CHAPTER 03

Maternal & Adolescent Healthcare

3.1. MATERNAL HEALTH

Massive and strategic investments have been made under the National Health Mission for improvement of maternal health. Maternal health is an important aspect for the development of any country in terms of increasing equity and reducing poverty. The survival and wellbeing of mothers is not only important in their own right but are also central to solving large broader, economic, social and developmental challenges.

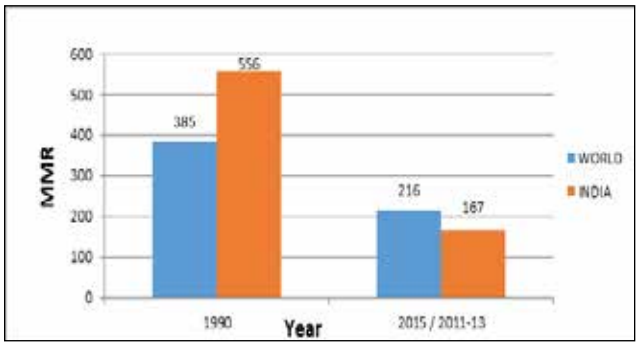
3.2 MATERNAL MORTALITY RATIO (MMR)

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 MMEIG report.

Millennium Development Goal (MDG) - 5 pertains to maternal health where target was to reduce the Maternal Mortality Ratio (MMR) by three quarters between 1990 & 2015. Based on the UN Inter–Agency Expert Group's MMR estimates in the publication "Trends in Maternal Mortality: 1990 to 2015", the target for MMR was 139 per 1,00,000 live births by the year 2015 taking a baseline of 556 per 100,000 live births in 1990. The MMR in India has declined by 68.7% and has come down from 556 in 1990 to 174 in 2015 (25 years), 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, an average annual decline of 2.3%.

India's progress on MDG-5 in global context

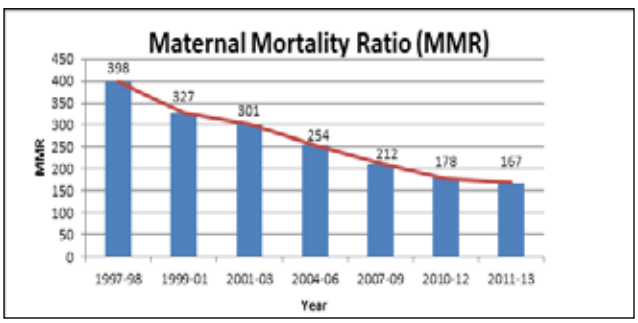


Source "Trends in Maternal Mortality: 1990 to 2015" - UN Inter–Agency Expert Group's & RGI -SRS

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 1,00,000 live births in the period 2007- 09 to 167 per 1,00,000 live births in the period 2011-13.

Accelerated pace of decline in MMR for India



Source: RGI–SRS

States' progress on MMR

a. The annual rate of decline of MMR during the period 2010-12 and 2011-13 is 6.2%.

