

**Quick Assessment of
Adolescent Anaemia Control Program (AACP)
in KBK and Mayurbhanj Districts of Orissa**



**On behalf of
Department of Health & Family Welfare (DH&FW), Government of Orissa**

**Commissioned by
Orissa Technical and Management Support Team (TMST)**

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ABBREVIATIONS

AACP	Adolescent Anaemia Control Program	FGD	Focused Group Discussion
ADMO	Assistant District Medical Officer	IEC	Information Education & Communication
AG	Adolescent Girl	IFA	Iron Folic Acid
ANM	Auxiliary Nurse Midwife	KSY	Kishori Shakti Yojana
AWC	Anganwadi Centre	LS	Lady Supervisor
AWW	Anganwadi Worker	MOIC	Medical Officer in Charge
BCC	Behavior Change Communication	NFHS	National Family Health Survey
BPO	Block Program Officer	NOP	Nutrition Operation Plan
CDMO	Chief District Medical officer	NTPP	Non Timber Forest Produces
CDPO	Child Development Project Officer	PHC	Primary Health Centre
CHC	Community Health Centre	PO	Program Officer
DH&FW	Department of Health and Family Welfare	RMRC	Regional Medical Research Centre
DIT	District Implementation Team	SDMU	State Drug Management Unit
DPM	District Program Manager	SPM	State Program Manager
DPMU	District Program Management Unit	ToTs	Training of Trainers
DSWO	District Social Welfare Officer	TSK	Technical Store Keeper
DW&CD	Department of Woman and Child Development	VHND	Village Health and Nutrition Day
DWH	District Drug Ware House		

1. Study Overview & Methodology

1.1 Introduction

India houses nearly 224 million adolescents within the age group of 10 to 19 years of them 105 million are girls. Adolescent accounts to be 22% of India's population which means every 5th person in India is an adolescent and every 10th person lives in the country is an adolescent girl. Among adolescents, girls are more vulnerable and are most neglected group as far as their health, nutrition, education and their overall growth and development are concerned. As a result, most of the adolescent girls in India make the transition to adulthood with low health and nutritional status which increases the risk of reproductive morbidity and mortality. However, there are very few programs implemented in the country which are meant for improving the health and nutrition status of adolescent girls. But of late there is an increasing realization among the country's planner, policy makers and service providers that women with better health and nutrition status during their adolescent stage are less likely to face adverse reproductive outcomes in their adulthood. So initiatives and steps have been taken to improve the health status of adolescent girls in the country.

One of such steps taken is to control Anaemia among the adolescent girls. The iron-deficiency Anaemia is a major health problem observed amongst most of the adolescent girls in the country. According to NFHS-III, 2005-06, prevalence of any Anaemia among the adolescent girls in the age group of 15-19 years is significantly high (61.4%) in Orissa as compared to all India figure of 55.8%. A recent study by the Regional Medical Research Centre (RMRC), ICMR, Bhubaneswar shows prevalence of Anaemia among 11-19 years girls in Orissa is as high as 96.5%.

Iron deficiency is caused by poor dietary intake, poor iron and other nutrient intake, poor bioavailability of dietary iron in phytate fibre rich, Indian diet and/or blood loss (Example: from hookworm, repeated childbirth or heavy menstruation which leads to loss of iron). The main causes of Anaemia among girls and women in India are poor diets with low bio available iron combined with worm infestation.

Anaemia if not treated can result in maternal mortality, weakness, diminished physical & mental capacity, increased morbidity from infectious diseases, peri-natal mortality, premature delivery, low birth weight etc. Children of mothers who have Anaemia are much more likely to be Anaemic. A woman with Anaemia has a greater risk of obstructed labour, having a baby with a low birth weight, having adverse pregnancy outcomes, producing lower quality breast milk, death due to postpartum haemorrhage and illness for her and her baby.

So there is a need for iron supplementation of adolescent girls which in turn will not only improve their physical and mental capacity but also improve their pre-pregnancy haemoglobin status and iron stores. In the later stage of their life, that will help in reducing the incidence of low birth weight of infants and maternal mortality rates.

With this in background, to combat Anaemia amongst Adolescent Girls, the Department of Health and Family Welfare (DH&FW) initiated implementation of Adolescent Anaemia Control Program (AACP) in 9 districts (all the 8 KBK districts viz. Koraput, Malkangiri, Raygada, Nabarangpur, Bolangir, Sonapur, Kalahandi and Nuapada and 1 Non-KBK district i.e. Mayurbhanj) of Orissa in late 2009.

1.2 AACP: A brief overview on program objectives & guideline

Objectives of AACP

The objective of AACP is to control Anaemia among adolescent girls through the followings:

- i) Providing weekly IFA supplementation under supervision of AWW,
- ii) Bi-annual De-worming,
- iii) Dietary education to promote and improve nutritional and health practices,
- iv) Formation/activation of Balika Mandals and identifying peer educators, and
- v) IEC interventions to amplify family and community endorsement

Implementation Approach & Strategy

The overall implementation strategy includes,

- Integration of AACP with Kishori Shakti Yojana (KSY) run by ICDS
- Execution of the program by Department of Women and Child Development (DW&CD) in collaboration with DH&FW

The other key implementing strategies outlined in the guideline are as follows:

- i) **Training/Orientation** (State ToT of DITs; District ToT of CDPOs and LSs; and training of AWWs by CDPOs and LSs)
- ii) **IEC/BCC** (Anaemia Booklet for Trainers and Adolescent girls; Compliance Tracking Register for AWWs; Self-monitoring Compliance Card for Adolescent Girls)
- iii) **Procurement & Distribution of IFA & De-worming** (SDMU to procure then supply to CDMO who in turn will supply to CDPOs through DSWO and then CDPOs to supply it to AWW)
- iv) **Program administration** (enrollment of 10-19yrs adolescent girls; formation/activation of Balika Mandals (1/1000) & identification of PEs; initiation of IFA during VHND & then weekly

supervised dose; Bi-annually de-worming during July and December; Nutrition education session of girls by AWW once in a month; and hemoglobin Test in the beginning & end of the year and quarterly height & weight measurement)

- v) **Program Monitoring** (LS to monitor the program with the support from CDPO and sharing of progress during Sector, Project, District and State level monthly joint review meetings)
- vi) **Reporting** (AWW to submit the utilization report and requirement to LS; LS to prepare the Sector report; CDPO to prepare project report and DSWO to prepare district report)

1.3 Study Purpose & Objectives

The AACP since its initiation in late 2009 has completed one and half year of operation. So to review and further strengthen the program implementation and reporting, the DH&FW initiated a quick assessment of AACP. The other purpose was to develop a comprehensive action plan based on the findings of the study for scaling up the program across all the 30 districts of Orissa. The objectives of the study were to:

- i) Conduct quick assessment of the process, implementation and compliance pattern of the IFA supplementation program
- ii) Based on the assessment, suggest required change in the strategies / modalities for better implementation of the program in the State

1.4 Scope of Work

- i) Mapping and assess the step by step processes adopted starting from the State to AWC level for implementation of AACP
- ii) Assess administration of program components (viz. identification of eligible adolescent girls; formation of Balika Mandals; initiation and continuance of IFA supplementation; De-worming; Nutrition education session;

- hemoglobin test; height and weight measurement)
- iii) Assess the compliance pattern of IFA supplementation by AWW and Adolescent Girls
 - iv) Assess and review the monitoring and reporting mechanism adopted for execution of the program starting from the State to AWC level
 - v) Suggest required changes in the strategies / modalities for better implementation of the program in the State

1.5 Methodology

1.5.1 Study design

The study adopted an exploratory study design for undertaking the quick assessment of the AACP. The said design particularly helped to explore into the processes and constraints in implementing the program.

1.5.2 Sampling

- i) In total 4 sample districts were selected for the study, 3 KBK (Bolangir, Kalahandi and Nabarangpur) and Mayurbhanj district. The 3 sample districts in KBK region were selected using random number method.
- ii) In each sample district, the study selected 2 sample blocks, one nearest and one distant block. In total 8 Blocks from 4 sample districts were covered in the study.
- iii) Further in each Block 2 AWCs were randomly visited (covered 16 AWCs from 4 districts)
- iv) The study team interviewed 5 Adolescent Girls in each district and covered a total of 80 girls from 4 sample districts.
- v) In each AWC, the study conducted FGDs with Adolescent Girls and their mothers separately
- vi) Apart from girls, the study interviewed the program functionaries of D&WCD and DH&FW at District, Block, Sector, Sub-centre & AWC level.

