4
Chapter

REPRODUCTIVE, MATERNAL, NEWBORN, CHILD AND ADOLESCENT HEALTH PROGRAMME

4.1 Reproductive and Child Health (RCH) programme is a comprehensive sector wide flagship programme, under the umbrella of the Government of India's (GoI) National Health Mission (NHM), to deliver the RCH targets for reduction of maternal and infant mortality and total fertility rates. RCH programme aims to reduce social and geographical disparities in access to and utilisation of quality reproductive, maternal, newborn, child and adolescent health services. Launched in April 2005 in partnership with the State governments, RCH is consistent with Government of India's National Population Policy-2000, the National Health Policy-2001 and the Millennium Development Goals. Six key components of the RCH programme are Maternal Health, Child Health, Nutrition, Family Planning, Adolescent Health (AH) and PC-PNDT.

Maternal health is central to the development of any country in terms of increasing equity & reducing poverty and building social capital. India has made remarkable progress in reducing maternal deaths in the last two decades. Millennium Development Goal (MDG) 5 is to reduce 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 2013", the MDG target for MMR in India is estimated to be 140 per 1,00,000 live births by the year 2015 taking a baseline of 560 per 100,000 live births in 1990.

As per the latest report of the Registrar General of India, Sample Registration System (RGI-SRS), Maternal Mortality Ratio (MMR) in India has declined from 212 per 100,000 live births in the period 2007-09 to 178 per 100,000 live births in the period 2010-12. If the current pace of decline in MMR is maintained India will achieve an MMR of 141 per 100,000 live births which is very close to the India's MDG5 estimated target of 140 per 100,000 live births.

Building on the phenomenal progress of the JSY scheme, Janani Shishu Suraksha Karyakram (JSSK, launched in 2011 provides service guarantee in the form of entitlements to pregnant women, sick newborns and infants for free delivery including caesarean section and free treatment in public health institutions. This includes free to and fro transport between home and institution, diet, diagnostics, drugs, other consumables and blood transfusion if required.

The child health programme under the National Health Mission (NHM) comprehensively integrates interventions that improve child survival and addresses factors contributing to infant and under-five mortality. Since neonatal deaths are the biggest contributor to child deaths which is approximately 57% of the under five deaths, improving child survival hinges on improving newborn health. It is now well recognised that child survival cannot be addressed in isolation as it is intricately linked to the health of the mother, which is further determined by her health and development as an adolescent.

Therefore, the concept of Continuum of Care, which emphasises care during critical life stages in order to improve child survival, is being followed under the national programme. Another dimension of this approach is to ensure that essential services are made available at home, through community outreach and through health facilities at various levels (primary, first referral units and tertiary health care facilities). The newborn and child health are key pillars of the Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A) strategic approach, 2013.

On 18th Sept. 2014, India Newborn Action Plan (INAP) was launched in response to Global Newborn Action Plan. INAP lays out a vision and a plan for India to end preventable newborn deaths, accelerate progress and scale up high-impact yet cost-effective interventions. INAP has a clear vision supported by goals, strategic intervention packages, priority actions and a monitoring framework. For the first time, INAP also articulates the Government of India's specific attention on preventing still births. With clearly marked timelines for implementation, monitoring and evaluation and scaling-up of proposed interventions, it is expected that all stakeholders working towards improving newborn health in India will stridently work towards attainment of the goals of *"Single Digit Neo-natal Mortality Rate (NMR) by 2030"* and *"Single Digit Still Birth Rate (SBR) by 2030"*. The efforts have been accelerated in identified 184 high priority districts in the country.

In order to address newborn health in high priority districts, Newborn Care Corners (NBCCs) are being established at delivery points to provide essential newborn care at birth, while Special Newborn Care Units (SNCUs) and Newborn Stabilization Units (NBSUs) provide care for sick newborns in these poorest priority districts with respect to health indicators. Complete elimination of out of pocket expenses with provision of free transport, drugs, diagnostics and diet to all sick newborns and infants is being ensured in the country through Janani Shishu Suraksha Karyakram (JSSK). All public and private health facilities are now guided to ensure single dose of Injection Vitamin K prophylaxis at birth even at the sub center by ANM.