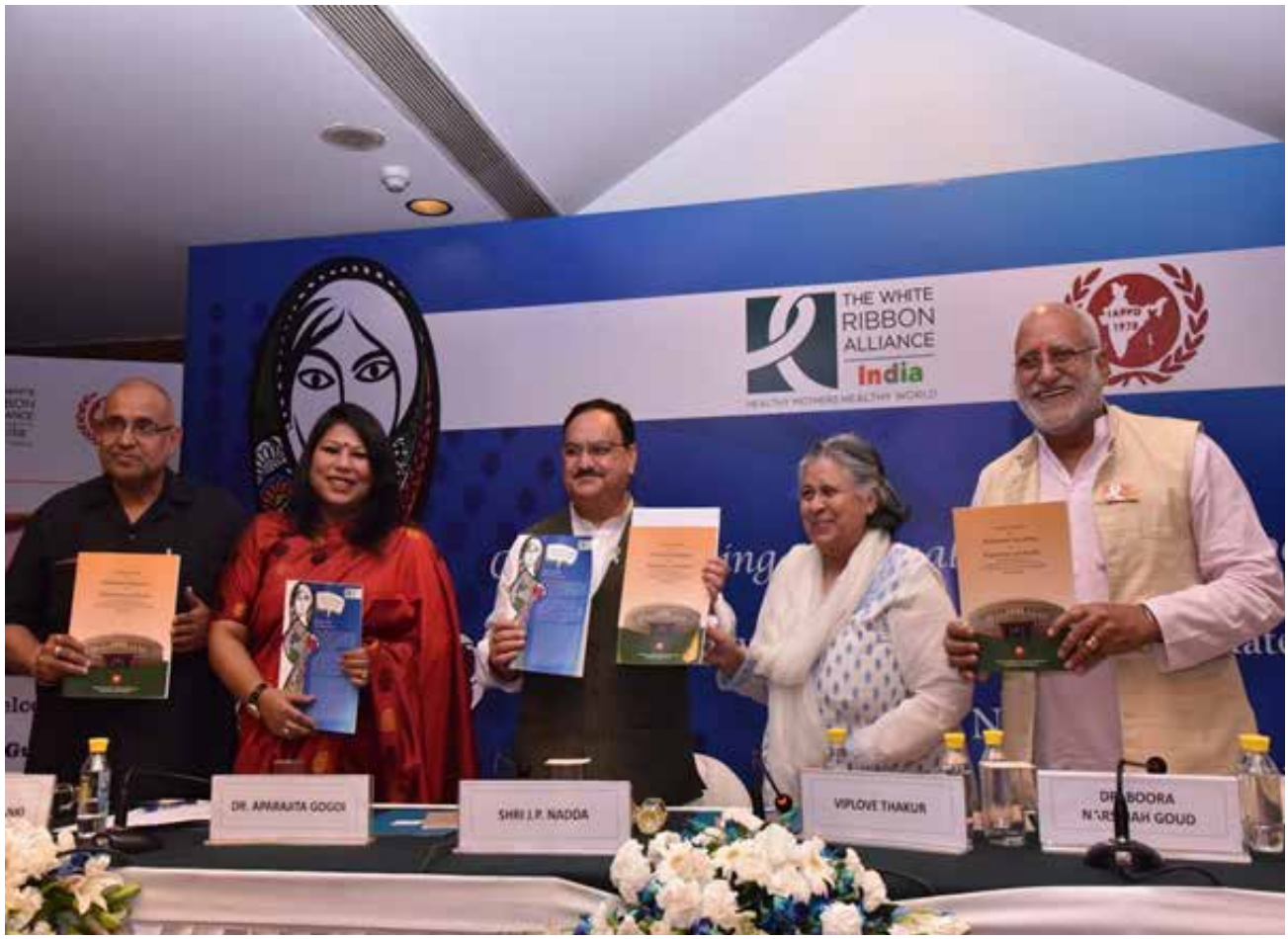
b. Assam continues to be the State with the highest MMR (300) followed by Uttar Pradesh/ Uttarakhand (285) and Rajasthan (244).

c. Maharashtra (21.8%), Andhra Pradesh (16.4%), Haryana (13%), Tamil Nadu (12.2%), Assam (8.5%), Gujarat (8.2%), Punjab (9.0%), Karnataka (7.6%) and Kerala (7.6%) have registered equal or higher decline as compared to the national decline.

d. States which have achieved an MMR of 100 per 1,00,000 live-births in 2011-13 are Kerala, Tamil Nadu, Maharashtra and Andhra Pradesh. The States of Gujarat, Haryana, Karnataka and West Bengal have also reached the MDG-5 target.

e. 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.

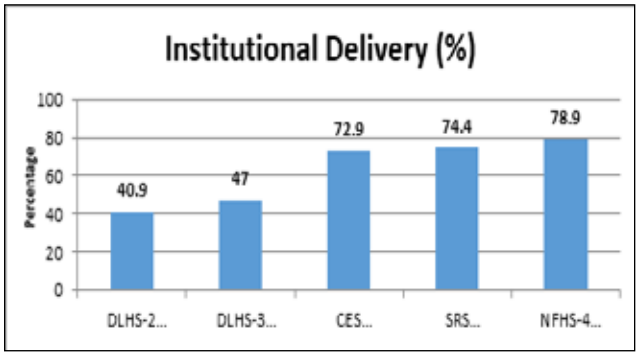
India has committed itself to the latest UN target for the **Sustainable Development Goals (SDGs)** for MMR at **70** per 1,00,000 live births by 2030. As per **NHP** (National Health Policy) 2017, the target for MMR is **100** per 1,00,000 live births by 2020.