The number of interviews carried out at different levels is presented in the table below:

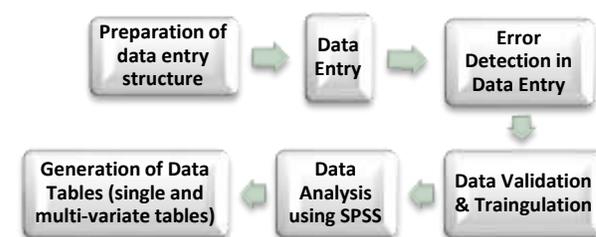
Administrative level	Study Respondents	No. of Sample Respondents
State	i) Point Person, AACP, NRHM	1
	ii) Point Person DW&CD and SPM, NOP	2
District	i) CDMO / ADMO, FW	4
	ii) DSWO / PO, ICDS	4
	iii) DPM	4
	iv) TSK / Pharmacist	4
Block / Sector / Sub-centre	i) CDPO	8
	ii) LS	8
	iii) MOIC & BPO	8
	iv) ANM	8
AWC	i) AWW	16
	ii) Adolescent Girls (AGs)	80 16 FGDs
	iii) Mothers of AGs	16 FGDs

1.5.3 Tools & techniques of data collection

Study Respondents	Techniques of Data Collection	Tools for Data Collection
Adolescent Girls	One to one Interview & Focused Group Discussion	Structured Interview Schedule & FGD Checklist
Mothers of Adolescent Girls	Focused Group Discussion	FGD Checklist
Service Providers	One to one Interview Method	Interview Guide / Checklist

1.5.4 Data computerization, analysis & reporting

The study used various quantitative and qualitative data analysis methods. The software packages like SPSS and Excel were used for computerization and analysis of quantitative data. Single and multivariate tables were generated from the data analysis, which are presented in the report with frequencies,



percentages and averages. Apart from the quantitative analysis, the study also prepared qualitative data tables / matrixes for reporting the open-ended responses.

2. Study Findings

This chapter brings out the findings of quick assessment of AACP carried out in 4 study districts viz. Kalahandi, Nabarangapur, Bolangir and Mayurbhanj. The responses of both beneficiaries and service providers operating at different levels have been analyzed in this chapter. The chapter has been broadly structured into following sub-sections:

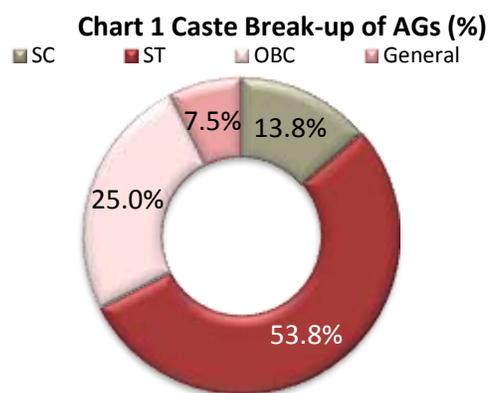
- i) Background information of the study respondents (Adolescent Girls and AWWs)
- ii) Training / orientation of service providers
- iii) Knowledge of service providers about AACP
- iv) Procurement and supply of IFA & De-worming
- v) Enrollment of adolescent girls by AWW
- vi) Formation of Balika Mandal and its function
- vii) Weight and height measurement of adolescent girls
- viii) Hemoglobin test of adolescent girls
- ix) IFA supplementation of adolescent girls
- x) De-worming of adolescent girls
- xi) IEC/BCC and Nutrition Education Sessions of adolescent girls
- xii) Compliance and monitoring of IFA supplementation
- xiii) Reporting by service providers at different levels

2.1 Background information of study respondents

As mentioned in the previous chapter, the study interviewed a number of service providers both from DW&CD and DH&FW operating at the State, District, Block, Sector & Sub-centre levels. Apart from them, the study also interviewed 80 adolescent girls and 16 AWWs at the AWC level. A brief profile of the adolescent girls and AWWs covered in the study is as follows.

2.1.1 Background profile of adolescent girls

The 80 adolescent girls interviewed in the study comprise of highest i.e. 43 (53.8%) Scheduled Tribes (ST) followed by 20 (25%) Other Backward Castes (OBC), 11 (13.8%) Scheduled Castes (SC) and the rest 6 (7.5%) General Castes.



The age wise break-up of AGs shows that majority i.e. 90% (72 out of 80) of adolescent girls covered in the study are in the age group of 14 to 18 years.

Only 6 (7.5%) adolescent girls were less than 14 years and 2 (2.5%) were within the age group of 18 to 19 years.

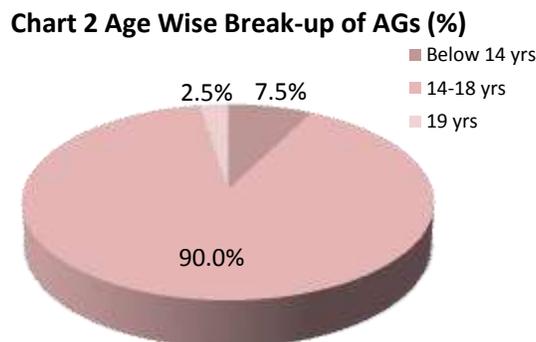
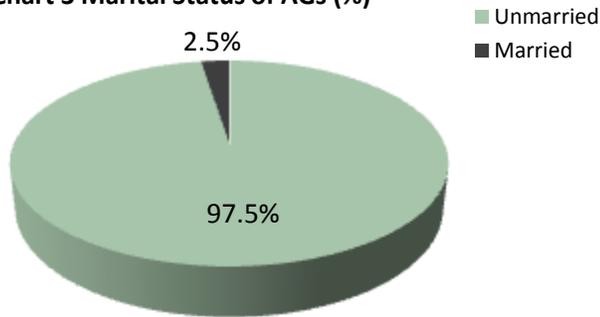
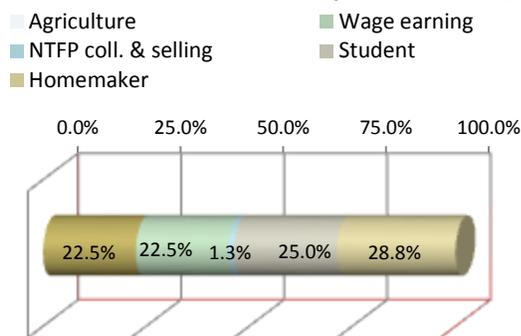


Chart 3 Marital Status of AGs (%)



Majority i.e. 97.5% (78 out of 80) of adolescent girls interviewed in the study were un-married and only the rest 2 (2.5%) were found to be married.

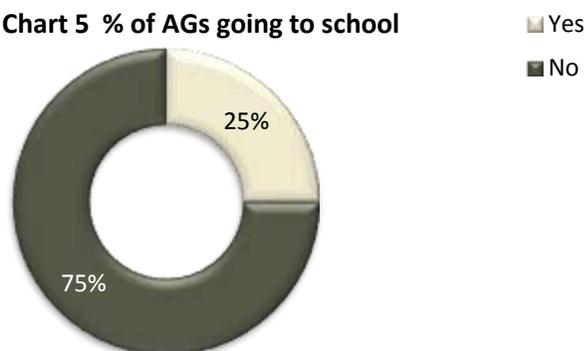
Chart 4 Occupation of AGs (in %)



As far as occupation of AGs is concerned, less than half i.e. 46.2% (37 out of 80) pursue any occupation. This comprises of 18 (22.5%) each engaged in daily wage labor and in agriculture. Only 1 (1.3%) is engaged in collection and selling of NTFPs. The rest 43 (53.8%) do not earn any income. 23 (28.8%) of them are homemaker or engaged in household chores and 20 (25%) are students who are currently going to school.