To ensure continuum of care, facility based care is linked to home based newborn care which provides opportunity for early diagnosis of danger signs, prompt referral to an appropriate health facility with provision for newborn care facility. All the rural live births are targeted to receive home based new born care through series of home visit by ASHAs. The ANMs are now empowered to give a pre-referral dose of antenatal corticosteroid (Injection Dexamethasone) to pregnant women going into preterm labour and pre-referral dose of Injection Gentamicin and Syrup Amoxicillin to newborns for the management of sepsis in young infants (upto 2 months of age).

Nutritional Rehabilitation Centers (NRCs) are facility based units providing medical and nutritional therapy to children with Severe Acute Malnourished (SAM) condition and children under 5 years of age with medical complications. In addition to this, there is special focus on improving the skills of mothers on child care and feeding practices so that child continues to receive adequate care at home. Expansion of NRCs has been ensured in High Need Areas such as tribal blocks. To prevent and manage Childhood Diarrhoeal Diseases, States/UTs are being supervised for procurement of ORS and Zinc and its supplies at each public health facility.

South-East Asia Region of World Health Organization has been certified polio free by Regional Certification Commission on 27th March 2014 and India is of one of the 11 countries of this region, achieved a huge milestone in the field of public health of country. Maternal and Neo natal

Tetanus elimination has been validated in 28 States/UTs and the country is committed to validate the remaining states by the target year 2015.

Government of India is planning to introduce three new vaccines in routine immunization programme as per recommendations of the National Technical Advisory Group of Immunization: Rubella containing Vaccine, Inactivated Polio Vaccine and Rotavirus Vaccine (RV).

Family Planning (FP) has been repositioned as a critical intervention to reduce maternal and child mortality and not just as a strategy for achieving population stabilization. The basket of choice has been expanded with an introduction of a new device Cu IUCD 375 and a new method PPIUCD. In 2014-15 the compensation scheme for sterilization was enhanced for 11 High Focus States. Additionally, for the promotion of PPIUCD, compensation scheme was introduced for PPIUCD service providers and ASHAs. There has been a greater emphasis on operationalization of many more facilities for providing FP services.

The ongoing ASHA schemes (Home Delivery of Contraceptives/Ensuring Spacing at Birth/ Pregnancy Testing Kits) have increased the community outreach of FP programme. The introduction of RMNCH+A counselors, besides IEC/BCC, has been a tool in generating awareness and demand for FP services.

In order to address concerns and health needs of 253 million adolescent, India launched the Rashtriya Kishor Swasthya Karyakram (RKSK) on 7th January, 2014. RKSK reaches out all adolescents including male and female, rural and urban, married and unmarried, in and out-of school adolescents. This programme envisions that all adolescents in India are able to realise their full potential by making informed and responsible decisions relating to their health and well-being.

Rashtriya Kishor Swasthya Karyakram (RKSK) is underpinned by evidence that adolescence is the most important stage of the life cycle for health interventions. Addressing adolescent health needs would obviate several health and development challenges including reproductive, maternal and child health challenge.

Rashtriya Kishor Swasthya Karyakram (RKSK) is one of the first of its kind initiative- which expands the scope of adolescent health programming in India, from being limited to sexual and reproductive health, now includes in its ambit nutrition, injuries and violence (including gender based violence), non-communicable diseases, mental health and substance misuse. The strength of the programme is its health promotion approach. It is a paradigm shift from the existing clinic-based services to promotion and prevention and reaching adolescents in their own environment, such as in schools and communities.

4.2 MATERNAL HEALTH PROGRAMME

Maternal Health is the key for the development of any country in terms of increasing equity and reducing poverty. 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.

Maternal Mortality Ratio (MMR) is one of the critical indicators to judge the quality of health services in any country. India has made remarkable progress in reducing maternal deaths in the last two decades. In 1990, Maternal Mortality Ratio (MMR) in India was very high with 600 women dying during child birth per hundred thousand live births, which meant approximately one and a half lakh women dying every year. Globally MMR at that time was 400, which translated into about 5.4 lakh women dying every year. India at that time contributed 27 percent of the global maternal deaths. In the year 2010 global MMR was 210.

