29 crores to Rs. 1668 crores in 2014-15 . Institutional deliveries in India have risen sharply from 47% in 2008 to over 78.7 % in 2013-14.

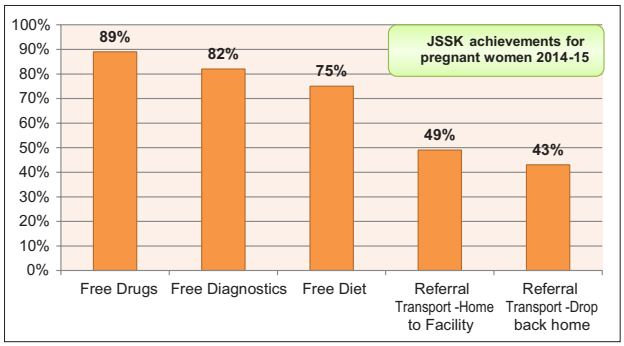
- Building on the phenomenal progress of the JSY scheme, Government of India has launched **Janani Shishu Suraksha Karyakram (JSSK)** on 1st June, 2011. The initiative entitles all pregnant women delivering in public health institutions to free and no expense delivery, including Caesarean Section (C-Section). The entitlements include free drugs and consumables, free diet during stay at normal delivery and 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 newborns accessing public health institutions for treatment till 30 days after birth. In 2013, the scheme was expanded to cover complications during ante-natal and post-natal period and also sick infants upto 1 year of age.

- Prior to 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.

- As per the States reports for 2014-15, 89% of pregnant women received free drugs, 82% free diagnostics, 75% free diet, 49% free home to facility transport while 43% received free drop back home after delivery.

- Utilization of public health infrastructure by pregnant women has increased dramatically as a result of JSY and JSSK. As many as 1.30 crore women delivered in Government

health facilities last year (2014-15).



- **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 a full range of immunization services. More than 9.58 crore pregnant women and 8.12 crore children have been registered under MCTS till Oct, 2015.
- **Establishing Maternal and Child Health (MCH) Wings** at high case load 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, as integrated facilities for providing quality obstetric and neonatal care. More than 30,000 beds for women & children are being added across 486 health facilities in 21 States.
- **Engagement of approximately 9.15 lakh Accredited Social Health Activists (ASHAs)** to facilitate accessing of health care services by the community, particularly pregnant women.
- **Maternal Death Review (MDR)** is being implemented across the country both at facilities and in the community. The purpose is to take corrective action at appropriate level and improve the quality of obstetric care. The process of Maternal Death Review (MDR) has been institutionalized across the country both at 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 (CAC)** is being provided as it is an important element in the reproductive health component of the RMNCH+A strategy as 8% of maternal deaths in India are attributed to unsafe abortions.
- **Free Treatment of Sexually Transmitted Infections (STIs) and Reproductive Tract Infections (RTIs)** is being provided at health facilities as they constitute an important public health problem in India. Studies suggest that 6% of the adult population in India is infected with one or more RTI/STI. Syndromic case management is being provided at the appropriate level delivery points. A policy decision has been taken for universal testing of HIV and syphilis in all pregnant women.
- Monthly **Village Health and Nutrition Days (VHND)** as an outreach activity at Anganwadi centers for provision of maternal and childcare including nutrition in convergence with the ICDS. In 2014-15, more than 80 lakhs VHNDs were conducted

in the States & UTs.