Safe Motherhood Day: 10th April 2017

3.4 INSTITUTIONAL DELIVERY

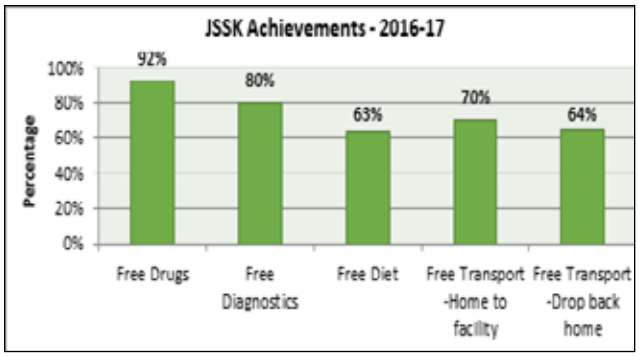
Institutional deliveries in India have risen sharply from 47% in 2007-08 to over 78.9% in 2015-16 (NFHS4) while Safe delivery has simultaneously climbed from 52.7% to 83.2% in the same period.



3.4.1 Key strategies for accelerating the pace of decline in MMR

i. For bringing pregnant women to health facilities for ensuring safe delivery and emergency obstetric care, Janani Suraksha Yojana (JSY), a demand generation scheme was launched in April, 2005. The number of JSY beneficiaries has risen from 7.39 lakhs in 2005-06 to more than 1.05 crore in 2016-17, with the expenditure on this scheme increasing from Rs.38.29 crores to Rs.1,788 crores in 2016-17.

ii. Building on the phenomenal progress of the JSY scheme, Government of India launched Janani Shishu Suraksha Karyakaram (JSSK) on 1st June, 2011. The initiative entitles all pregnant women delivering in public health institutions to have absolutely free and no expense delivery, including caesarean section. The entitlements include free drugs, consumables, free diet during stay, free diagnostics and free blood transfusion, if required. This initiative also provides 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 up to 1 year of age.



In 2016-17, 92% of pregnant women received free drugs, 80% free diagnostics, 63% free diet, 70% free home to facility transport while 64% received free drop back home after delivery. Utilization of public health infrastructure by pregnant women has increased significantly as a result of JSY & JSSK. As many as 1.33 crore women delivered in Government health facilities last year (2016-17).

a. 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. Over 550 dedicated Maternal and Child Health Wings (MCH Wings) with more than 32,000 additional beds have been sanctioned.

b. The process of Maternal Death Review (MDR) has been institutionalized across the country both at facilities and in the community to identify not just 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. According to the State Reports, 33% of the estimated maternal deaths have been reported in 2016-17. Out of these, 72.5% deaths have been reviewed by the District MDR Committees.

c. Comprehensive abortion care is being provided as it is an important element in the reproductive health component of the RMNCH+A strategy

as 8% (2001-03 SRS) of maternal deaths in India are attributed to unsafe abortions.

d. Screening and care for Sexually Transmitted Infections (STIs) and Reproductive Tract Infections (RTIs) are being provided at health facilities as they constitute an important public health problem in India. A policy decision has been taken for universal testing of HIV and syphilis in pregnant women. As per HMIS report for FY 2017-18, till December 2017, over 32 lakh pregnant women are screened for syphilis and approximately 1.06 crore pregnant women have been screened for HIV.

e. Capacity building involves training of MBBS doctors in Anaesthesia (Life Saving Anesthesia Skills - LSAS) and Emergency Obstetric Care including C-section (EmOC) skills to overcome the shortage of specialists in these disciplines, particularly in rural areas and Skilled Birth Attendants (SBA) training of SNs/ANMs/ LHVs for improving quality of care during delivery and childbirth. About 1800 doctors have been trained in Emergency Obstetric Care including C-sections and 2200 doctors in LSAS. Over 1,17,000 SNs/LHVs/ANMs have been trained as SBAs as per State reports.

f. "Prevention of Post-Partum Hemorrhage (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 delivery at institutions.

g. Setting up of Skill Labs has been done with earmarked skill stations for different training programmes to 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. Five National Skills labs are now operational for conducting training of trainers. 54 stand-alone skills labs have been established at different States such as Gujarat, Haryana, Maharashtra, MP, West Bengal, Odisha, Tamil Nadu and Karnataka. 1900 health personnel have been trained at the skills labs till date.

