

Maternal Health Programme

4.1 INTRODUCTION

The National Rural Health Mission (NRHM) and under its umbrella, the Reproductive and Child Health Programme Phase II, the Government of India has taken a number of steps to accelerate the pace of reduction in Maternal Mortality by focusing on the following strategies and interventions:

- Promotion of institutional deliveries through Janani Suraksha Yojana.
- Antenatal, Intranatal and Postnatal Care including Iron and Folic Acid supplementation to pregnant & lactating women for prevention and treatment of anaemia.
- Mother and Child Protection Card in collaboration with the Ministry of Women and Child Development to monitor service delivery for mothers and children.
- Operationalisation of Sub-Centers, Primary Health Centers, Community Health Centers and District Hospitals for providing 24x7 basic and comprehensive obstetric care services.
- Delivery Points (DPs) : Government of India has introduced the concept of Delivery Points for all the States/UTs for prioritizing and focus attention in terms of strengthening and upgrading the facilities where there is demand for services and which are conducting deliveries above a certain benchmark.
- Capacity Building of health care providers in basic and comprehensive obstetric care.
- Village Health and Nutrition Days in rural areas as an outreach activity, for provision of maternal and child health services.
- Engagement of 8.71 lakhs Accredited Social Health Activists (ASHAs) to generate demand and facilitate accessing of health care services by the community.

4.2 NEW INITIATIVES

- **MCTS:** Name Based web enabled tracking of Pregnant Women to ensure antenatal, intranatal and postnatal care has been introduced.

- **Janani Shishu Suraksha Karyakram (JSSK)** has been launched on 1st June, 2011, to eliminate any out of pocket expense for pregnant women delivering in public health institutions and sick newborns accessing public health institutions for treatment till 30 days after birth.
- **Maternal Death Review (MDR)** : To review every maternal death at facility and community, Maternal Death Review has been initiated and States have started reporting the progress made.
- **Maternal and Child Wings (MCH Wing)** : More than 20,000 additional beds have been sanctioned in form of 100 bedded Maternal and Child Wings, 70/50 and 30 bedded wards across 11 States, who have proposed it in their Annual Project Implementation Plans.

4.3 MATERNAL MORTALITY RATIO (MMR)

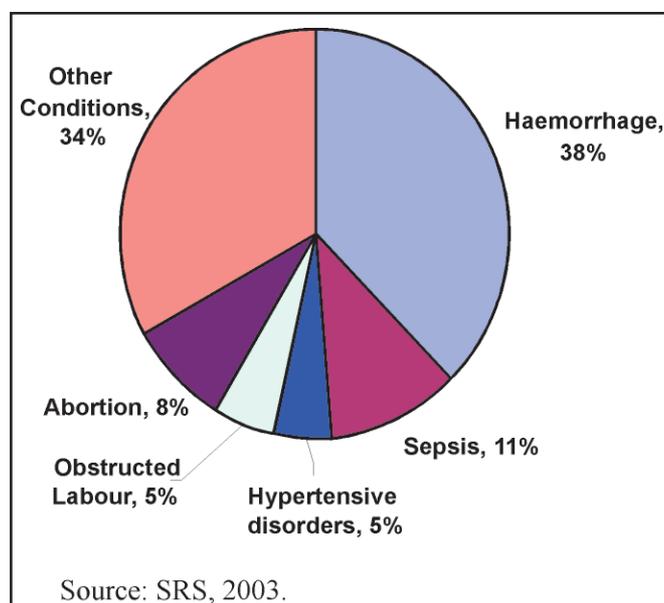
MMR is defined as the number of maternal deaths per 100,000 live births due to causes related to pregnancy or within 42 days of termination of pregnancy, regardless of the site or duration of pregnancy.