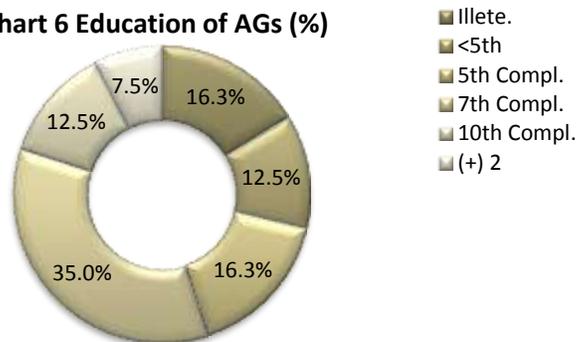
The educational status of adolescent girls presented

Chart 5 % of AGs going to school



in the graph below shows that highest i.e. 28 (35%) have completed 7th standard and 23 (28.8%) have studied up to 5th standard. There are 16 (20%) adolescent girls having education above 10th standard. Around, 16% (13 out of 80) of girls are

Chart 6 Education of AGs (%)



completely illiterate.

2.1.2 Background profile of AWWs

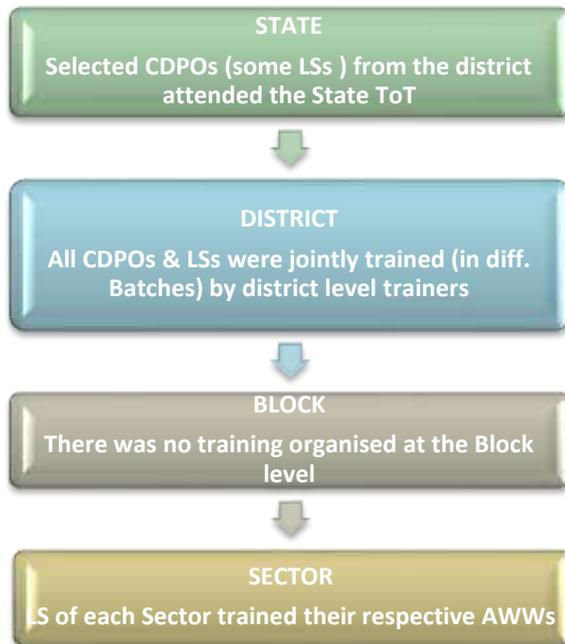
Out of the 16 AWWs interviewed, 15 have educational qualification of 7th standard or above. Again out of these 15 AWWs, 8 have educational qualification of 10th standard or above. Only one AWW has studied up to 5th standard.

All the 16 AWWs know about AACP and have attended the one day training organized on the same.

2.2 Training / orientation of service providers

Before execution of the program, the first task of the DW&CD and DH&FW was to orient / train the functionaries in the district on the processes of implementing different program components of AACP. So, as per the need, a one day State level Training of Trainers (ToT) was organized in March 2010 with the support from UNICEF. Selected ICDS functionaries (CDPOs and LSs) from the 9 program districts attended the same. The training focused on the need & importance of controlling Anaemia amongst adolescent girls followed by sessions on guidelines and processes of executing different

program components of AACP. The very purpose of the State level ToT was to see that the trainers in turn shall train all the CDPOs and LSs in their respective district.



After the State level ToT, a one day training of CDPOs and LSs was conducted in each study district. This district level ToT was conducted after a time gap of 3 to 4 months (during July 2010 in Bolangir and during August 2010 in Kalahandi and Nabarangpur)¹ from the date of State level ToT was organized. Only in Mayurbhanj, the district level training was organized in two batches due to more number of Blocks (26 Blocks) in the district.

Immediately after the completion of district level ToT, a one day training of AWWs was organized by the LSs in their respective sector. The training of AWWs in Kalahandi and Bolangir was undertaken in August 2010 and Nabarangpur was done in September 2010.

Following are some important assessments made with regard to the training of AWWs:

¹ In Mayurbhanj, the ICDS functionaries could not correctly recollect the month when the district level training was organized.

- According to the LSs interviewed in the study, some of the AWWs residing in remote pockets arrived late at the training venue for which there was delay in starting the training program.
- The training was undertaken for a maximum of 4 hours. It was started after 10am in the morning and was ended by the lunch time as the AWWs had to return their villages on the same day.
- In one of the Sectors in Kalahandi, the training of AWWs was done for only 2 hours.
- On an average, only 2 to 4 hours of training inputs were imparted to AWWs to explain all the program components of AACP.
- As reported by LSs and AWWs, the time period for the training was too short to explain and understand the key program components such as:
 - Process of forming Balika Mandal;
 - Distribution and filling-up of compliance card and AG tracking register;
 - Process to administer IFA supervised dose;
 - Initiation of 1st dose of Albendazole; etc.

The mini AWWs were not trained across all sectors covered in the study. It is important to note that the mini AWCs have been created in the tagged village of AWCs. So it is essential to train the mini AWWs for coverage of adolescent girls in the tagged villages.

But, more importantly, in none of the study districts the functionaries of Health were trained or associated during the training of ICDS functionaries carried out at district and sector levels. Also, there was no program launching workshop or meeting organized at the district and Block levels.

2.3 Knowledge & understanding of service providers about the program

Since the health functionaries were not sensitized or trained on AACP, it has clear reflection on their understanding about the program components and activities. Except the Technical Store Keeper (TSK) and

District Program Manager (DPM) of Bolangir and Mayurbhanj, the other key health functionaries interviewed viz. CDMO, MOIC, BPO and ANM lack clarity about the key program components of AACP such as:

- i) Weekly supervised IFA supplementation of adolescent girls
- ii) Bi-annual De-worming of adolescent girls
- iii) Hemoglobin tests and height & weight measurements of adolescent girls
- iv) Formation/activation of Balika Mandals and identifying peer educators
- v) Dietary education of adolescent girls

In contrast, the ICDS staffs particularly the CDPOs and LSs have clear understanding on the key program components of AACP as mentioned above.

But at the district level, the interview with DSWOs in 3 (Kalahandi, Nabarangapur and Mayurbhanj) out of 4 study districts reveals their lesser engagement in AACP. They do not have idea on how the key program components of AACP are being executed in the AWCs and the constraints faced by the AWWs. Also, for example, the DSWOs did not have information about the stock of IFA & Albendazole with AWWs, the status of hemoglobin tests and height/weight measurement of adolescent girls, the status of Balika Mandals formed and PEs identified, etc.

Most importantly, the AWWs who have been entrusted with the responsibility of executing the

program did not have understanding on following key program areas (in the 16 AWCs visited by the study team).

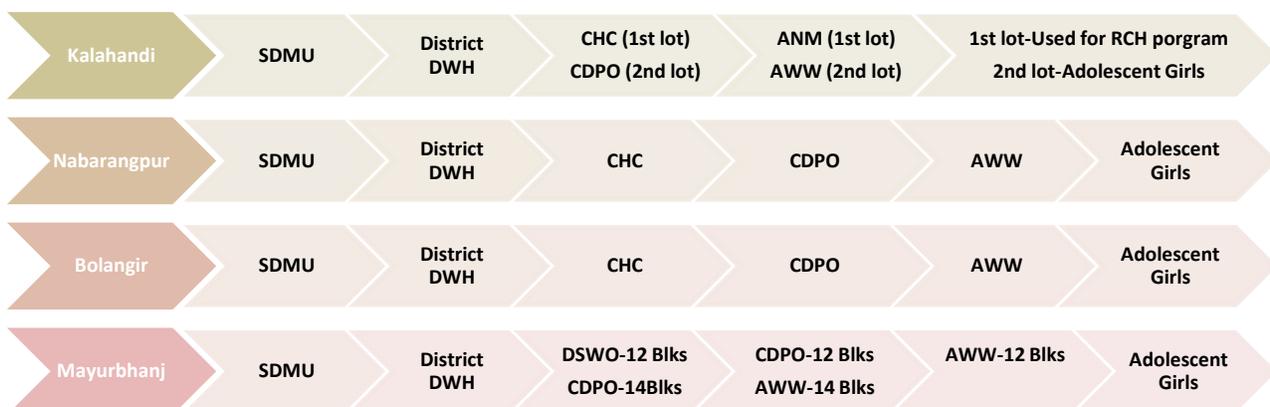
- i) How and when to initiate the 1st dose of IFA Supplementation and De-worming?
- ii) Need of identifying PEs in Balika Mandal and process of engaging them to mobilize and educate adolescent girls
- iii) How to maintain the Compliance Tracking Register?
- iv) Confusion on IFA supplementation of school going girls
- v) Key messages need to be communicated on dietary education / NHED

Improper training and supportive supervision of AWWs by the concerned LSs could be attributed as primary reasons of not having clarity on key program areas.