A view of 6 days training at National Skills lab

h. Pre-Service Education for strengthening Nursing Midwifery Cadre: Five National Nodal Centre (NNC) at College of Nursing, Vadodara; Kasturba Nursing College, Sewagram, Wardha; Regional College of Nursing, Guwahati; College of Nursing, Kanpur; and College of Nursing and MMC, Chennai have been strengthened achieving above 70% of performance standards. Around 43% of the targeted ANM & GNM Nursing institutions in the high focus States have fully equipped mini-skill labs and 85% of these institutions have library and around 89% have IT labs. Capacity building of 700 nursing faculties in the country through customized 6 Week Training has been conducted and 6 days training of 250 nursing faculties also have been conducted at National Skills lab "Daksh".

i. More than 20,000 'Delivery Points' have been identified across the country based on performance. These are being strengthened in terms of infrastructure, equipment, trained manpower for provision of comprehensive reproductive, maternal and newborn child health services along-with services for Adolescents & Family Planning etc. and are being monitored for service delivery.

j. Maternal Health Tool Kit has been developed as a ready reckoner/handbook for programme managers to plan, implement and monitor services at health facilities. It focuses on the Delivery Points, which includes setting up adequate physical infrastructure, ensuring logistics & supplies and recording/reporting & monitoring systems with the objective of providing good quality comprehensive RMNCH services.

k. Monthly Village Health and Nutrition Days (VHNDs) is an outreach activity at Anganwadi centers for provision of maternal and child care including nutrition in convergence with the ICDS. In 2016-17, more than 1.23 crore VHNDs were conducted in the States & UTs.

l. Mother and Child Protection (MCP) Card is being used by all States as a tool for monitoring and improving the quality of MCH and Nutrition interventions.

m. Web Enabled Mother and Child Tracking System (MCTS) is being implemented to register and track every pregnant woman, neonate, infant and child by name for quality ANC, INC, PNC, FP, Immunization services etc. More than 13.88 crore pregnant women and 11.93 crore children have been registered under MCTS till 10.01.2018.

n. Prevention & Control of Anemia: Under the National Iron+ Initiative, for prevention and control of anemia in pregnant and lactating women, iron and folic acid supplementation is being given at health facilities and during outreach activities. States have also been directed for line listing and tracking of severely anemic pregnant women by name for their timely management at health facilities.

o. Engagement of approximately 9.62 lakh Accredited Social Health Activists (ASHAs) to facilitate accessing of health care services by the community, particularly pregnant women.

p. Regular IEC/BCC is done for early registration for ANC, regular ANC, institutional delivery, nutrition and care during pregnancy etc. Funds are being provided to the States through PIPs for comprehensive IEC/BCC on Maternal and Newborn Health. Standardized IEC/BCC packages have been prepared at national level and have been disseminated to the States.

q. Further to sharpen the focus on the low performing districts, 256 High Priority Districts (HPDs) have been identified. These districts would receive 30% higher per capita funding, have relaxed norms, enhanced monitoring and focused supportive supervision and are encouraged to adopt innovative approaches to address their peculiar health challenges.

r. To further accelerate the pace of decline in MMR, new operational guidelines for obstitric HDU & ICU have 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 Syphillis during pregnancy and Dakshata guidelines for strengthening intra-partum care. Guidance Note on Use of Uterotonics during labour, Guidance Note on Prevention and management of Postpartum Hemorrhage, Training Manual for Facilitators and Training manual for Participants for the Daksh Skills Lab for RMNCH+A services are the latest guidelines release.

Trends in Maternal Mortality Ratio (per 1,00,000 live births)