Against this, as per latest SRS estimates MMR in India has declined to 178 per hundred thousand live births in 2011, India now contributing to only 16 percent of the global maternal deaths. Globally, there has been a decline of 47% between the years 1990 and 2010. Compared to this, India has registered a decline of 70% between 1990 and 2011. The pace of decline in India has shown an increasing trend from 4.1% annual rate of decline during 2001-03 to 5.5% in 2004-06 to 5.8% in 2007-09 and is maintained at almost the same level of 5.7% in 2010-12.

The highest rates of declines are evident from the years 2004-06, which incidentally coincides with the period immediately after the launch of NRHM, and the numerous initiatives taken under this flagship scheme including the Janani Suraksha Yojana (JSY) which has resulted in a surge in institutional deliveries since its launch. Currently, as many as 1.66 crore women are reported to deliver in public health institutions.

Building on the phenomenal progress of the JSY scheme, Janani Shishu Suraksha Karyakram (JSSK), launched in 2011 provides service guarantee in the form of entitlements to pregnant women, sick newborns and infants for free delivery including Caesarean section and free treatment in public health institutions. This includes free to and fro transport between home and institution, diet, diagnostics, drugs, other consumables and blood transfusion if required. More than Rs. 2,000 crore was sanctioned for this scheme in 2013-14.

However, an estimated 47,000 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 haemorrhage, sepsis, abortion, hypertensive disorders, obstructed labor and 'other' causes including anemia. A host of socio-economic-cultural determinants like illiteracy, low socio-economic status, early age of marriage, low women's empowerment, traditional preference for home deliveries and other factors contribute to the delays leading to these deaths.

4.3 DECLINING MATERNAL MORTALITY RATIO (MMR)

- Maternal Mortality Ratio (MMR) has declined from 301 per 100,000 live births in 2001-03 to 254 in 2004-06 and further declined to 212 in 2007-09 and 178 in 2010-12 as per RGI-SRS data;
- The pace of decline has shown an increasing trend from 4.1% annual rate of decline during 2001-03 to 5.5% in 2004-06, 5.8% in 2007-09 to 5.7% in 2010-12 and
- India's MMR declined much faster than the global MMR during the period 1990 to 2010 with India showing an annual rate of decline of 5.6% as compared to 2.4% at the global level.

4.4 MATERNAL MORTALITY RATIO (MMR) (RGI-SRS 2010-12)

Salient features:

- As per the latest figures released by Registrar General of India (RGI), the Maternal Mortality Ratio (MMR) of India for the period 2010-12 is 178 per 100,000 live births as compared to 212 for the period 2007-09. The annual decline in MMR has been 5.7% during 2007-09 to 2010-12 as compared to the annual decline of 5.8% during 2004-06 to 2007-09;
- The State of Assam continues to be the State with the highest MMR (328) followed by Uttar Pradesh/Uttarakhand (292) and Rajasthan (255);
- The States of Kerala (66), Maharashtra (87) and TamilNadu (90) and have achieved the MMR level of below 100;

- It is heartening to note that the States of Andhra Pradesh (6.4%), Bihar/Jharkhand (5.7%), Gujarat (6.2%), Karnataka (6.8%), Kerala (6.6%), Rajasthan (7.1%), Uttar Pradesh/ Uttarakhand (6.7%) and West Bengal (6.9%) have registered equal or higher decline as compared to the national decline;
- The highest annual decline has been observed in Rajasthan (7.1%) followed by Karnataka (6.8%), Uttar Pradesh (6.7%) and Kerala (6.6%) and
- The States of West Bengal has done remarkably well to reduce the MMR and to reverse the increase observed during the period 2004-06 to 2007-09.