4.3.1 MMR in India: As per the latest Registrar General of India–Sample Registration System (RGI-SRS) estimates on Maternal Mortality Ratio (2007-09), the MMR in India has declined from 254 per 100,000 live –births in 2004-06 to 212 per 100,000 live-births in 2007-09 which translates into a decline from approximately 67,000 maternal deaths per year in 2004-06 to approximately 56,000 per year in 2007-09. This in itself is very high compared to the international scenario like Sweden (4), USA (21), Brazil (56) and even in neighbouring countries like Bangladesh (240), Pakistan (260), Sri Lanka (35) and Thailand (48) (Source- ‘Trends in Maternal Mortality; 1990-2010 -Estimates developed by WHO, UNICEF, UNFPA and the World Bank’). Some of the States with high Maternal Mortality as per the RGI-SRS report of

2007-09 are:

States	MMR
Uttar Pradesh/Uttarakhand	: 359
Rajasthan	: 318
Madhya Pradesh/Chhattisgarh	: 269
Bihar/Jharkhand	: 261
Assam	: 390

4.3.2 Causes of Maternal Mortality: The major causes of maternal deaths have been identified as Haemorrhage (both ante and post partum), Hypertensive disorder of pregnancy including Eclampsia, obstructed labour and unsafe abortion besides causes classified as “Others” which includes Anaemia.



As can be seen Haemorrhage accounts for more than one- third of all deaths followed by puerperal sepsis and abortion. Besides these, anemia which has been included in “other conditions” is a major contributory factor. Most of these deaths are preventable with good ante natal care, timely identification and referral of pregnant women with complications of pregnancy and timely provision of emergency obstetric care. Moreover social factors like Illiteracy, low socio-economic conditions, poor access to health facilities are also contributing factors leading to higher maternal mortality.

4.4 OTHER KEY MATERNAL HEALTH INDICATORS

Other indicators of maternal health status like antenatal check up, institutional delivery and delivery by trained and skilled personnel etc. are used for this purpose. All India figure for these indicators as per the District Level Household Survey (DLHS III) conducted in the period 2007-08 respectively along with the UNICEF, Coverage Evaluation Survey 2009 (UNICEF, CES-2009), a nationwide survey covering all States and Union Territories of India which was conducted during November 2009 to January 2010 are tabled below. The comparison between DLHS II (2002-04), DLHS III (2007-08) and CES (2009) and SRS 2010 is depicted below :

Indicators	DLHS-II (2002-04)	DLHS-III (2007-08)	CES 2009	SRS 2010
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
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

4.4.1 Results of Annual Health Survey 2010-11

This survey provides district disaggregated data for better planning & intervention. Results released recently for 284 districts of 8 EAG States and Assam have ranked with these states based on MMR. The situation in Bihar, Jharkhand, MP, Chhattisgarh and Rajasthan indicates that there is much need for improvement in these States.

State-wise MMR as per SRS 2007-09 and AHS 2010-11 is tabulated below:

MMR (SRS (2007-09) and AHS(2010-11))		
State	MMR-SRS (2007-09)	MMR-AHS (2010-11)
INDIA TOTAL	212	
Assam	390	381
Bihar	261	305
Jharkhand	261	278
Madhya Pradesh	269	310
Chhattisgarh	269	275
Odisha	258	277
Rajasthan	318	331
Uttar Pradesh	359	345
Uttarakhand	359	188

It is evident that there has been considerable improvement in all the Maternal Health indicators after the launch of NRHM and RCH II Programme.

4.4.2 Strategies and Interventions under Maternal Health (MH)

Under National Rural Health Mission (NRHM), several initiatives are under implementation to achieve the goal of reduction in Maternal Mortality. These interventions are as follows:

4.5 JANANI SURAKSHA YOJANA (JSY)

Janani Suraksha Yojana, a demand promotion scheme for reduction of MMR and IMR has led to steep increase in Institutional Delivery in government health facilities.

Cash incentive are provided to promote institutional delivery. The number of beneficiaries has increased from 7.38 lakhs in 2005-06 to more than 1.09 crores in 2011-12. Expenditure increased from Rs 38.29 crores in 2005-06 to Rs 1552.85 crores in 2011-12.

Janani Suraksha Yojana a safe motherhood intervention under the National Rural Health Mission (NRHM), was

launched on 12th April 2005 to promote institutional delivery among the poor pregnant women. The Yojana is being implemented in all States and Union Territories. JSY is a 100% Centrally Sponsored Scheme.

The scheme focuses on the poor pregnant women with special dispensation for States having 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 classified as Low Performing Status (LPS) the remaining States have been named as High Performing States (HPS).