2.4 Procurement and Supply of IFA and Albendazole Tablets

The execution of AACP largely depends on timely supply of IFA and Albendazole tablets in required quantity to the AWCs. Thus, one of the important tasks before the study was to understand the procurement and supply process of IFA and De-worming tablets and find out any gaps or constraints therein. The details of the same are presented in a matrix form in the next page of the report.

DISTRICT WISE CHANNELS / ROUTES USED FOR SUPPLY OF IFA AND ALBENDAZOLE



PROCESS OF PROCUREMENT AND SUPPLY OF IFA AND ALBENDAZOLE TABLETS					
Procurement & Supply of IFA & Albendazole	State to District	<ul style="list-style-type: none"> The State NRHM placed the office order and budget to SDMU under AACP in late 2009 for procurement of IFA and Albendazole tablets for a period of one year. District wise IFA requirement was given by DW&CD to DH&FW which was then given to SDMU for supply SDMU procured the IFA in January 2010 and supplied it to the District Drug Ware House (DWH) in 9 program districts in February 2010. After IFA, the SDMU could not procure Albendazole due to some internal reason. The left out fund for non-procurement of Albendazole was returned back to the NRHM in August 2010. Thus, the districts were advised to distribute the Albendazole to ICDS from their stock. 			
		Kalahandi	Nabarangapur	Bolangir	Mayurbhanj
Supply of IFA Tablets	District to Block	<ul style="list-style-type: none"> Received 3,225,900 IFA Tablets by District DWH The supply of IFA was recorded by DWH in drug receipt register but the purpose / program head of supply was not recorded in the register A major quantum of IFA was then supplied (1st lot) to the Block CHCs without mention of the purpose of its supply Afterwards, on being enquired by the DSWO, the remaining IFA (small quantity) (2nd lot) was then supplied to CDPOs Since only a small quantity of IFA supplied, it was decided at DSWO level to equally divide among AWCs 	<ul style="list-style-type: none"> Received 3,462,900 IFA Tablets by District DWH Recorded in the receipt register with clear mention of the purpose / program head DWH distributed it to the CHCs 	<ul style="list-style-type: none"> Received 5,456,000 IFA Tablets by District DWH Recorded in the receipt register with clear mention of the program head DWH distributed it to the CHCs 	<ul style="list-style-type: none"> Received 5,941,900 IFA Tablets by District DWH Recorded in the receipt register with clear mention of the program head DWH distributed it to the DSWO for 12 Blocks and to CDPOs for 14 Blocks
	Block to AWCs	<ul style="list-style-type: none"> CHCs received the 1st lot of IFA after a time gap of 4 months (June'10) & then supplied to ANM without knowing the purpose The ANM then used it for RCH program instead of AACP The 2nd lot was directly supplied to CDPOs after 8 months (in Oct'10) who in turn supplied to AWWs through LSs Each AWC was given equal quantum of IFA (only 300 tablets per AWC) irrespective of need On an average, each AWC received IFA for approximately two & half months only 	<ul style="list-style-type: none"> CHCs received IFA after a time gap of 4 months and then supplied to CDPOs The CDPOs received the IFA after 7 months (in Sep'10) gap from the date of receipt by DWH. It was then supplied to the AWWs through LSs 1000-1500 IFAs was given to AWCs having larger population and 500-1000 to AWCs with smaller population Approximately only 4 to 5 months of IFA supply was made 	<ul style="list-style-type: none"> CHCs received IFA after a time gap of 10 months & then supplied to CDPOs The CDPOs received the IFA after same 10 months (in Sep'10) gap from the date of receipt by DWH. It was then supplied to the AWWs through LSs On an average, each AWC was supplied only 1000 IFA tablets That was approximately for 4 to 6 months 	<ul style="list-style-type: none"> CDPOs received IFA after a time gap of only 1 month (Mar'10) from the date of receipt by DWH and then supplied to the AWWs through LSs Each AWC received IFA for 1 year period on the basis of no. of adolescent girls in the AWC
Supply of Albendazole Tablets	District to Block & then to AWC	<ul style="list-style-type: none"> The District DWH supplied the Albendazole to CDPOs from its own stock The supply chain pattern of Albendazole from District to Block and then to AWCs was same as in case of supply of IFA The AWCs were given 100 Albendazole tablets each 	<ul style="list-style-type: none"> There was no stock with the District DWH, hence, the Albendazole tablets were not supplied 	<ul style="list-style-type: none"> The District DWH supplied the Albendazole to CDPOs from its own stock The supply chain pattern of Albendazole from District to Block and then to AWCs was same as IFA The AWCs were given 100 Albendazole tablets each 	<ul style="list-style-type: none"> The District DWH supplied the Albendazole to CDPOs from its own stock on the basis of no. of adolescent girls in the project which in turn was supplied to AWCs

The processes presented in the previous page on procurement and supply of IFA and Albendazole tablets insinuates the following key findings:

- Timely procurement and supply of IFA was made by SDMU but there was delay by District DWHs in Kalahandi (4months gap), Bolangir (10months gap) and Nabarangapur (7 months gap) to supply it to Blocks.
- Albendazole was not supplied to districts. The District DWH managed from its own stock except in Nabarangpur where there was no stock.
- Although the SDMU supplied IFA for 1 year, the AWCs at the end received IFA for a period ranging from 2 to 6 months except in Mayurbhanj district.
- Multi channels / routes were used for supply of IFA (e.g. in Kalahandi the DWH first supplied it to CHC and 2nd time directly supplied to CDPOs; in Mayurbhanj a part of IFA was given to DSWO and another to CDPOs of 14 Blocks; in Bolangir & Nabarangapur it was supplied to CHC who in turn supplied to CDPOs). There was no uniformity and systematic procedure followed for supply of IFA.
- At the time of study in July'11, only 2 AWCs in Bolangir and 3 AWCs in Nabarangapur had the IFA stock ranging from 40 to 1960 tablets out of the 16 AWCs visited by the study team. This includes the IFA provided by ANM under other program.
- None of the AWCs covered in Kalahandi and Mayurbhanj had the IFA stock at the time of study.
- Albendazole tablets were not supplied in Nabarangapur. The AWCs in Kalahandi and Bolangir were given only 100 tablets each.

2.5 Enrollment of adolescent girls by AWW

The status of enrollment of adolescent girls in the 16 AWCs visited by the study team is presented in Table 3. Highest i.e. 96% (233 out of 244) of adolescent girls were enrolled with AWW in Bolangir followed by 82% (102 out of 124) in Mayurbhanj for supplementation of IFA. Lowest enrollment was found in Kalahandi (29%, 112 out of 386) and Nabarangpur (41.4%, 169 out of

408) districts. Non-inclusion of school going girls and engagement of girls in wage earning were found to be the main causes of low enrollment.

District	No. of AWC covered	Total No. of AGs in AWC	No. of AGs Enrolled	
Kalahandi	4	386	112	*100% enrollment in 1 AWC *School going AGs not enrolled in 3 AWC
Bolangir	4	243	233	*100% enrollment in 3 AWCs *10 AGs in the age of 11yrs are yet to be enrolled in 1 AWC
Nabarangpur	4	408	169	*100% enrollment in 2 AWCs *AGs in 1 AWC not turning up for enrollment *Some AGs stay in hostel and some others engaged in wage-earning in 1 AWC
Mayurbhanj	4	124	102	*100% enrollment in 2 AWCs *Married AGs and School going AGs not enrolled in 1 AWC each

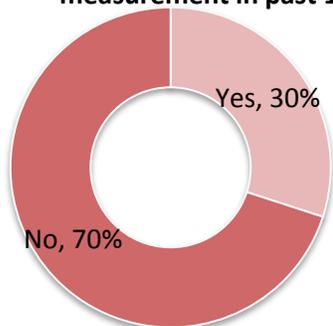
Source: AWC register

In 3 AWCs in Kalahandi and 1 AWC in Mayurbhanj, the school going girls were not enrolled. But, interestingly, they were enrolled in other AWCs visited in the same districts. That means a uniform message was not given to the AWWs on the enrollment of school going girls. Absence of adolescent girls at homes was the other important cause of non-enrollment, which creates difficulty for the AWW to enroll them under the program.