4.4.1 Maternal Mortality Ratio (MMR): Goals

Indicator	Goal NHM (2012)	Target MDG 5	Progress
Maternal Mortality Ratio	100 per 100,000 live births	Reduce by three-fourths the MMR of 1990 by 2015	Declined from 301 per 100,000 live births in 2001-03 to 254 in 2004-06 , declined to 212 in 2007-09 and as per 2010-12 RGI-SRS, it is 178 per 100,000 live births

4.4.2 Maternal Mortality Ratio (MMR) Progress Trends:

Latest estimates on MMR are available for the year 2010-12. MMR over different periods is placed below:

Period	MMR (per 100,000 live births)	Approximate nos. of Maternal Deaths/year
1999-01	327	100,000
2001-03	301	80,000
2004-06	254	67,000
2007-09	212	56,000
2010-12	178	47,100

4.4.3 MMR Periodicity

Maternal deaths are rare events and single year data does not provide adequate sample size required for robust estimates of MMR. So, estimation of MMR is done periodically by pooling of three years data to yield reliable estimates through the Sample Registration System (SRS) of Registrar General of India (RGI). State wise data is available only for more populous states.

Comparison of MMR (Sample Registration System & Annual Health Survey) for 9 High Focus States

State/UT	MMR				
	SRS		AHS		
	2007-09	2010-12	2010-11	2011-12	2012-13
Assam	390	328	381	347	301
Bihar	261	219	305	294	274
Chhattisgarh	-	-	275	263	244
Jharkhand	-	-	278	267	245
Madhya Pradesh	269	230	310	277	227
Odisha	258	235	277	237	230
Rajasthan	318	255	331	264	208
Uttar Pradesh	359	292	345	300	258
Uttarakhand	-	-	188	162	165

4.5 OTHER MATERNAL HEALTH INDICATORS

Some of the key indicators for maternal health are antenatal check-up, institutional delivery and delivery by trained and skilled personnel, postnatal care etc. All these indicators are monitored regularly through Health Management Information System (HMIS) and also periodically through District Level Household surveys (DLHS), National Family Health Surveys (NFHS), and Annual Health Survey (AHS). Independent surveys like Coverage Evaluation Surveys (CES) by UNICEF are also being done.

4.5.1 Comparison of MH indicators in DLHS II (2002-04), DLHS III (2007-08), CES (2009) and SRS 2010:

Indicators	DLHS-2 (2002-04)	DLHS-3 (2007-08)	CES 2009	SRS 2010	SRS 2012
Mothers who had received any ANC (%)	73.6	75.2	89.6	-	
Mothers who had 3 or more ANC (%)	50.4	49.8	68.7	-	
Mothers who had full ANC check-up (%)	16.5	18.8	26.5	-	
Institutional Delivery (%)	40.9	47.0	72.9	60.5	73.1
Safe Delivery (%)	48	52.7	76.2	-	
IFA tablets consumed for 100 days	20.5	46.6			
Mothers who received PNC within 2 weeks of delivery (%)	NA	49.7	60.1*	-	

**PNC within 10 days*

4.5.2 Key Maternal Health Strategies

4.5.2 (a) Free Service Guarantees at Public Health Facilities: Janani Shishu Suraksha Karyakram (JSSK)

To complement JSY, Government of India launched Janani Shishu Suraksha Karyakaram (JSSK) on 1st June, 2011, to eliminate out of pocket expenditure for pregnant women and sick newborns and infants on drugs, diet, diagnostics, user charges, referral transport etc. The scheme entitles all pregnant women delivering in public health institutions to absolutely free and no expense delivery including Caesarean section. This initiative also provides for free transport from home to institution, between facilities in case of a referral and drop back home. Similar entitlements have been put in place for all sick newborns & infants accessing public health facilities.

More than Rs. 2000 crore have been allocated to the States for the year 2013-14 for providing the free entitlements under JSSK while Rs. 2107 crore was allocated during 2012-13 under RCH & NRHM Flexipool.