Maternal Mortality Ratio (per 1,00,000 live births)								% Compound Rate of Annual Decline					
India /States	**1997-98**	**1999-01**	**2001-03**	**2004-06**	**2007-09**	**2010-12**	**2011-13**	**1999-01**	**2001-03**	**2004-06**	**2007-09**	**2010-12**	**2011-13**
India	398	327	301	254	212	178	167	-7.6	-4.1	-5.5	-5.8	-5.7	-6.2
Andhra Pradesh	197	220	195	154	134	110	92	4.5	-5.9	-7.6	-4.5	-6.4	-16.4
Assam	568	398	490	480	390	328	300	-13.3	11.0	-0.7	-6.7	-5.6	-8.5
Bihar/ Jharkhand	531	400	371	312	261	219	208	-10.7	-3.7	-5.6	-5.8	-5.7	-5.0
Gujarat	46	202	172	160	148	122	112	80.7	-7.7	-2.4	-2.6	-6.2	-8.2
Haryana	136	176	162	186	153	146	127	10.9	-4.1	4.7	-6.3	-1.5	-13.0
Karnataka	245	266	228	213	178	144	133	3.3	-7.4	-2.2	-5.8	-6.8	-7.6
Kerala	150	149	110	95	81	66	61	-0.3	-14.1	-4.8	-5.2	-6.6	-7.6
Madhya Pradesh/ Chhattisgarh	441	407	379	335	269	230	221	-3.2	-3.5	-4.0	-7.1	-5.1	-3.9
Maharashtra	166	169	149	130	104	87	68	0.7	-6.1	-4.4	-7.2	-5.8	-21.8
Odisha	346	424	358	303	258	235	222	8.5	-8.1	-5.4	-5.2	-3.1	-5.5
Punjab	280	177	178	192	172	155	141	-16.8	0.3	2.6	-3.6	-3.4	-9.0
Rajasthan	508	501	445	388	318	255	244	-0.6	-5.8	-4.5	-6.4	-7.1	-4.3
Tamil Nadu	131	167	134	111	97	90	79	10.2	-10.4	-6.1	-4.4	-2.5	-12.2
Uttar Pradesh/ Uttarakhand	606	539	517	440	359	292	285	-4.6	-2.1	-5.2	-6.6	-6.7	-2.4
West Bengal	303	218	194	141	145	117	113	-12.3	-5.7	-10.1	0.9	-6.9	-3.4

Source: Registrar General of India, Ministry of Home Affairs (SRS Estimates)

3.5 JANANI SURAKSHA YOJANA (JSY)

Janani Suraksha Yojana (JSY) is a safe motherhood intervention under National Health Mission (NHM), being implemented with the objective to reduce maternal and neonatal mortality by promoting institutional delivery among pregnant women.

JSY is a centrally sponsored scheme which integrates cash assistance with delivery and post-delivery care. The Yojana has identified Accredited Social Health Activist (ASHA) as an effective link between the Government and pregnant women.

3.5.1 Important Features of JSY

The scheme focuses on pregnant woman especially in States that have low institutional delivery rates, namely, the States of Uttar Pradesh, Uttarakhand, Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Assam, Rajasthan, Odisha, and Jammu & Kashmir. While these States have been named as Low Performing States (LPS), the remaining States have been categorized 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 centers, such as Sub Centers (SCs)/Primary Health Centers (PHCs)/Community Health Centers (CHCs)/First Referral Units (FRUs)/general wards of District or State hospitals
HPS	All BPL/Scheduled Caste/Scheduled Tribe (SC/ST) women delivering in a Government health centre, such as SC/PHC/CHC/FRU/ general wards of District or State hospital
LPS & HPS	BPL/SC/ST women in accredited private institutions

3.5.3 Cash Assistance for Institutional Delivery (in Rs)

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

Category	Rural area		Total	Urban area		Total
	Mother's package	ASHA's package*		Mother's package	ASHA's package**	(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 regardless of her age and any number of children.

3.5.6 Accrediting private health institutions

In order to increase the choice of delivery care institutions, States are encouraged to accredit at least two willing private institutions per block to provide delivery services.

3.5.7 Direct Benefits Transfer under JSY

Payments under the Janani Suraksha Yojana are being made through Direct Benefit Transfer (DBT) mode. Under this initiative, eligible pregnant women are entitled to get JSY benefit directly into their Aadhaar linked bank accounts/Electronic funds transfer. Details of payments made through DBT mechanism in FY 2017-18 till 31.12.2017 are as under:

Period: 01.04.2017-31.12.2017	Amount (in Rs.)
Payment through Aadhaar / PFMS / Electronic Fund Transfer	5,23,58,76,229

3.5.8 Physical & Financial progress

JSY has been a phenomenal success both in terms of number of mothers covered and expenditure incurred on the scheme. From a modest figure of 7.39 lakhs beneficiaries in 2005-06, the scheme currently provides benefit to more than one crore beneficiaries every year. Also, the expenditure of the scheme has increased from Rs. 38 crores in 2005-06 to 1788 crores in 2016-17.

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

- Increase in institutional deliveries from 47% (District Level Household Survey-III, 2007-08) to 78.9% (NFHS-4, 2015-16);
- Maternal Mortality Ratio (MMR) declined from 254 maternal deaths per 1,00,000 live births in 2004-06 to 167 maternal deaths per 1,00,000 live births during 2011-13;
- IMR has declined from 58 per 1000 live births in 2005 to 34 per 1000 live births in 2016; and
- The Neo-Natal Mortality Rate (NMR) has declined from 37 per 1000 live births in 2006 to 24 per 1000 live births in 2016.