- **Prevention & Control of Anaemia:** Under the National Iron+ Initiative, for prevention and control of anaemia in pregnant and lactating women, iron folic acid supplementation is being given at health facilities and also during outreach activities. Iron Folic Acid (IFA) is now being given for six months during ANC and six months in the PNC period. States have also been directed for line listing and tracking of severely anaemic pregnant women by name for their timely management at health facilities.
- A joint **Mother and Child Protection (MCP) Card** of Ministry of Health & Family Welfare and 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.
- **Capacity building of MBBS doctors in 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 rural areas alongwith Skilled Birth Attendants (SBAs) training of Staff Nurses (SNs)/Auxiliary Nurse Midwifes (ANMs)/Lady Health Visitors (LHVs) for improving quality in care during pregnancy and childbirth. About 1350 doctors have been trained in Emergency Obstetric Care including C-sections and 1800 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 high 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 ANC and deliver at institutions.
- Setting up of **Skill Labs** with earmarked skill stations for different training programmes 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 stand-alone 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.
- 30 stand-alone skills lab has been established at different States such as Gujarat, Haryana, Bihar, Maharashtra, Madhya Pradesh, West Bengal, Odisha, Tamil Nadu and Telangana. Additionally, 186 MCH wings have been approved across the country which has in built skills lab. 797 health personnel have been trained at the skills labs till date.
- **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:** One National Nodal Centre (NNC) at College of Nursing, NRS, Kolkata is operational and five others are under process for strengthening (Government College of Nursing, Vadodara, Kasturba Nursing College, Sewagram, Wardha, Regional College of Nursing, Guwahati, College of Nursing, Kanpur, College of Nursing, MMC Chennai). Around 25% of the targeted ANM & GNM Nursing institutions in the high focus States have fully equipped mini-skill labs and 50% of these institutions have library with necessary books & Government of India guidelines and around 41% have IT labs. Capacity building of 212 nursing faculties in the country through customized 6 Week Training has been conducted in functional NNC and SNCs to improve the teaching and clinical skills and 6 days training of 211 nursing faculties also have been conducted at National Skills Lab *"Daksh"*. Recent assessments show marked improvements in competency of clinical skills of nursing students (Madhya Pradesh & Odisha) passing out from targeted institutions on key Maternal & Newborn Health (MNH) practices over a duration of 18 months (Baseline- December 2013, Midline- July 2015).
- For placing emergency obstetric care services at the health facilities, more than 17,000 **'Delivery Points'** fulfilling certain benchmarks 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 and recording/reporting and monitoring systems with the objective of providing good quality comprehensive RMNCH services.
- Engagement of approximately 9.15 lakh ASHAs to facilitate accessing of healthcare services by the community, particularly pregnant women.
- Regular Information, Education & Communication (IEC)/Behaviour Change Communication (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 Newborn health. Standardised IEC/BCC packages have been prepared at national level and have been disseminated to the States.
- **RMNCH+A:** 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 are encouraged to adopt innovative approaches to address their peculiar health challenges. Harmonised technical assistance to States

by Development Partners to strengthen implementation of Interventions under RMNCH+A with a focus on High Priority Districts.

- Newer Guidelines: To further accelerate the pace of decline in MMR, new guidelines has been prepared and disseminated to the States for screening for diagnosis & management of gestational diabetes mellitus, hypothyroidism during pregnancy, Training of General Surgeons for performing caesarean section, calcium supplementation during pregnancy and lactation, de-worming during pregnancy, maternal near miss review, screening for syphilis during pregnancy and ``Dakshata" guidelines for strengthening intra-partum care is being done. Guidance Note on use of Uterotonics during labour, guidance note on prevention and management of postpartum haemorrhage, training manual for facilitators and training manual for participants for the Daksh Skills Lab for RMNCH+A services are released.

3.5 JANANI SURAKSHA YOJANA (JSY)

Janani Suraksha Yojana (JSY) is a safe motherhood intervention under the National Health Mission (NHM). It is being implemented with the objective of reducing maternal and neo-natal mortality by promoting institutional delivery among poor pregnant women. Launched on 12 April 2005, the scheme is under implementation in all 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 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, Uttar Pradesh, Uttarakhand, Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Assam, Rajasthan, Odisha and Jammu and Kashmir. While these States have been named Low Performing States (LPS), the remaining States have been classified as 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 Centres (SCs)/ Primary Health Centres (PHCs)/Community Health Centres (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:

(in Rs.)

Category	Rural area		Total	Urban area		Total
	Mother's package	ASHA's package*		Mother's package	ASHA's package**	Amount (in Rs.)
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. 8.5.2013.

3.5.6 Accredited 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 payments was initially rolled out in 43 districts w.e.f. 1.1.2013 and in 78 districts from 1.7.2013. Now the initiative has been expanded across the country in all the districts. Under this initiative, eligible pregnant women are entitled to get JSY benefit directly into their bank accounts through Aadhaar number. Payments made through DBT mechanism in FY 2015-16 till 30.09.2015 are as under:

Payment Made (from 01.04.2015 to 30.09.2015)	**Number of Beneficiaries**	**Amount** (in Rs.)
Aadhaar based payments	13851	20953019
Payments through Core Banking Solution (CBS)	1702004	2120030645
Total	**1715855**	**2140983664**

3.5.8 Progress and achievement

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 gone up from 47% (District Level Household Survey-III, 2007-08) to 78.7% (RSOC: 2013-14);
- Maternal Mortality Rate (MMR) which 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;
- Infant Mortality Rate (IMR) has declined from 58 per 1000 live births in 2005 to 40 per 1000 live births in 2013 and
- The Neo-Natal Mortality Rate (NMR) has declined from 37 per 1000 live births in 2006 to 28 per 1000 live births in 2013.

ADOLESCENT HEALTH (AH)

3.6 RASHTRIYA KISHOR SWASTHYA KARYAKRAM (RKSK)

Rashtriya Kishor Swasthya Karyakram aims to implement programmes in order to ensure holistic health and development of 253 million adolescents of our country, 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 programme are community based interventions; facility based interventions; social and behaviour change communication; and inter-sectoral convergence.