4.5.2 (b) Essential and Emergency Obstetric Care:

Following are some highlights:

- Skilled Attendance at birth (domiciliary & health facilities)- Nearly 69,760 ANMs, LHVs and Staff Nurses have been trained in SBA, as per State reports;

- Multi-skilling of doctors to overcome shortage of skilled manpower in critical specialties-training on Life Saving Anesthesia Skills (LSAS) and Comprehensive Emergency Obstetric Care (including C-Section). 1,862 Medical Officers have been trained in LSAS and 1,352 Medical Officers in Comprehensive EmOC;
- A 10 day training on Basic Emergency Obstetric Care (BEmOC) Skills for Medical Officers is being conducted in the states and
- **Delivery Points:** More than 17,000 **'Delivery Points'** which are health facilities fulfilling certain bench marks of performance, have been identified for prioritising resources-infrastructure, equipments, trained manpower to provide comprehensive Reproductive, Maternal, Newborn & Child Health services, along with Family Planning and services for Adolescents.

4.6 COMPREHENSIVE ABORTION CARE SERVICES (CAC)

Eight percent of maternal deaths in India are attributed to unsafe abortions. Besides this, women who survive unsafe abortion are likely to suffer long-term reproductive morbidity. Comprehensive Abortion Care is an important element in the reproductive health component of the RMNCH+A strategy.

- Provision of comprehensive safe abortion services at public health facilities including 24×7 PHCs/ FRUs (DHs/SDHs/CHCs) with a focus on "Delivery Points" (about 17,000 health facilities performing deliveries/Cesarean sections above a certain benchmark);
- Funds are being provided to States/UTs for operationalisation of safe abortion services at health facilities including procurement of equipment and drugs for medical abortion;
- Capacity Building of Medical Officers in safe MTP Techniques and of ANMs, ASHAs and other field functionaries to provide confidential counselling for MTP and promote post-abortion care including adoption of contraception;
- Certification of private and NGO sector facilities through District level committees to provide quality MTP services;
- Supply of Nischay Pregnancy detection kits to sub-centres for early detection of pregnancy and
- Print material for IEC/BCC on CAC shared with the States.

4.6.1 Management of Sexually Transmitted Infections and Reproductive Tract Infections (RTI and STI)

- Sexually Transmitted Infections (STIs) and Reproductive Tract Infections (RTIs) 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.
- These services are to be provided at all CHCs, and at 24×7 PHCs with priority on Delivery Points. Convergence with the National AIDS Control Programme (NACP) is essential for the provision of services for case management, laboratory services, HIV counselling services, anti-retroviral drugs, equipment and blood safety and skilled and trained manpower.
- For syndromic management of RTIs/STIs, availability of colour-coded kits, RPR testing kits for syphilis and also whole blood finger prick testing for HIV are being ensured.

4.6.2 Village Health & Nutrition Days (VHND)

Village Health & Nutrition Days (outreach services for comprehensive Maternal and Child Health Care): More than 4.81 crore Village Health and Nutrition Days have been held uptill June, 2014 (NRHM- MIS).

4.6.3 A Joint **Mother and Child Protection (MCP) Card** of Ministry of Health & Family Welfare (MoH&FW) and Ministry of Women and Child Development (MoWCD) is being used by all States as a tool for monitoring and improving the quality of MCH and Nutrition interventions.

4.7 MOTHER AND CHILD TRACKING SYSTEM (MCTS)

A name, telephone, address based web enabled system has been introduced by Government of India to track every pregnant women and child in order to ensure and monitor timely services to them including ANC, JSY benefit, Immunization etc. While States like Gujarat, Tamil Nadu and Rajasthan already have such a tracking system in place, others are moving ahead for adopting and expanding this system.

4.8 MATERNAL DEATH REVIEW (MDR)

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, with the objective of taking appropriate corrective action.

4.9 MATERNAL AND CHILD HEALTH (MCH) WINGs

477 dedicated Maternal and Child Health Wings (MCH Wings) with more than 29,000 additional beds have been sanctioned in 20 States. These 100 / 50/ 30 bedded state of the art MCH Wings are being established in District Hospitals/District Women's Hospitals/Sub-District Hospitals/CHC-FRUs to overcome the constraints of increasing case load and institutional deliveries at these facilities.

4.9.1 Skill Labs

- To strengthen the quality of capacity building of different cadres of service providers training, Skill Labs are being established in the States. Guideline and training modules of Skill Labs have been disseminated to the States.