Besides maternal care, the scheme provides cash assistance to all eligible mothers for delivery care. The scheme has identified ASHA, the Accredited Social Health Activist as an effective link between the health facility and the community.

4.5.1 Eligibility for cash Assistance for pregnant women

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

States	Eligibility
Low Performing States (Uttar Pradesh, Uttarakhand, Madhya Pradesh, Chhattisgarh, Bihar, Jharkhand, Odisha, Rajasthan, Assam and Jammu & Kashmir)	Available to all women regardless of age and number of children in public health facilities
High Performing States (All remaining States/UTs)	Available to only BPL/SC/ST women aged 19 years or above up to two live births, in public health facilities

4.5.2 Cash Assistance for Institutional Delivery

The cash entitlement for mothers is as follows:

Category	Rural Area		Urban Area	
	Mother's package	ASHA'S package	Mother's Package	ASHA'S package
Low Performing States	1400	600	1000	200
High Performing States	700	200	600	200

Further, ASHAs are also entitled to Rs. 600/- per delivery for facilitating institutional delivery in the North Eastern States (excluding Assam) and in respect of rural tribal woman in the tribal areas notified by the Ministry of Tribal Affairs in the High Performing States of Andhra Pradesh, Karnataka, West Bengal, Himachal Pradesh, Gujarat, Maharashtra, Tamil Nadu, Kerala, A&N Islands, Dadra and Nagar Haveli, Daman & Diu and Lakshadweep.

Subsidizing cost of Caesarean Section

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

Assistance for Home Delivery

All BPL pregnant women aged 19 years and above, preferring to deliver at home are entitled to cash assistance of Rs. 500/- per delivery, up to two live births in all the States/UTs.

4.5.3 Progress of Janani Suraksha Yojana (JSY)

The coverage of the JSY has been increasing since its inception in 2005 as per the details below :

Year	No. of beneficiaries (in lakhs)	Expenditure (in crores)
2005-06	7.39	38.29
2006-07	31.58	258.22
2007-08	73.29	880.17
2008-09	90.37	1241.33
2009-10	100.78	1473.76
2010-11	106.97	1618.39
2011-12	109.37	1606.18
Total	519.75	7116.34

Antenatal, Intranatal and Postnatal care

- **Quality Ante Natal care and Post natal care**
Quality ANC includes minimum of at least 4 ANCs including early registration and 1st ANC in first trimester along with physical and abdominal examinations, Hb estimation and urine investigation, 2 doses of T.T Immunization and consumption of IFA tablets for 100 days.

- Health and nutrition education to promote dietary diversification, inclusion of iron and folate rich food as well as food items that promote iron absorption.
- Iron and Folic Acid supplementation to pregnant & lactating women for prevention and treatment of anaemia.
- The Mother and Child Protection Card (MCP Card)
 - The Mother and Child Protection Card (MCP Card) has been introduced through a collaborative effort of the Ministry of Women and Child Development and the Ministry of Health & Family Welfare, Government of India to monitor service delivery for mothers and children. The card also captures some of key services delivered to the mother & baby during Antenatal, Intranatal & Post natal care for ensuring that the minimum package of services are delivered to the beneficiary. MCP card has been disseminated in the year 2010-11 for implementation by the States.
 - The MCP card helps in timely identification, referral and management of complications during pregnancy, child birth and post natal period. The card also serves as a tool for providing complete immunization to infants and children, early and exclusive breast feeding, complementary feeding and monitoring their growth.
- Ensuring 48 hrs stay in hospital during childbirth and through subsequent home visits on 3rd, 7th and 42nd day is the important components for identification and management of emergencies occurring during post natal period. The ANMs, LHV's and Staff Nurses are being oriented and trained as SBA for tackling emergencies.

4.5.4 Intra Natal Care

Government of India has a commitment to provide skilled attendance at every birth both at community and Institution level.