3.6.1 Peer Education (PE) Programme

It is proposed to select and train four peer educators i.e. two male and two female peer educators 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 refer adolescents to Adolescent Friendly Health Clinics (AFHCs), Adolescent Helpline and Adolescent Health Day.

During the first phase of implementation of PE programme, 50% CHC in RKSK districts [213 chosen RKSK distt.] have been selected; two PHC under each of these selected CHCs have been identified for roll-out of PE programme. PE selection and training is being conducted in all villages under the two identified PHCs.

3.6.2 Weekly Iron Folic Acid Supplementation Programme (WIFS)

- WIFS entails provision of weekly supervised Iron Folic Acid (IFA) tablets to in-school boys and girls and out-of-school girls for prevention of iron and folic acid deficiency anaemia and biannual albendazole tablets for helminthic control. The programme is being implemented across the country in both rural and urban areas, covering government, government aided schools, municipal schools and Anganwadi centres. Screening of targeted adolescents population for moderate/severe anaemia and referral of these cases to an appropriate health facility; and information & counselling for prevention of nutritional anaemia are also included in the programme.
- The programme is being implemented through convergence with key stakeholder ministries- Ministry of Women and Child Development and Ministry of Human Resource Development, with joint programme, planning, capacity building and communication activities. The programme aims to cover a total of 11.2 crore beneficiaries including 8.4 crore in-school and 2.8 crore out-of-school adolescents.
- Till 30th June 2015, the average monthly coverage of adolescents under the WIFS programme was 25%, with 28% in-school and 13% out of school coverage.

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

- The Ministry of Health and Family Welfare has launched Scheme for the 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 among adolescent girls in rural areas and

(iii) To ensure safe disposal of sanitary napkins in an environmentally friendly manner.

- Under the scheme, a pack of 6 sanitary napkins was provided under the NRHM's brand *'Freedays'*. These napkins were sold to the adolescents 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 got 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.

- Since 2015-16, the scheme has been decentralized for procurement by States themselves and funds were approved in the State Programme Implementation Plans (PIPs) for procurement of sanitary napkin packs, for safe storage and disposal and for training of ASHA and nodal teachers. The States have been advised to undertake procurement of sanitary napkins packs at prices decided through competitive bidding. The funds have been approved for State-level procurement of sanitary napkin packs in 162 districts across 20 states in 2015-16 RoPs.

- Till 30th June 2015, a total of 6.8 crore packs of sanitary napkins supplied through central procurement have been utilized, with a coverage of approximately 2.5 crore rural adolescent girls.

3.6.4 Adolescent Friendly Health Clinics (AHFC)

- 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. 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 already completed National Level Training of Trainers for Medical Officers, ANMs/LHVs and Counsellors. These master trainers are further providing state/district level training to service providers at designated district training sites.

- As on 30th June 2015, as many as 7,381 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 testing and treatment of RTI/STI cases. In addition to 1,402 AH counsellors working in the primary care health facilities, around 753 ICTC counsellors (in 213 RKSK districts) are also providing Adolescent Health counselling services. Till October 2015, 1400 Medical Officers and 1207 ANMs have been trained across health care facilities in Adolescent Friendly Health Services.

3.6.5 Convergence with others

- **Within Health & Family Welfare** – Family Planning (FP), Maternal Health (MH), Rashtriya Bal Swasthya Karyakram (RBSK), National AIDS Control Programme (NACP), National Tobacco Control Programme (NTCP), National Mental Health Programme

(NMHP), Non-Communicable Diseases (NCDs) and Information, Education & Communication (IEC).

- **With other departments/schemes** – Women and Child Development (WCD) [Integrated Child Development Scheme (ICDS), Kishori Shakti Yojana (KSY), Balika Samriddhi Yojana (BSY), SABLA[1]], Human Resource Development (HRD) [Adolescence Education Programme (AEP), Mid-Day Meal (MDM)], Youth Affairs and Sports (Adolescent Empowerment Scheme), National Service Scheme, Nehru Yuva Kendra Sangathan (NYKS), NPYA.

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

After wide spread consultations, a comprehensive communication strategy has been developed by Adolescent Health division in collaboration with UNICEF country office. The strategy provides overall guidance to 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, the strategy was shared with state and district level managers during RKSK regional reviews in November-December 2015.

3.6.7 Recent initiatives under RKSK

- National level trainings of Medical Officers and ANMs have been completed and State and district level trainings are being rolled-out;
- Regional Training of Trainers under PE programme have been completed and States have initiated block level training of peer educators;
- State-level trainings of dedicated AH counsellors have been rolled-out;
- National level RKSK review workshop and dissemination of communication strategy was conducted in June 2015;
- Five Regional level RKSK review meetings held in November- December 2015 and
- Adolescent health indicators have been included in Health Management Information System.

[1] *Rajiv Gandhi Scheme for Empowerment of Adolescent Girls (RGSEAG)-SABLA*