2.6 Weight and height measurement of adolescent girls

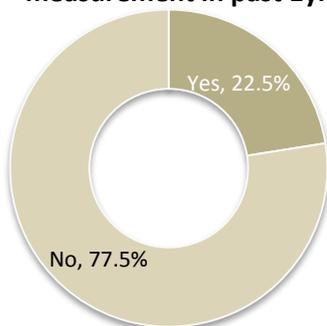
The study findings reveal that the weight of only 30% (24 out of 80) of adolescent girls was measured in the AWCs visited by the study team. Non-availability of adult weighing machine at most of the AWCs was one of the important reasons for which a large

Chart 7 % of AGs undergone weight measurement in past 1yr



number of adolescent girls were not weighed under AACP. Interesting to mention, none of the 307 AWCs in Umerkote Block of Nabarangapur district had the weight measurement machine for adults.

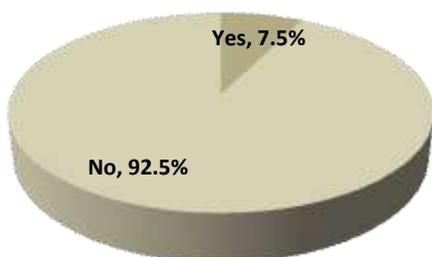
Chart 8 % of AGs undergone height measurement in past 1yr



The height of relatively higher percentage of adolescent girls (77.5%) was not measured in the AWCs. None of the AWWs interviewed in the study was supplied with height measuring tapes.

2.7 Hemoglobin test of adolescent girls

Chart 9 % AGs had Hemoglobin test at AWC



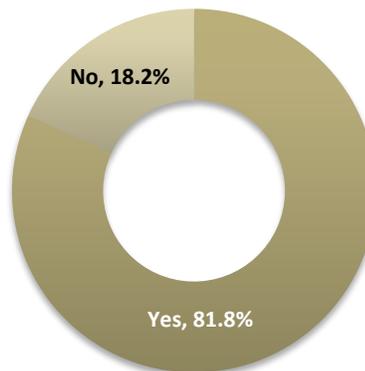
Out of the 80 adolescent girls interviewed in the study, only 6 (7.5%) were examined hemoglobin by the ANM. The hemoglobin test of majority i.e. 92.5% of adolescent girls was not examined. The following reasons were cited by the ANMs for not undertaking the hemoglobin test of adolescent girls:

- There was no official communication to ANMs for testing of hemoglobin of adolescent girls
- Dysfunctional hemoglobin meter (2 out of 8 ANMs interviewed)
- Finish up of the liquid solution required in the hemoglobin meter (2 out of 8 ANMs)

2.8 IFA supplementation of adolescent girls

The study findings in Chart 10 shows that maximum i.e. 65 (81.8%) adolescent girls were supplemented with IFA at least once by the AWW. Out of them, highest i.e. 18 (27.7%) were given 10 or less number of tablets followed by 16 (24.6%) were given 21 to

Chart 10 % AGs was supplemented with IFA



50 tablets and 13 (20.6%) were provided 11 to 20 tablets. 6 (9.2%) adolescent girls reported receipt of 51 to 150 tablets.

It is clear from the above data that a large number of adolescent girls were distributed IFA for consumption at their homes particularly those who were given 50 or more tablets.

No. of Tablets	No. of AGs	%
10 or less	18	27.7%
11-20	13	20.0%
21-50	16	24.6%
51-150	6	9.2%
1 bottle of liquid IFA	6	9.2%
Don't remember	6	9.2%
Total	65	100.0%

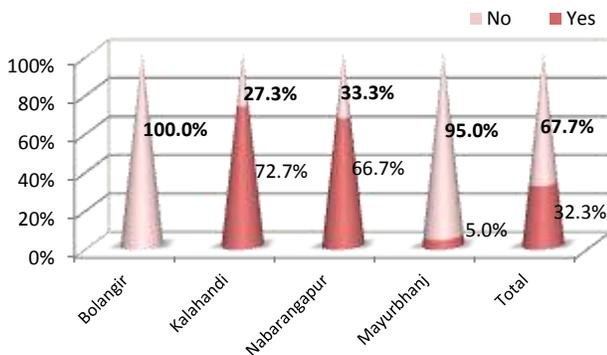
Interestingly, the liquid IFA supplied for children (<2yrs) is given to 6 (9.2%) adolescent girls (1 bottle each) interviewed in Mayurbhanj district.

None of the AWCs covered in Bolangir and Mayurbhanj initiated the 1st dose of IFA to adolescent girls during VHND. In the rest 2 districts viz. Kalahandi and Nabarangapur, only 2 out of 8 AWCs initiated the 1st doses of IFA during VHND. The remaining 6 initiated the same on a Saturday of the week.

More importantly, the study reveals that only 32.3% (21 out of 65) of adolescent girls were supplemented with IFA under the direct supervision of AWWs whereas almost two third i.e. 67.7% (44 girls) were distributed IFA for self consumption at their home. Instead of giving weekly supervised IFA dose, the adolescent girls in Bolangir and Mayurbhanj were distributed 50 IFA tablets each (for one year) for self-consumption at home (came out during the FGD). The Chart 11 also shows that 100% of adolescent girls interviewed in Bolangir and 95% in Mayurbhanj were distributed IFA tablets for self consumption at their home.

Unlike these two districts, a greater percentage in

Chart 11 % of AGs consumed IFA tablet under the direct supervision of AWW (District-wise)



Kalahandi (8 out of 11, 72.7%) and Nabarangpur (12 out of 18, 66.7%) were given supervised IFA dose. But it is important to remember that only 11 out of 20 girls interviewed in Kalahandi were supplemented with IFA.

Frequency	Count	Column %
Daily	5	7.7
Weekly	40	61.5
Monthly	2	3.1
Occasionally	17	26.2
Twice a day	1	1.5
Total	65	100.0

Again, out of the 65 girls supplemented with IFA, nearly two third i.e. 61.5% (40) consumed the same on weekly basis. One fourth i.e. 17 (26.2%) of adolescent girls consumed the IFA occasionally.

Following are some of the important factors that led to lesser percentage of adolescent girls had supervised IFA doses (informed by the AWWs and adolescent girls).

- Non-availability of adolescent girls at their home due to their economic engagement
- Less frequent visit by the AWW to mobilize the adolescent girls staying in the distant hamlets
- The IFA tablets distributed to adolescent girls by the AWWs were not consumed regularly
- The girls find difficulty to remember the next date on which they have to consume the IFA
- Less importance to consuming IFA due to lack of awareness

2.9 De-worming of adolescent girls

In comparison to 81.3% of adolescent girls given IFA supplementation, much lesser i.e. only 40% (32 out of 80) were provided Albendazole tablet for de-worming. As mentioned earlier, Albendazole tablets were not supplied from the State under AACP. So 3

out of 4 study districts (Bolangir, Kalahandi and Mayurbhanj) managed a part of the Albendazole requirements from their own stock. In rest one district (i.e. Nabarangapur) there was no stock for which it could not be supplied to the AWCs.

