03 CHAPTER

Maternal & Adolescent Healthcare

3.1 MATERNAL HEALTH

Women are strong pillars of any vibrant society. Sustained development of the country can thus be achieved only if we take holistic care of our women and children. Massive and strategic investments have been made under the National Health Mission 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 well being of mothers is not only important in their own right but are also central to solving large broader, economic, social and developmental challenges.

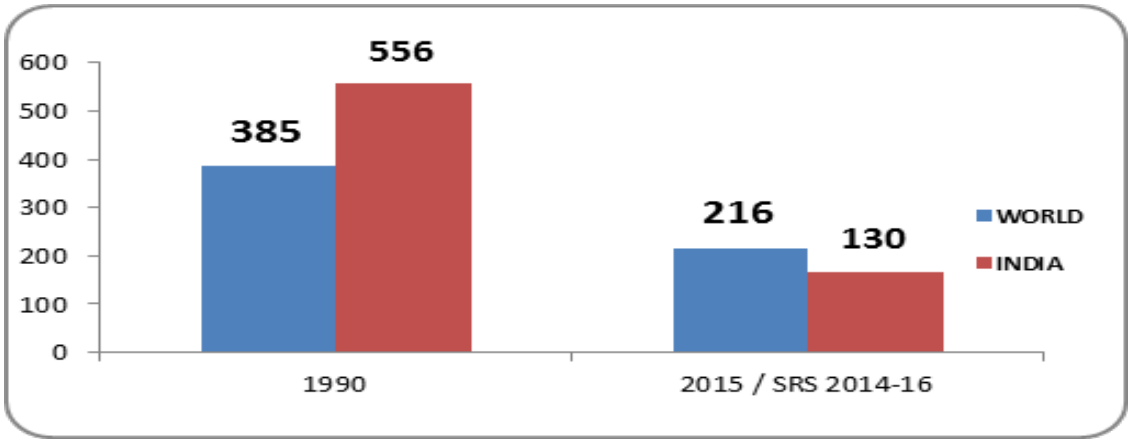
3.2 MATERNAL MORTALITY RATIO (MMR)

Maternal Mortality Ratio (MMR) in India was exceptionally high in 1990 with 556 women dying during child birth per hundred thousand live births. Approximately, 1.38 lakh women were dying every year on account of complications related to pregnancy and child birth. The global MMR at the time was much lower at 385. There has however, been an accelerated decline in MMR in India. MMR in the country has declined to 130 (SRS 2014-16) against a global MMR of 216 (2015). The number of maternal deaths stands reduced by

77%. India's share among global maternal deaths has declined significantly as per the MMEIG report.

- Sustainable Development Goal (SDG) 3 pertains to Maternal Health where target is to reduce the Maternal Mortality Ratio (MMR to be less than 70 per 100,000 live births by 2030)
- Globally, the World's MMR fell by nearly 44% over the past 25 years, to an estimated 216 maternal deaths per 100 000 live births in 2015, from an MMR of 385 in 1990 at an average annual decline of 2.3%, While India recorded a decline of 77% reduction in maternal deaths over 25 years.

India's progress on MDG-5 in global context

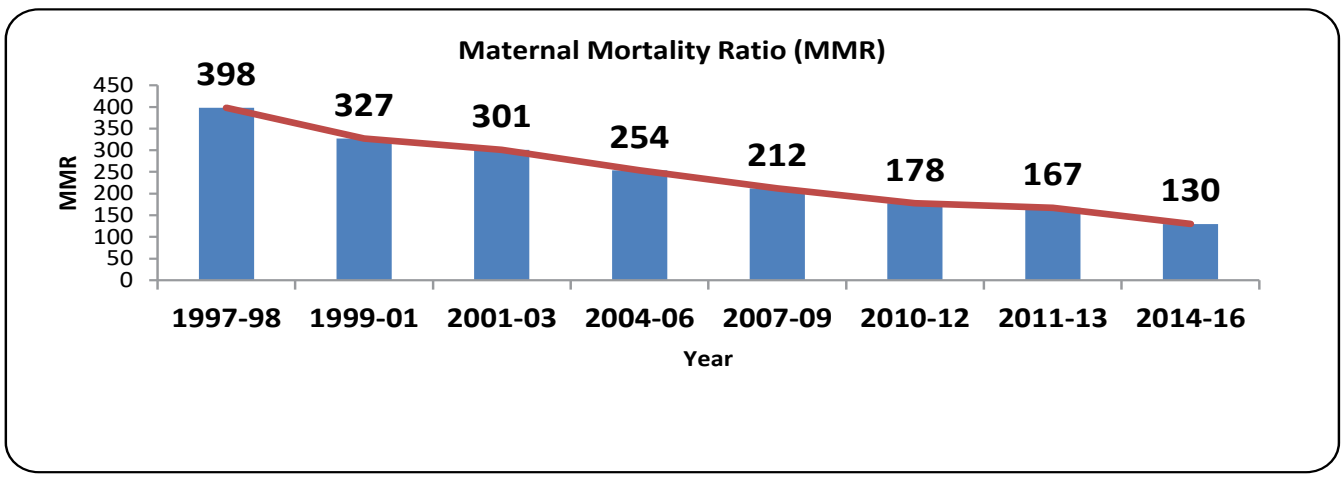


Source "Trends in Maternal Mortality: 1990 to 2015" - UN Inter–Agency Expert Group's & RGI -SRS

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 130 per 1,00,000 live births in the period 2014-16.