State/UT-wise and year-wise physical and financial progress of JSY

Year	No. of beneficiaries (in lakhs)	Expenditure (in crores)
2005-06	7.39	38.29
2006-07	31.58	258.22
2007-08	73.29	880.17
2008-09	90.37	1241.34
2009-10	100.78	1473.76
2010-11	106.97	1619.33
2011-12	109.37	1606.18
2012-13	106.57	1672.42
2013-14	106.48	1764.32
2014-15	104.38	1777.03
2015-16	104.16	1708.72
2016-17	104.59	1788.10
2017-18*	46.01	723.54

** Figures are provisional, till September, 2017 only.*

3.6 PRADHAN MANTRI SURAKSHIT MATRITVA ABHIYAN (PMSMA)

The Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA) has been launched by the Ministry of Health & Family Welfare (MoHFW) in June, 2016. Under PMSMA, all pregnant women in the country are provided fixed day, free of cost assured and quality Antenatal Care. As part of the campaign, a minimum package of antenatal care services (including investigations and drugs) is being provided to the beneficiaries on the 9th day of every month. The Abhiyan also involves Private sector's health care providers as volunteers to provide specialist care in Government facilities. So far, over 1 crore ANC checkups were conducted by over 4,800 volunteers in over 12,800 Government facilities. Also more than 5.62 lakh high risk pregnancy cases were identified across the country.

Hon'ble Union Minister for Health & FW Sh. J.P. Nadda delivering Keynote Address on Safe Motherhood Day on 10th April, 2017

3.7 RASHTRIYA KISHOR SWASTHYA KARYAKRAM (RKSK)

About 25.3 crore adolescents in the age group 10-19 years in India are in a transient phase of life requiring nutrition, education, counseling and guidance to ensure their development into healthy adults.

Considering the magnitude of various health problems and risk factors among adolescents, which may have an impact on maternal and child health outcomes and occurrence of non-communicable disease in future, RKSK was launched with the objectives:

a. to increase the awareness and access to information about adolescent health,

b. provision of counseling and health services,

c. provision of specific services such as sanitary napkins; iron and folic acid supplementation.

3.7.1 Interventions under Rashtriya Kishor Swasthya Karyakram (RKSK)

Adolescent Friendly Health Clinics (AFHCs): The intervention is implemented through establishment

of Adolescent Friendly Health Clinics (AFHCs) at various levels of health facilities. Till date, 7298 AFHCs have been established across the country and around 60 lakh adolescent clients avail services in a year.

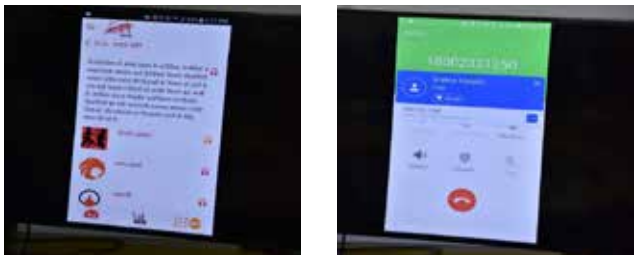
Weekly Iron Folic Acid Supplementation (WIFS): WIFS entails provision of weekly supervised IFA tablets and biannual albendazole tablets, besides Nutrition & Health Education to in-school boys and girls and to out-of-school girls. The programme aims to cover a total of 11.6 crore beneficiaries including 9.5 crore in-school and 2.1 crore out-of-school beneficiaries. Around 3.8 crore beneficiaries received weekly IFA supplementation in the current year so far.

3.7.2 Menstrual Hygiene Scheme: The scheme is being implemented for the rural adolescent girls. In FY 2017-18, Rs. 44.76 crores have been allocated through NHM to 18 States for decentralized procurement of sanitary napkins.

3.7.3 Peer Education (PE) Programme: Under the programme four peer educators (Saathiya) - two male and two female are selected per 1000 population to orient the adolescents on various health issues. Till date, 1.93 Lakh PEs have been selected and are being trained.

Launch of Saathiya Resource Kit by Former Secretary(HFW) on 20th February, 2017

3.7.4 Newer Initiatives: Mission Steering Group in its meeting held on 18th January, 2017 approved Rs. 340 crores for Strengthening of School Health Activities under National Health Mission. It is proposed to initiate age appropriate health promotion and prevention activities in collaboration with MoHRD, through two identified Nodal teachers as Health Ambassadors in each school.



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