- To manage and handle some common obstetric emergencies at the time of birth, the Government of India has taken a policy decision to permit Staff Nurses (SNs) and ANMs to give certain injections

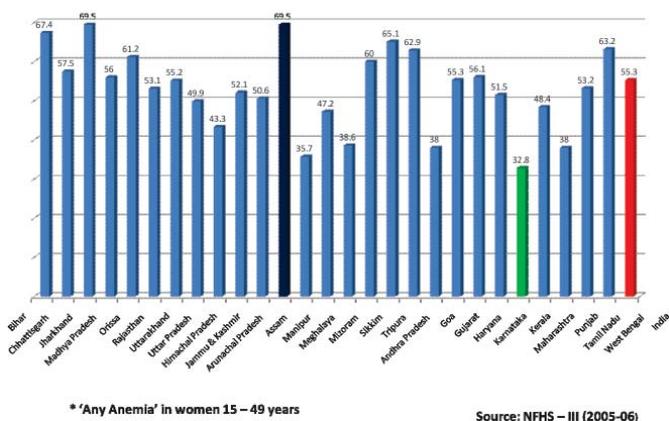
and also perform certain interventions under specific emergency situations to save the life of the mother.

- Training Strategy involves a 3 weeks training of SNs/ ANMs/LHVs in Skilled Attendance at Birth. For this Curriculum and Technical Guidelines have been revised and training is being implemented accordingly in all the States and UTs.

4.5.5 Prophylaxis and treatment of Nutritional Anemia

- As per results of NFHS III (2005-06), 55.3% of women aged 15-49 years are anemic in the country, and the state-wise prevalence is shown in the bar chart below. The problem is more severe during pregnancy, with 58.7% of pregnant women (15-49 years) and 63.2 % of lactating women being anemic. A programme for prophylaxis and treatment of anemia has been under implementation through out the country since 1997-98.
- Under the NRHM /RCH II Programme all pregnant and lactating women are provided with one tablet (containing 100 mg of elemental iron and 0.5 mg of Folic Acid) daily for 100 days. Those who have severe anemia are provided with double dose of these tablets. Iron Folic Acid (IFA) tablets are distributed to the Sub-Centres and through outreach activities at Village Health and Nutrition Days (VHNDs) and also at other health facilities like PHCs, CHCs, Sub District health facilities and District Hospitals.

Prevalence of Anemia in India by States



- **Tracking of severe anaemic women:** Line listing of severely anaemic pregnant women is being done at the Sub Centres and PHCs. The PHC MO I/c has been asked to keep a list of the severely anaemic women in his area.

- Operationalisation of the health facilities for provision of Basic Emergency Obstetric Care (BeMOC) and Comprehensive Emergency Obstetric Care (CEmOC) services:
- Primary Health Centers, Community Health Centers and District Hospitals are being strengthened for providing 24x7 basic and comprehensive obstetric care services.

4.6 DELIVERY POINTS

- Government of India has introduced the concept of Delivery Points for all the States/UTs for prioritizing and focus attention in terms of strengthening and upgrading the facilities where there is demand for services and which are conducting deliveries, so that these facilities provide comprehensive Reproductive and Child health services i.e. Maternal Health, Child Health, Family Planning, Immunization, ARSH services etc.
- The States have shared the list of such Delivery Points. Based on the above criteria, state-wise reports show that nearly 16,800 health facilities are conducting deliveries out of more than 1,70,000 health facilities in the country.
- The focus of Government of India (GoI) during 2012-13 is to strengthen all these functioning health facilities fulfilling the criteria as Delivery Points in terms of Infrastructure, Human Resource, Equipments, Capacity Building etc, so that these facilities are equipped to provide comprehensive Reproductive Maternal Newborn and Child Health (RMNCH) services.
- Regular performance monitoring of these Delivery Points are being done by the States.

- **Setting up of Blood Storage Centers (BSC) at FRUs:** Timely treatment of complications associated with pregnancy is sometimes hampered due to non-availability of Blood Transfusion services at FRUs. The Drugs and Cosmetics Act has been amended to facilitate establishment of Blood Storage Centers at such FRUs. This has helped the States in quick implementation of services for the availability of blood and thus helped in accelerating the operationalization of the FRUs.

4.6.1 Capacity building of health care providers

To Operationalise PHCs, CHCs, DH and other health facilities, the health providers working at these facilities are being trained and oriented for improving their knowledge and skills in providing quality obstetric care services. Some of the key trainings being imparted are:

SBA: Training Strategy involves a 3 weeks training of SNs/ANMs/LHVs in Skilled Attendance at Birth. For this Curriculum and Technical Guidelines have been revised and training is being implemented accordingly in all the States and UTs.