- Operational Guidelines and Reference Manual for Advance Distribution of Misoprostol to Prevent Postpartum Haemorrhage during Home Births have been disseminated to the States for prevention of PPH at home for women who deliver at home.

4.10 NEW POLICY DECISIONS

India needs to prepare for achieving the goals and targets beyond the present MDGs which will require accelerated progress. To ensure this acceleration, it is imperative that we address the entire spectrum of causes for Maternal Mortality and morbidity at all levels of facilities as well the community. To this end, the Maternal Health Division is under the process of preparation of operational guidelines for screening of:

- Gestational Diabetes Mellitus;
- Congenital syphilis in pregnancy;
- Hypothyroidism for high risk group during pregnancy;
- Cancer Breast;
- Cervical Cancer;
- Training of General Surgeons for performing Caesarean Section;
- Calcium supplementation during ANC;
- IV Iron sucrose for treatment of severe anaemia and
- Deworming during pregnancy for Soil Transmitted Helminthes (STH) in endemic areas where STH worm infestation is more than 20%.

Appendix-1

Maternal Mortality Ratio (MMR) (per 1,00,000 births)				% Compound Rate of Annual Change	
States	**2004-06**	**2007-09**	**2010-12**	**2007-09**	**2010-12**
Andhra Pradesh	154	134	110	-4.5	-6.4
Assam	480	390	328	-6.7	-5.6
Bihar/Jharkhand*	312	261	219	-5.8	-5.7
Gujarat	160	148	122	-2.6	-6.2
Haryana	186	153	146	-6.3	-1.5
Karnataka	213	178	144	-5.8	-6.8
Kerala	95	81	66	-5.2	-6.6
Madhya Pradesh/Chhattisgarh*	335	269	230	-7.1	-5.1
Maharashtra	130	104	87	-7.2	-5.8
Odisha	303	258	235	-5.2	-3.1
Punjab	192	172	155	-3.6	-3.4
Rajasthan	388	318	255	-6.4	-7.1
Tamil Nadu	111	97	90	-4.4	-2.5
Uttar Pradesh/Uttarakhand*	440	359	292	-6.6	-6.7
West Bengal	141	145	117	0.9	-6.9
India	**254**	**212**	**178**	**-5.8**	**-5.7**

** Combined estimates*

Appendix-II

Trend: Institutional Delivery

States	Institutional Delivery (%)	
	DLHS-3 (2007-08)	**CES-2009**
Andhra Pradesh	71.8	94.3
Arunachal Pradesh	47.6	69.9
Assam	35.1	64.4
Bihar	27.5	48.3
Chhattisgarh	18	44.9
Delhi	68.7	83.6
Goa	96.4	99.8

States	Institutional Delivery (%)	
	DLHS-3 (2007-08)	CES-2009
Gujarat	56.4	78.1
Haryana	46.8	63.3
Himachal Pradesh	48.3	50.3
Jammu & Kashmir	54.9	80.9
Jharkhand	17.7	40.1
Karnataka	65.1	86.4
Kerala	99.4	99.9
Madhya Pradesh	46.9	81
Maharashtra	63.5	81.9
Manipur	41	80
Meghalaya	24.5	63.7
Mizoram	55.7	83
Nagaland	--	30.4
Odisha	44.1	75.5
Punjab	63.1	60.3
Rajasthan	45.4	70.4
Sikkim	49.5	68.9
Tamil Nadu	94	98.4
Tripura	46.2	82.6
Uttar Pradesh	24.5	62.1
Uttarakhand	30	53.5
West Bengal	49.1	69.5
UTs		
Andaman & Nicobar	76.4	88.1
Chandigarh	76.1	
Daman and Diu	64.1	
Dadra & Nagar Haveli	44	
Lakshadweep	90.7	
Puducherry	99	
INDIA	**47**	**72.9**

4.11 JANANI SURAKSHA YOJANA (JSY)

Janani Suraksha Yojana (JSY) is a safe motherhood intervention under the National Health Mission (NHM). It is one of the largest conditional schemes in the world and is being implemented with the objective of reducing maternal and neonatal mortality by promoting institutional delivery among pregnant women. Launched on 12 April 2005, JSY is being implemented 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 using Accredited Social Health Activist (ASHA) as an effective link between the government and pregnant women.