Chart 12 % of AGs provided Albendazole tablet for de-worming (district-wise)

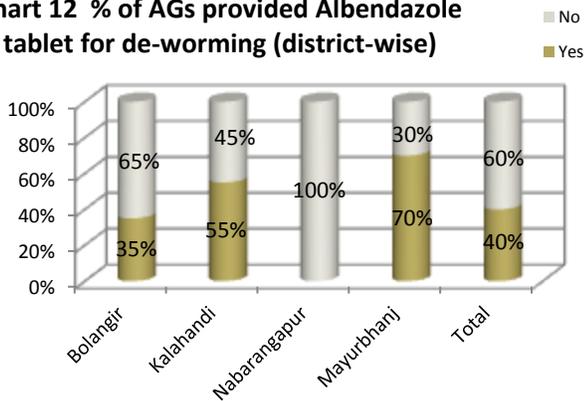
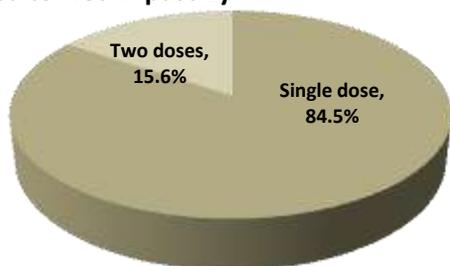


Chart 12 also shows that all the 20 (100%) girls interviewed in Nabarangpur were not given Albendazole tablets for de-worming whereas highest i.e. 70% (14 out of 20) of girls in Mayurbhanj followed by 55% (11 out of 20) in Kalahandi and only 35% (7 out of 20) in Bolangir were given Albendazole tablets.

The study findings also reveal that the Albendazole tablet/s was/were consumed by all the 32 adolescent girls who were provided the same. Out of them, majority i.e. 27 (84.4%) were given single dose and 5 (15.6%) were given two doses of Albendazole (de-worming) since the start of the program.

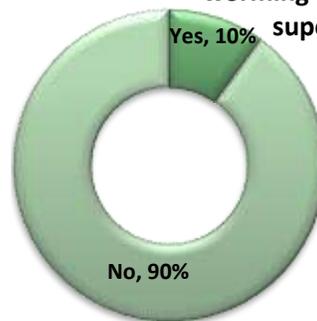
Chart 13 No. of times Albendazole administered to AGs in past 1yr



The study findings also reveal, while 40% (32) were given Albendazole tablets, only 10% (8 out of 32) consumed the same under the direct supervision of

AWWs. More importantly, these 8 adolescent girls are only from the Kalahandi district. None of them in rest two districts (viz. Bolangir and Mayurbhanj) was given supervised Albendazole for de-worming.

Chart 14 % of AGs consumed de-worming tablet under the direct supervision of AWW



Apart from the above findings, the following few important observations were made during the visit to AWCs with regard to de-worming of adolescent girls:

- Since the Albendazole was supplied after the IFA received by the AWWs, the adolescent girls were given the same after initiation of IFA.
- At least 6 out of 16 AWWs were ignorant about the need to have de-worming before the start of IFA supplementation.
- None of the AWCs provided Albendazole in the fixed months (viz. July and December) of the year.
- None of the AWCs have the stock of Albendazole tablets at the time of study.
- In Nabarangapur, the ANM instead of bi-annual de-worming administered Albendazole tablets on quarterly basis under the School Health Program.

2.10 Formation of Balika Mandal and Identification of PEs

As informed by the AWWs, Balika Mandals have been formed in 8 (50%) out of 16 AWCs covered in the study. But the interview carried out with adolescent girls reveals that only 6 (37.5%) AWCs have Balika Mandal.

Out of 80 girls interviewed, only 16 (20%) reported the existence of Balika Mandal in their village. More importantly, all the 20 adolescent girls in Mayurbhanj and 19 in Bolangir reported the non-existence of Balika Mandal in their village.

Since most of the AWCs did not have Balika Mandal, only 19% (15 out of 80) of girls are members of the same. Out of them, 13 informed that the meeting of Balika Mandal was held. Again out of these 13 girls, 11 reported weekly meeting and only 2 informed monthly meeting of Balika Mandal held.

During weekly supervised IFA supplementation, the AWW holds discussion with the girls on hygienic practices; importance of IFA; healthy dietary practices; timely IFA supplementation; etc. which was considered by them as the meeting of Balika Mandal. But the monthly meeting of Balika Mandal was not practiced in any of the AWCs covered in the study.

The PE has been identified in only 3 AWCs as reported by the AWWs. Interestingly, only 1 out of 80 adolescent girls covered in the study acts as PE in the Balika Mandal.

In brief, due emphasis was not given by the AWWs and Ls for formation and strengthening of Balika Mandal and identification of PEs amongst the members of Balika Mandal.

2.11 IEC/BCC/Nutrition Education Sessions of adolescent girls

Along with IFA supplementation, nutrition education of adolescent girls is one of the important interventions planned under AACP. It was decided at the State level that UNICEF will provide the IEC materials to AWW and adolescent girls for their nutrition education. In this regard, two Anaemia booklets were developed by UNICEF, one for the AWWs and another for the adolescent girls.

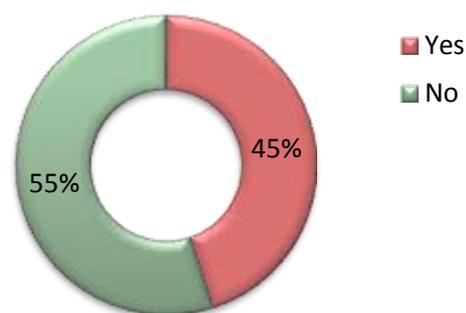
But as per the information gathered during the visit to AWCs, only the Anaemia booklet was provided to the AWWs whereas the adolescent girls were not given any such booklet.

Apart from the supply of IEC/BCC materials, one of the key responsibilities entrusted on AWW is to hold monthly nutrition education session of all the adolescent girls in the AWC. However, the same was not conducted in the AWCs visited in Bolangir and Mayurbhanj districts. In other two study districts (viz. Kalahandi and Nabarangapur) the nutrition education session was conducted during the meeting of Balika Mandal, as informed by the AWWs in 5 out of 8 AWCs visited by the study team.

But when it was cross verified with the adolescent girls, the study team came to know that the discussions held during weekly IFA supplementation was reported by them as the nutrition education session of adolescent girls. But except that, no such formal monthly meeting / session was conducted for nutrition education of adolescent girls.

Therefore, as many as 44 (55%) out of 80 adolescent girls covered in the study never heard the word 'Anaemia' or 'Rakta Hinata' before.

Chart 15 % of AGs knows about Anemia



21 (26.3%) reported 'lack of proper dietary intake', 18 (22.5%) informed 'too much loss of blood' and 11 (13.8%) said 'vitamin deficiency' as the main cause of Anaemia. Interestingly, only 3 (3.8%) knows 'iron deficiency' as the primary cause of Anaemia.

Table 6 Causes of Anaemia reported by AGs

Causes	Count	%
Too much loss of blood	18	22.5%
Iron deficiency	3	3.8%
Vitamin deficiency	11	13.8%
Any under lying disease / infection	2	2.5%
Lack of proper dietary intake	21	26.3%
Don't Know about Anaemia	44	55.0%
Total	80	

Note: Multi response table

Among the various symptoms of Anaemia reported by adolescent girls, 'weakness' was told by the maximum i.e. 31 (38.8%).

Table 7 Symptoms of Anaemia reported by AGs

Symptoms	Count	%
Fatigue (very common)	5	6.3%
Weakness (very common)	31	38.8%
Dizziness	4	5.0%
Headache	9	11.3%
Numbness or coldness in your hands and feet	1	1.3%
Pale skin	9	11.3%
Chest pain	2	2.5%
Irritability not doing well at work	4	5.0%
Don't Know about Anaemia	44	55.0%
Total	80	

Note: Multi response table

'IFA supplementation' was reported by 28 (35%) and 'proper dietary intake' was informed by 25 (31%) adolescent girls as the steps to address Anaemia. So, only 35% of girls know that the supplementation of IFA would help to overcome Anaemia.

Table 8 Steps to address Anaemia reported by AGs

Steps	Count	%
IFA Supplementation	28	35.0%
Proper dietary intake	25	31.3%
Treatment of illness	1	1.3%
Taking vitamins	1	1.3%
Don't Know about Anaemia	44	55.0%
Total	80	

Note: Multi response table

Lack of educative sessions of adolescent girls could be the reason as more than half i.e. 47 (58.8%) did not know the frequency of consuming the IFA. 29 (36.3%) reported weekly, 3 (3.8%) reported daily and 1 (1.3%) informed monthly supplementation of IFA should be made to address Anaemia.