LSAS: Training of MBBS Doctors in Life Saving Anaesthetic Skills for Emergency Obstetric Care

The operationalization of First Referral Units, at sub- district i.e. CHC level for providing Emergency Obstetric Care (EmOC) to pregnant women is a critical strategy of RCH-II, which needs focused attention. It has not been possible to operationalize these FRUs till now due to various factors most pertinent being shortage of specialist manpower, i.e. Gynecologist and Anesthetist, particularly at district and sub district level. In view of this, for effective and better management of Emergency Obstetric needs at the grass root levels, GoI has taken a policy decision and is implementing 18 weeks programme for training of MBBS doctors in life saving anesthetic skills for Emergency Obstetric care at FRU. The training programme is presently being implemented in nearly 100 medical colleges across all the major States including NE Region.

4.6.2 EmOC: Training in Obstetric Management Skills

Government of India has also introduced training of MBBS doctors in Obstetric Management & Skills in collaboration with Federation of Obstetric and Gynecological Society of India (FOGSI). A 16 weeks training programme in obstetric management & skills including Caesarian Section operation is being implemented at the level of Medical Colleges and District Hospitals in nearly 25 Medical Colleges of the States.

BEmOC: A 10 day training for the Medical Officers in Basic Emergency Obstetric Care is being conducted at identified training centres and training is being implemented accordingly in the States and UTs.

The achievements in key maternal health trainings are as follows:

- ❖ Capacity building of Doctors, ANMs & Nurses:
 - For giving emergency anaesthesia: 1381 Medical Officers have been trained in Life Saving Anesthetic Skills (LSAS) as on Sept, 2012.

- For conducting C –sections: 867 Medical Officers have been trained in Emergency Obstetric Care (EmOC).
- 43,376 ANMs/ SNs/ LHVs have been trained as Skilled Birth Attendants as on Sept, 2012.
- 7,665 Medical Officers have been trained in the 10 day training on Basic Emergency Obstetric Care (BEmOC) Skills.
- 12584 Medical Officers, 4793 SNs/ANMs/LHVs and 3337 Lab Technicians have been trained in RTI/STI.

4.6.3 Referral Services at both Community and Institutional level

An effective perinatal referral transport service is critical in preventing maternal deaths in India. It enables a pregnant woman for timely reaching a facility at which she and her baby can receive appropriate care. There are a number of emergency or referral transport (RT) services operating in rural India today that provides transport and assistance to obstetric emergencies. Different solutions can be made for different contexts, but the aim of establishing a perinatal referral transport service is to ensure that a woman needing obstetric care reaches an adequately resourced facility safely, in sufficient time and in a condition that provides a fair chance for survival for her and her baby. It is also important that every model provides a minimum acceptable level of services at an optimal cost.

Under NRHM, states are provided financial assistance for establishing the emergency response services and patient transport ambulances. The states have the flexibility to choose from various models. Government of India has a thrust to establish a network of basic patient care transportation ambulances with aim to reach the beneficiary in rural area within 30 minutes of the call for quick service delivery. Presently states have been given the flexibility to establish assured referral systems to transport pregnant mothers and sick newborns, etc which includes different models including public, private partnership models.

The states have been given flexibility to use different models of emergency referral transport for establishing the necessary linkages between home and health facility and between different levels of health facilities and for drop back home for pregnant women and post delivered women and sick neonates for whom it is to be provided free of cost.

Key features for assured referral services are:

- linking with a centralized 24x7 call centre having an universal toll free number either district-wise or state-wise as per the situation.
- Vehicles are being GPS fitted for equitable geographical distribution and effective network and utilization.
- A prudent mix of basic level ambulances and emergency response vehicles are being established with focus on adequate coverage by Basic level ambulances.
- Response time for the ambulance should be reaching the beneficiary within 30 minutes and the woman reaches the health facility within the next 30 minutes.
- Universal access to referral transport throughout the State, including transport to difficult and hard to reach areas, to be ensured.