4.11.1 Important Features of JSY

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

4.11.2 Eligibility for Cash Assistance

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

Low Performing States (LPS)	All pregnant women delivering in government health centres, such as Sub Centers (SCs)/Primary Health Centers (PHCs)/Community Health Centers (CHCs)/First Referral Units (FRUs)/general wards of district or State hospitals or accredited private institutions
High Performing States (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 or accredited private institutions.

4.11.3 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.*

4.11.4 Physical & Financial progress

The number of beneficiaries under the scheme has increased manifold i.e. from 7.38 lakhs in 2005-06 to 106.48 lakhs in 2013-14. Similarly, expenditure has increased from Rs. 38.29 crores in 2005-06 to Rs. 1762.82 crores in 2013-14.

4.11.5 Subsidizing cost of Caesarean Section

The Yojana subsidizes the cost of Caesarean Section or for the management of Obstetric complications, up to Rs. 1500/- per delivery to the Government Institutions, where Government specialists are not in position.

4.11.6 Cash assistance for Home Delivery

In addition to institutional delivery benefit, BPL pregnant women who prefer to deliver at home are entitled to a cash assistance of Rs. 500 per delivery under the JSY. 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.

4.11.7 Direct Benefits Transfer (DBT) under JSY

Direct Benefit Transfer (DBT) mode of payments has been rolled out in 43 districts w.e.f. 1.1.2013 and in 78 districts from 1.7.2013. 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 till 17.11.2014 are as under:

Period: 01.01.2013-17.11.2014	Numbers	Amount (in Rs.)
Aadhaar based payments	60355	5,00,53,152
Payments through Core Banking Solution (CBS)	790082	77,09,24,874
Total	**850437**	**82,09,78,026**

4.12 ADOLESCENT HEALTH (AH)

Adolescent Health component includes the:

(A) Adolescent Reproductive and Sexual Health programme (ARSH),

(B) Menstrual Hygiene Scheme (MHS) and

(C) Weekly Iron and Folic Acid Supplementation Programme (WIFS) components.

The newly launched Rashtriya Kishor Swasthya Karyakram (RKSK) subsumes these components into a comprehensive programme. Achievement under each component and salient features of RKSK are as below:

(A) Adolescent Reproductive and Sexual Health (ARSH) programme:

- Adolescent Reproductive and Sexual Health programme focuses on reorganizing the existing public health system in order to meet health service needs of adolescents through provision of promotive, preventive and curative services at designated Adolescent Friendly Health Clinics across level of care.;
- The numbers of operational Adolescent Friendly Health Clinics have increased from 3356 in 2011-12 to 6519 in 2013-14 showing 94 % increment over a period of 2 years and
- 697 dedicated Adolescent Health counsellors have been enrolled to provide counselling services in Adolescent Friendly Health Clinics.

(B) Scheme for Promotion of Menstrual Hygiene:

- The Scheme for Promotion of Menstrual Hygiene has been initiated for rural adolescent girls in the age group of 10-19 years. This programme aims at that girls in rural areas have adequate knowledge and information about menstrual hygiene and have access to high quality sanitary napkins along with safe disposal mechanisms.
- *Key activities under the scheme include:*
  - o Community based Health education and outreach in the target population to promote menstrual health;
  - o Ensuring regular availability of Sanitary napkins to the adolescents;
  - o Sourcing and Procurement of Sanitary napkins;
  - o Storage and distribution of Sanitary napkins to the adolescent girls;
  - o Training of ASHA and nodal teachers in Menstrual Health and
  - o Safe disposal of Sanitary napkins.

- Scheme for promotion of menstrual hygiene has rolled out in 17 States in 1012 blocks through Central supply of '*Freedays*' sanitary napkins. Till June 2014, over 2.9 crore rural adolescent girls have been reached and a total of 4.5 crore sanitary napkins packs have been distributed.