Table 9 Frequency of IFA needs to be consumed as understood by AGs

Frequency	Count	%
Daily	3	3.8%
Weekly	29	36.3%
Monthly	1	1.3%
Don't Know	47	58.8%
Total	80	

Note: Multi response table

More importantly, 95% (76 out of 80) of adolescent girls did not have idea about the frequency in which the Albendazole tablets should be consumed.

Table 10 Frequency of Albendazole needs to be consumed for de-worming as understood by AGs

Frequency	Count	%
Weekly	1	1.3%
Annually	1	1.3%
Bi-annually	2	2.5%
Do not know	76	95.0%
Total	80	100.0%

Apart from the above, the study also made an effort to assess the impact of educative sessions on the sanitary practices of adolescent girls during menstruation. However, since there was not much educative sessions held, it was not useful for the study to assess the impact of the same. Nonetheless, the responses of adolescent girls were collected on this. Out of the 77 girls attained menarche, 72 (93.5%) use cloth during menstruation whereas only 4 (5.2%) use sanitary napkin. The rest 1 (1.3%) girl uses both.

Table 11 Sanitary practices during menstruation by AGs

Practices	Count	%
Use Cloth	72	93.5%

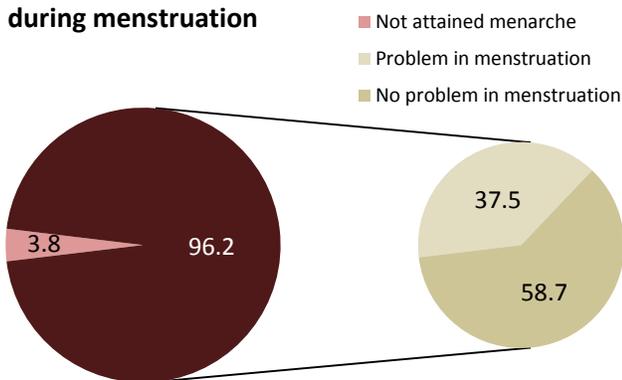
Practices	Count	%
Use Sanitary Napkins	4	5.2%
Use Cloth	1	1.3%
Total	77	

Note: Multi response table

While majority uses cloth during menstruation, cleanliness of the same was maintained by all during the menstruation, as informed by both adolescent girls and their mothers during the focused group discussions.

The study also captured information on the problems faced by the adolescent girls during menstruation. Chart 16 shows that out of 77 (96.3%) adolescent girls attained menarche, 30 (37.5%) had problem during menstruation.

Chart 16 % of AGs have attained menarche and any problem faced during menstruation



The various problems faced during menstruation are listed in Table 12. Highest i.e. 14 (46.7%) out of 30 adolescent girls reported painful periods followed by 12 (40%) complained about abdominal pain during menstruation. 7 (23.3%) reported irregular periods and 3 (10%) had problem of frequent / short period.

Problems	Count	%
Painful periods	14	46.7%

Problems	Count	%
Frequent or short periods	3	10.0%
Irregular periods	7	23.3%
Prolonged bleeding	1	3.3%
Scanty bleeding	1	3.3%
Blood clots/ excessive bleeding	1	3.3%
Chest pain	1	3.3%
Abdominal pain	12	40.0%
Total	30	

Note: Multi response table

The problems faced by the adolescent girls during their menstruation are as follows (captured during the FGD with girls and their mothers):

- Prolonged and heavy bleeding during menstruation
- Frequent (2 to 3) menstrual periods in a month
- Some AGs face infrequent menstruation, once in two or three or six months
- Vomiting tendency felt during menstruation
- Weakness, restless, tiredness, numbness of hand & feet and abdominal pain
- Fever, head reeling, nausea and joint pain
- Lack of interest to work

2.12 Compliance and monitoring of IFA supplementation

Apart from the educative sessions, it is important for the program that the compliance of IFA supplementation is made by the AWW with the adolescent girls to ensure timely supplementation of IFA by them and the tracking of the same.

Accordingly, the provision of Self Compliance Card for adolescent girls and Compliance Tracking Register for AWWs was introduced with the support from UNICEF.

The information collected on this reveals that the adolescent girls in 12 out of 16 AWCs were provided with the Self Compliance Card. In the 2 AWCs visited each in Thakurmunda and Lanjigarh Blocks, the Self

Compliance Card was not provided to the adolescent girls. This can be further corroborated from the fact that only 31% of adolescent girls interviewed in the study received the Self Compliance Card.

However, the Self Compliance Card was filled up by the AWWs instead of filling-up by the adolescent girls. The AWWs instructed the adolescent girls to bring the card with them during weekly supervised IFA supplementation so that she can fill-up the same after the supplementation. It was practiced in all the 12 AWCs where the Self Compliance Card was given. Interestingly, in an AWC visited by the study team in Umerkote Block of Nabarangapur district the AWW used *Bindi* for filling-up the rounded box in the self compliance card.

The Compliance Tracking Register to AWWs was provided in 13 out of 16 AWCs covered in the study. None of the AWWs interviewed in Thakurmunda Block and one AWW in Umerkote Block did not receive the same. But, out of those 13 AWWs received the register, only 3 filled-up the same properly and updated it on a regular basis.



In Lanjigarh Block, one of the AWWs interviewed did not know about the page where de-worming of adolescent girls is to be recorded in the register. Also it was observed by the study team that 10 out of 13 AWWs discontinued filling up the register. The AWWs across all the 13 AWCs lack required skill and understanding to fill-up the compliance register.

The study team also found that there is no scope to record the receipt of IFA and Albendazole tablets in the compliance register. So, the AWWs and LSs find difficulty to track the utilization of the same.

2.13 Reporting by service providers at different levels

As per the guideline, the AWW prepares monthly report on IFA supplementation of adolescent girls and submits it to the LS. The format prescribed in the guideline was used by all the 16 AWWs for reporting.



However, the study team observed that the actual number of adolescent girls supplemented with IFA was not reported. In all the AWCs visited, the AWWs multiply the number of adolescent girls enrolled with 4 tablets per girl and report the figure to LS in every month.

The LS in turn consolidates the monthly report of all the AWCs in her sector and then submits the sector report to the CDPO in the same reporting format used by the AWW. Likewise, the CDPO consolidates the report of all the Sectors in the project and prepares the monthly report of the project and submits to the DSWO.

But, except the reporting tool for AWW, no such tool was introduced at the Sector and Project level for monthly reporting of IFA supplementation to adolescent girls.

Chapter - III

3. Recommendations and Concluding Remarks

3.1 Key Challenges and Recommendations

The study findings presented in the previous section not only brings out the various initiatives taken up under AACP for IFA supplementation of adolescent girls but also identifies certain operational gaps or difficulties in execution of the program. Based on the operational gaps and difficulties, the study has identified here the key challenges faced by the program and has suggested some possible measures to overcome the same challenges. It is important to mention that the recommendations made here are based on the expectations and suggestion of the beneficiaries; and the service providers of both DW&CD and DH&FW engaged in AACP. The key challenges and recommendations are presented in the matrix below:

Sl. No.	Key Challenges	Recommendations
1	Lack of uniformity in implementation of AACP across Districts / Projects / Sectors / AWCs	<ul style="list-style-type: none"> ➤ There is a need of clear and specific guidelines on implementation of various program components such as: <ul style="list-style-type: none"> - Capacity Building of Service Providers - Supply chain process of IFA & Albendazole - Process of IFA Supplementation and De-worming - IEC/BCC Process - Roles & Responsibilities of Service Providers (DH&FW and W&CD) - Compliance Mechanism - Supportive Supervision and Monitoring - Reporting
	Providers lack required understanding on program components	<ul style="list-style-type: none"> ➤ AACP Program launching workshop needs to be held at the State, District and Block level in presence of State, District and Block Administration (the