4.7 COMPREHENSIVE ABORTION CARE SERVICES

Unsafe Abortion is a significant medical and social problem in India. 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 health complications. Comprehensive abortion care services in both public and private sector are available for termination of unintended pregnancies (within the framework of the MTP Act, 1971) and providing post abortion care for spontaneous/induced abortions and their complications.

To reduce maternal mortality and morbidity due to unsafe abortion, consistent efforts have been made to expand safe abortion services in peripheral health care facilities in rural areas. These include provision of drugs and equipment for EVA, Manual Vacuum Aspiration (MVA), Medical Methods of Abortion (MMA) at PHCs, CHCs, DHs with focus on the delivery points.

Encouraging private and NGO sectors to provide quality MTP services, Certification and Regulation of these sectors through District Level Committees (DLCs) within the framework of the MTP Act 1971.

4.7.1 Strategies

Development of appropriate IEC /BCC messages to create awareness on MTP, Availability of safe abortion,

legality of MTP & availability of services at public health institutions, Capacity building of Medical Officers to equip them with skills necessary to provide safe abortion services at PHC level and above, and of ANMs, ASHAs other field functionaries and RMNCH Counsellors to provide confidential counselling for MTP and post-abortion care including family planning.

Funds for implementing safe abortion services are being allocated to states through State Programme Implementation Plans (State PIP) under NRHM.

4.7.2 Services of Reproductive & Tract Infections (RTI /STI)

Priority for testing of pregnant woman for HIV using Whole Blood Finger Prick Test is being given to the high focus districts under National AIDS Control Program. Services for RTI /STI are provided at all health facilities from PHC upwards including CHCs, other Sub District Hospitals and District Hospitals with a focus on Delivery Point in convergence with the NACP. These include Syndromic management of RTIs/STIs, provision of colour coded kits, RPR testing kits and Whole Blood Finger Prick Testing at the delivery points.

The provision of these services should be given first at all identified Delivery Points. Convergence with the National AIDS Control Programme (NACP) is essential for provision of services for case management, laboratory services, counselling services, drugs, equipment, blood safety etc.

4.7.3 Prevention of Parent to Child Transmission (PPTCT) Services

To enhance coverage of PPTCT services, HIV screening of pregnant women is being offered during routine Ante natal care visits on a voluntary basis. NACO has launched new Guidelines for PPTCT under the NACP.

4.7.4 Outreach activities**Village Health and Nutrition Day**

Organizing of Village Health & Nutrition Day (VHNDs) at Anganwadi center at least once every month to provide ante natal/ post partum care for pregnant women, promote institutional delivery, immunization, Family Planning & nutrition are the part of various services being provided during VHNDs. More than 3.7 Crore Village Health and Nutrition Days (VHNDs) have been held at Anganwadi Centres (NRHM- MIS) since the launch of NRHM.

4.7.5 Involvement of professional associations for skill based training under Public Private Partnership (PPP)

Services of Private Health facilities for providing reproductive health services are being mobilized under various demand side financing schemes through the mode of Public Private Partnership (PPP). Many states such as Gujarat (Chiranjeevi Yojana) Jharkhand (Mukhya Mantri Janani Shishu Swasthya Abhiyan), West Bengal (Ayushmati Scheme) are being implemented under Public Private Partnership. For better implementation of this, Government of India (GoI) guidelines have been issued to the states.

Government of India (GoI) Guidelines for engaging the services of private health facilities for up-scaling SBA Training for ANMs/ SNs/LHVs have also been issued to the States.

ASHAs: Engagement of 8.71 lakhs Accredited Social Health Activists (ASHAs) to generate demand and facilitate accessing of health care services by the community.

The key role of the Accredited Social Health Activists (ASHA) is to generate demand and facilitate accessing of health care services including services for institutional delivery by the community.

The activities undertaken by the ASHA include visit the pregnant women regularly, prepare micro-birth plans and explain to them the benefits of institutional delivery, to escort the pregnant woman to the nearest public health facility at the time of delivery, to facilitate arrangement for referral transport and stay with the mother in the institution till her delivery, to assist the ANM in providing care to the mother during the postnatal period through home visits and to facilitate the pregnant women in getting the benefits under the JSY scheme.