(C) Weekly Iron and Folic Acid Supplementation (WIFS) Programme:

- The Ministry of Health and Family Welfare has rolled out the Weekly Iron and Folic Acid Supplementation (WIFS) Programme in 2012-13 to meet the challenge of high prevalence and incidence of Iron Deficiency Anaemia amongst adolescent girls and boys;
- The long term goal is to break the intergenerational cycle of anaemia, the short term benefits is of a nutritionally improved human capital;
- *WIFS programme includes:* Weekly supervised administration of Iron and Folic Acid supplements to in-school adolescent girls and boys and out-of-school adolescent girls, screening of target groups for moderate/severe anaemia and referral, biannual de-worming and provision of information and counselling and
- WIFS targets a total of 11.7 crore Adolescents between the age of 10-19 years. 9.1 crore adolescents attending government/government aided and municipal schools in classes 6th to 12th are covered under the programme. 2.6 crore out of school adolescent girls are targeted by WIFS. As of now WIFS reaches out to 3.8 crore adolescent boys and girls.

4.13 New Policy and Programmatic initiative: Rashtriya Kishor Swasthya Karyakram (RKSK)

- Rashtriya Kishor Swasthya Karyakram (RKSK) was launched on 7th January 2014 to reach out to 253 million adolescents-male and female, rural and urban, married and unmarried, in and out-of- school adolescents.
- Rashtriya Kishor Swasthya Karyakram is underpinned by evidence that adolescence is the most important stage of the life cycle for health interventions.

  The salient features of RKSK are:

  - o RKSK uses a health promotion approach and provides information, counselling and services to adolescent across level of care both in the community and at the facilities;
  - o The programme expands the scope of adolescent health programming in India- from being limited to sexual and reproductive health, it now includes in its ambit nutrition, injuries and violence (including gender based violence), non-communicable diseases, mental health and substance misuse and
  - o RKSK is a paradigm shift from the existing clinic-based services to promotion and prevention and reaching adolescents in their own environment, such as in schools and communities.

4.13.1 Package of services offered under RKSK:

- **Community based interventions:-**
  - o Peer Education (PE);
  - o Quarterly Adolescent Health Day (AHD);
  - o Weekly Iron and Folic Acid Supplementation Programme (WIFS) and
  - o Menstrual Hygiene Scheme (MHS).
- **Facility based intervention:-**
  - o Adolescent Friendly Health Clinic (AFHC).

- **Convergence with other departments/ schemes:-**
  - o Within Health & Family Welfare
  - o With other departments/schemes
- **Social Behaviour Change Communication with focus on Inter Personal Communication**

4.13.2 The community level interventions involve selection of "Four Peer Educators (PEs) one per thousand population" to establish information and support network for adolescents in the community. The PEs will be trained in a comprehensive set of topics spanning the following issues: objectives of RKSK, roles and responsibilities of PEs, understanding adolescents as transition to adulthood, gender and sexual identity, health concerns of adolescents, peer pressure, emotional stress and other specific concerns of child marriages, gender based violence, child and ARSH rights etc.

Service to be provided at the Adolescent Health Day:

- **Information:** IEC and IPC on Nutrition, SRH, Mental Health, GBV, NCD and Substance misuse.
- **Commodities:** Sanitary Napkins, IFA, Albendazole, anti-spasmodic tablets and contraceptives.
- **Services:** Registration, general health check-up, (BMI, anaemia and diabetes), Referral to AFHCs (for counselling and clinical services).

4.13.3 Adolescent Friendly Health services at the facilities:

Service package	Level: SC, PHC, CHC and DH
ANC for pregnant adolescents	All levels
Counseling on Nutrition, Skin, Pre-marital Counseling, Sexual Problems, Contraceptive, Abortion, RTI/STI, Substance abuse, Learning problems, Stress, Depression, Suicidal Tendency, Violence, Sexual Abuse, Other Mental Health Issues	All levels (by ANM at SC)
Other adolescent specific health services including menstrual disorders, injuries (accidents & violence) and NCD like hypertension, stroke, cardio-vascular diseases and diabetes	PHC, CHC, DH
Treatment by specialists	CHC, DH
Referral	All levels