Sl. No.	Key Challenges	Recommendations
	(CDMO, MOIC, DPMU, TSK, BPMU and ANM from Health and DSWO and AWW from ICDS)	<p>program launching should be made using campaign mode which would help to generate awareness among the target beneficiaries on AACP).</p> <ul style="list-style-type: none"> ➤ At least 2 days of joint training of Health and ICDS needs to be conducted at the District and Block levels for bringing clarity on program components and their roles in the same. ➤ At least 1 day training of AWWs in each Sector requires to be organized (ANMs in each sector may be asked to join the training) ➤ Quality supervision of the training of AWWs should be made through CDPO, MOIC and BPMU.
	Establishment of prudent IFA & Albendazole Supply chain mechanism	<ul style="list-style-type: none"> ➤ The program needs to adopt a bottom-up approach instead of top down approach for knowing the IFA requirements of an AWC, Sector, Project and District. The ANM of Health Dept. requires to be engaged in the process of assessing IFA requirement. ➤ There is a need to introduce proper indenting procedure and tool at starting from AWC to State level (IFA: Quarterly indenting by AWC and Annual indenting at Project and District level) (Albendazole: Half yearly indenting by AWC and Annual indenting at Project and District level) ➤ Delay in procurement of IFA & Albendazole by SDMU may be avoided (procurement process may be started at least 6 months before the completion of stock to avoid any delay) ➤ After receiving the supply of IFA from SDMU, the TSK may directly supply the same to the Projects (CDPOs) under joint approval of DSWO and CDMO (the TSK may avoid supply to

Sl. No.	Key Challenges	Recommendations
		<p>DSWO or CHC/PHC)</p> <ul style="list-style-type: none"> ➤ Respective Sector LS may be instructed to collect their requirement of IFA on placement of indent from CDPO on quarterly basis and Albendazole on half yearly basis (there needs to be stock taking by LS in every month at AWC) ➤ Storing arrangements of IFA and Albendazole tablets at the Project and AWC level may be made. ➤ The Block health administration may avoid supply of IFA from ANM to AWWs. ➤ There is a need to follow single route of supply to avoid any confusion of supplying IFA from different routes.
	Complete enrollment of AGs in the AWC	<ul style="list-style-type: none"> ➤ Irrespective of School Going and Non-School Going girls, all AGs in an AWC needs to be enrolled and covered under AACCP through AWW. ➤ AWW may be entrusted with the responsibility of covering residential school, if it is located in her AWC.
	Weight & Height Measurement and Hemoglobin Testing of all AGs	<ul style="list-style-type: none"> ➤ AWWs may be engaged under close supervision of LS for measurement of weight & height of AGs regularly as per the guideline. ➤ Height measuring instrument or measuring tape should be provided to the AWWs. ➤ Office order may be issued by CDMO for hemoglobin testing of all AGs by the ANM regularly as per the guideline (Hemoglobin meter and extra liquid solution needs to be provided to ANM for the same) ➤ AWWs need to be oriented on time to time assessment of the growth and hemoglobin level of AGs and educating the AGs on the same.
	Supervised weekly IFA Supplementation and Bi-annual De-worming to AGs	<ul style="list-style-type: none"> ➤ Focus should be on consumption of IFA by the adolescent girls ➤ LSs need to help the AWWs to develop proper community level strategy for IFA supplementation keeping in mind the local context. ➤ Instead of Saturday, the AWW may be allowed to fix-up the day

Sl. No.	Key Challenges	Recommendations
		<p>for Weekly IFA supplementation keeping in mind the suitability of adolescent girls. As suggested by adolescent girls and mothers that weekly market day would be appropriate for the same as majority on that day stay in the village do not go for wage earning or other activities.</p> <ul style="list-style-type: none"> ➤ The AWW may take visit to the distant hamlets for supervised IFA supplementation instead of asking adolescent girls to visit the AWC for the same (visit should be made on a fixed day and time suitable to the girls) – This would help in increasing coverage and avoid LOs/DOs. ➤ Balika Mandals needs to be formed in all AWCs (flexibility may be given to AWW to identify the number of Balika Mandals need to be formed in an AWC) and PEs in each Balika Mandal should be identified (savings, credit and vocational activities may be initiated in the Balika Mandal with support from other line departments for sustainability of the same which in turn would also help in regular IFA supplementation). ➤ Every week one adolescent girl in the Balika Mandal may be entrusted with the responsibility of mobilizing all the members under the leadership of PE for weekly supervised dose. ➤ Reward system for PEs and members of Balika Mandal for their active role and regular IFA supplementation.
	Awareness generation and sensitization of AGs and their Mothers for IFA supplementation and Hygienic practices	<ul style="list-style-type: none"> ➤ Regular monthly meeting of adolescent girls needs to be conducted by the AWW (AWW should be properly trained by LS for use of IEC/BCC materials to facilitate the NHED session of adolescent girls) ➤ Village level fun fair, Simulations, Game, Ice Breaking Exercises, Interactive Discussions, etc. should be taken up during NHED session in order to keep and sustain the interest of adolescent girls and to educate their mothers. ➤ District and Block level

Sl. No.	Key Challenges	Recommendations
		networking and exchange program of adolescent girls may be organized periodically.
Other Recommendations		
<ul style="list-style-type: none"> ➤ Proper orientation of AGs needs to be undertaken for correctly filling-up the compliance card (reward system for regular filling-up of card without the support of AWW) ➤ AWW needs to be properly oriented on how to fill-up the AWC Compliance Tracking Register ➤ There should be scope for keeping records of the IFA received in the compliance tracking register of AWW. ➤ Reward mechanism needs to be kept for best performing AWWs under AACP. ➤ Reporting tool at LS and Block should be introduced. ➤ Joint review meeting of AACP at Sector, Block and District may be introduced by Health and ICDS. ➤ Incentives for AWW may be provided under AACP. ➤ The GKS needs to be empowered and engaged for monitoring of AACP at the AWC. ➤ Supportive supervision and monitoring by LSs should be undertaken to handhold and support AWW on the execution of the program (CDPO needs to take active role for ensure the effective engagement of LS with the AWW). 		

3.2 Concluding Remarks

Initiated in late 2009, the Adolescent Anaemia Control Program (AACP) has completed one and half year of implementation in the 9 districts (KBK and Mayurbhanj districts) of Orissa. So, this quick assessment of the program was carried out in 4 program districts to strengthen and improve the operational modalities of AACP for scaling up to other 21 districts of Orissa. The findings of the assessment presented in the previous chapter has brought out lot of insights and learning to strengthen or improve the IFA supplementation of adolescent girls in the State.

The first and foremost learning that the study findings insinuate is about greater involvement of health functionaries in the program. Particularly at the district, Block and Sub-centre level, the health functionaries need to be sensitized or provided training for their greater involvement in the program. More importantly, the assessment reveals that the AWWs did not have clarity on program execution due to their improper training. So it is essential that the capacity of AWWs should be developed through training and supportive supervision by the LSs.

Besides improving the knowledge of providers, the program requires to streamline the gaps in the supply chain of IFA and Albendazole tablets. Instead of top-down approach, there is a need to apply bottom-up approach for knowing the IFA requirements of an AWC, Sector, Block and District so that adequate quantity of IFA can be provided to AWCs. The confusion at the DWH can be avoided by clear mention of the program head for which the IFA was received and by proper mechanism for onward distribution of IFA to AWCs. Instead of supplying IFA through different channels, the DWH may directly distribute the IFA to CDPOs which in turn can be provided to AWWs under supervision of LSs.

At the AWC level, both school and non-school going adolescent girls need to be enrolled in order to avoid any LOs/DOs. Due to lack of proper supervision of LSs, the AWWs could not execute contextual strategy for mobilization and IFA supplementation of adolescent girls. Balika Mandals were either not formed or were inactive. Monthly educative session of adolescent girls was not undertaken which has adverse impact on their knowledge level and affects the weekly supervised IFA supplementation. So there is a need to support the AWW in formation of Balika Mandal, identification and engagement of PE, mobilizing adolescent girls for IFA supplementation, provision of supervised weekly IFA supplementation in distant hamlets, etc. Apart from the above, the adolescent girls and AWW should be oriented for filling-up of compliance card and register respectively.

More importantly, based on the findings of the assessment and recommendations made in the report the State may need to fine tune the guideline and implementation mechanism of each and every program component planned under AACP. This would not only help to ensure effective engagement & convergence of health and ICDS functionaries operating at different levels but also contribute to Anaemia reduction among the adolescent girls in Orissa.