Incentives: States are incentivizing the ASHA as per their local situation and needs for different activities like Institutional Delivery under JSY, timely referral of high risk cases during ANC, Full ANC, IFA administration like the DOTS Programme, screening of HIV in pregnant women and accompanying referrals to ICTCs, reporting of maternal death, registration of births, etc.

4.8 NEW INITIATIVES

MCTS: Name Based web enabled tracking of pregnant women and children to ensure and monitor

preventive, promotive and curative health services to them.

- An online MCTS has been made operational for all the States and UTs. After entering the data, work plan is being generated for the ANMs and ASHAs to deliver the health services during any point of time. MCTS call centre has been setup to call the beneficiaries and validate their data.
- SMS of mother and child count are sent to various officials, ANM/ASHA which are registered on MCTS server to validate their names, mobile numbers and location details with the purpose ultimately to send work plans to them through SMS. Now SMS has started being sent to the pregnant women reminding her of impending visits for her due services.
- Data for around **3.17 crore** pregnant women have been captured and for **2.41 crore** children have been captured on the MCTS central server till 19.11.12.

4.9 JANANI SHISHU SURAKSHA KARYAKRAM (JSSK)

- Government of India has launched Janani Shishu Suraksha Karyakram (JSSK) on 1st June, 2011. The initiative entitles all pregnant women delivering in public health institutions to absolutely free and no expense delivery, including caesarean section. The entitlements include free drugs and consumables, free diet up to 3 days during normal delivery and up to 7 days for C-section, free diagnostics, and free blood wherever required. This initiative also provides for free transport from home to institution, between facilities in case of a referral and drop back home. Similar entitlements have been put in place for all sick newborns accessing public health institutions for treatment till 30 days after birth.
- The scheme is estimated to benefit more than 12 million pregnant women who access Government health facilities for their delivery. Moreover it will motivate those who still choose to deliver at their homes to opt for institutional deliveries.
- All the States and Union Territories have initiated implementation of free entitlements under JSSK both to the pregnant women and sick neonates upto 1 month of age.

- In the year 2012-13, a sum of Rs 2107 crores have been allocated to the States for the implementation of free entitlements under JSSK.

4.10 MATERNAL DEATH REVIEW (MDR)

- Maternal Death Review (MDR) is one of the important interventions under the RCH Programme to accelerate the pace of decline of MMR in the country.
- The MDR process has been institutionalised across the country to Serve as a tool for improving the quality of obstetric care and reducing maternal mortality and morbidity. Under the process, reporting and analysis of the maternal deaths provides an opportunity to identify the delays that contribute to maternal deaths at various levels and use the information to take corrective actions to overcome the systemic and programmatic gaps in service provision.
- The MDR Guidelines and monitoring tools have been disseminated to the States and UTs for guiding states in rolling out and monitoring the MDR Process. All the States & UTs are currently reporting on the MDR process through monthly reports to MoHFW. Tamil Nadu and Kerala have well established processes to conduct MDR for a number of years. Other States like Maharashtra, Odisha, Punjab, Madhya Pradesh and Assam have shown considerable progress in reporting and analysis of maternal deaths.

4.11 MATERNAL AND CHILD HEALTH WING

- Janani Suraksha Yojana, a demand promotion scheme for reduction of MMR and IMR has led to steep increase in Institutional Delivery in government health facilities. ASHAs are also generating demand and facilitating access of women and children to public health institutions.
- As a result, these hospitals are overstretched in order to ensure quality of care. Major expansion of District Hospital, Sub-District Hospital, and Community Health Centres with high case load of institutional deliveries has been proposed by the States in the Financial Year 2012-13.
- 100 bedded state of the art Maternal and Child Health Wing have been introduced at 156 District Hospitals & MCs. Besides this, 70/50/30 bedded maternity wards have been sanctioned at other DHs/SDHs/

CHCs with high volume delivery load at 122 health facilities.

- More than 20,000 additional beds have been sanctioned across 11 states to be completed in next 2 to 3 years.

4.12 ADOLESCENT HEALTH

Adolescent Health includes Adolescent Reproductive and Sexual Health Programme (ARSH), School Health Programme (SHP), Menstrual Hygiene Scheme (MHS) and Weekly Iron Supplementation Programme (WIFS) components.

Glimpse of the Programmes under Adolescent Health and progress in the last three years

A. Adolescent Reproductive and Sexual Health (ARSH)

3356 AFHCs across the States and UTs are providing focused care to the Adolescents SRH issues. Other adolescent-friendly services such as Nutrition counselling, treatment for RTIs/STIs and referral services are also provided to adolescents during the clinic sessions. Iron & Folic Acid tablets and contraceptives are also made available in the clinics for the adolescents. States have also proposed new clinics in 2012-13 in order to expand the delivery of services. States have trained a cadre of health professionals on ARSH to ensure effective delivery of services as per national guidelines. 4311 MOs and 15573 ANMs/LHVs have been trained across the country under ARSH.

The ARSH component has seen a phenomenal improvement in terms of improved budgetary allocation by the States in the PIP of 2012-13. Three National Consultations over 2 years have helped the States comprehend the importance of Adolescent Health and accordingly plan for the activities. The allocation for ARSH has gone up from Rs 1376.00 lakhs in 2011-12 to Rs 4866.00 lakhs in 2012-13.

The platform of Village Health Nutrition Day (VHND) is utilized for reaching out to the adolescents and providing health services with the help of Auxiliary Nurse Midwife (ANM) and Anganwadi Workers (AWW). Outreach services are also provided through peer educators for which 95244 peer educators have been selected across the country in the last three years.

Innovations by States on ARSH

ARSH Implementation in Karjat Block, Maharashtra

National Institute for Research in Reproductive Health (Indian Council of Medical Research), Mumbai is implementing a project for strengthening the ARSH Services in Karjat Block of Raigad District in Maharashtra as per the National Standards of ARSH Implementation Guide. The project was launched by NIRRH, in order to ensure convergence of various activities under ARSH and NACP through involvement of different departments and sectors and NGOs through their grass root level workers. The project has proved a model of networking of ARSH functionaries as well as convergence between different departments sectors, NGOs etc.

The objective of the project is to provide assistance and mentoring support to GOM in delivery of linked ARSH-HIV services. Some of the specific objectives are to:

1. To establish and operationalise ARSH services as per the National standards and guidelines
2. To sensitize community (parents, teachers, community leaders) and young people for seeking services
3. To bring about block level convergence between RCH and NACP and other related intra- and inter-sectoral programmes
4. Piloting Quality Assessment Tools
5. To document process, challenges, barriers and facilitative factors.

B. School Health Programme (SHP)

Keeping children free from physical and mental health concerns is the focus of the School Health Programme. The programme targets school going children and adolescents in 6-18 years age group in the Government

and Government aided schools. The programme entails biannual health screening and early management of disease, disability and common deficiency and linkages with secondary and tertiary health facilities as required. (Details in Chapter on Child Health)

C. Menstrual Hygiene Scheme (MHS)

The Ministry of Health & Family Welfare has introduced a scheme for promotion of menstrual hygiene among adolescent girls in the age group of 10-19 years in rural areas. The pilot is being implemented in 152 districts across 20 states in the country, wherein supply of Sanitary napkins in 107 districts, is through central procurement and in 45 districts through local Self Help Groups. The sanitary napkin pack (containing 6 pieces each) has been branded as 'Freedays'.

D. Weekly Iron and Folic acid Supplementation (WIFS)

Adolescent Anaemia is a long standing public health problem in India and it is estimated that more than 5 Crores adolescents (15 to 19 years) are anaemic in the country. Anaemia is caused by Iron deficiency and thereby anaemia is due to accelerated growth and body mass building, poor dietary intake of iron and high rate of infection and infestation. In girls, deficiency of iron is further aggravated with higher demands with onset of menstruation and also due to the problem of adolescent pregnancy and conception. Guided by the empirical evidence that weekly supplementation of 100mg elemental Iron and 500 µg Folic Acid(IFA) is effective in decreasing prevalence of anaemia in adolescents, MoHFW is soon going to launch the Weekly Iron and Folic Acid supplementation (WIFS) Programme for school going adolescent girls and boys and for out of school adolescent girls.

The Programme envisages administration of supervised weekly IFA supplementation and biannual deworming to approximately 13 crores rural and urban adolescents through the platform of Government/Government aided and Municipal Schools for school going children and Anganwadi Kendras for out of school adolescent girls.