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 2011-13 and 2014-16 is 8.01%.

b. Assam continues to be the State with the highest MMR (237) followed by Uttar Pradesh/Uttarakhand (201) and Rajasthan (199).

c. States which have achieved an MMR of 100 per 100,000 live-births in 2014-16 are Kerala, Tamil Nadu, Maharashtra, Telangana, Gujarat and Andhra Pradesh. The States of Kerala, Maharashtra and Tamil Nadu have reached the SDG-3 target of MMR <70 per 100000.

d. Additional efforts will be required for lowering the MMR, especially, in the States of Assam (237), Uttar Pradesh (201), Rajasthan (199), Odisha (180), Madhya Pradesh / Chhattisgarh (173) and Bihar/ Jharkhand (165), which have quite high MMR as compared to the national level, if the SDG target is to be achieved in an equitable manner.

e. 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.

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 81.4% in the same period.

3.4.1 Key strategies for accelerating the pace of decline inMMR

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. 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 Rs.1835 crores in 2017-18. In the financial year 2018-19, the expenditure reported is Rs. 1743.46 crores (provisional). Institutional delivery has increased from 40.8% in 2005-06 (NFHS-3) to 78.9% (NFHS-4) 2015-16.

ii. Building on the phenomenal progress of the JSY scheme, Government of India launched 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 2018-19, 87% of pregnant women received free drugs, 99% free diagnostics, 60% free diet, 49% free home to facility transport while 279% 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 1.34 Crore women delivered in Govt. facilities last year (2018-19).

iii. 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 590 dedicated Maternal and Child Health Wings (MCH Wings) with more than 32,000 additional beds have been sanctioned.

iv. 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 these 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 MDSR and MNM. According to the State Reports, 64% of the estimated maternal deaths have been reported in 2018-19. Out of these, 64% deaths have been reviewed by the District MDR Committees.

v. 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. Revised guidelines have been issued for service delivery in India in Feb 2019. More than 13,000 MOs have been trained in CAC trainings.

vi. 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 2018-19, over 80 lakh pregnant women are screened for syphilis and approximately 1.86 crore pregnant women have been screened for HIV.

vii. 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 2,412 doctors have been trained in Emergency Obstetric Care including C-sections and 2,683 doctors in LSAS. Over 3,30,000 SNs/LHVs/ANMs have been trained as SBAs as per State reports.

viii. "Prevention of Post-Partum Hemorrhage (PPH) through Community based advance distribution of Misoprostol" by ASHAs/ ANMs has been launched for >20% 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.

ix. 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. 104 stand-alone skills labs have been established at different States such as Gujarat, Haryana, Maharashtra, Madhya Pradesh, West Bengal, Odisha, Tamil Nadu, Tripura, Jammu & Kashmir, Meghalaya, Kerala, Nagaland, Sikkim, Andhra Pradesh, Manipur, Himachal Pradesh, Arunachal Pradesh, Uttrakhand, Punjab, Delhi, Telangana, Puducherry, Assam and Karnataka. Till date 1184 health

personnel have been trained in National Skill Lab & 2,213 participants in State Skill Labs.

A view of 6 days training at National Skills Lab

x. To bring down the Maternal Mortality Ratio (MMR) and Neonatal Mortality Rate (NMR), the Govt. of India has launched Dakshata in 2015 in 7 States with an objective to improve the quality of care at the time of birth by focusing on delivering high impact, evidence based practices. Till date 16,419 health care providers have been trained in Dakshata trainings. Dakshata planning meeting done in 6 States (Bihar, Jammu & Kashmir, Nagaland, Meghalaya, Assam, Kerala, and Delhi) and 13 ToT batches completed in 5 States (Bihar, Jammu & Kashmir, Nagaland, Meghalaya, Assam and Kerala). Till date 743 health institutions have been saturated.

a. Pre-Service Education for strengthening Nursing Midwifery Cadre: Five National Nodal Centres (NNCs) 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 and 7 State Nodal Centres in Dehradoon, Meerut, Varanasi, Kota, Udaipur, Jabalpur, Ujjain, Patna, Ranchi, Berhampur have been strengthened achieving above 70% of performance standards.

b. 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.

c. 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.

d. Monthly Village Health and Nutrition Days (VHNDs) is an outreach activity at Anganwadi centers for provision of maternal and childcare including nutrition in convergence with the ICDS.

e. 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. New Mother and Child Protection (MCP) Cards have been developed.

f. 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.

g. Anaemia Mukt Bharat: Launched recently to combat widespread anaemia in the country. The Anaemia Mukt Bharat -Intensified Iron Plus Initiative aims to strengthen the existing mechanisms and foster newer strategies to tackle anaemia, focused on six target beneficiary groups, through six interventions and six institutional mechanisms; to achieve 2% annual decline in prevalence of anaemia.

h. Engagement of more than 10 lakh Accredited Social Health Activists (ASHAs) to facilitate accessing of health care services by the community, particularly pregnant women.

i. 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.

j. Further to sharpen the focus on the low performing districts, 256 High Priority Districts (HPDs) & 117 aspirational Districts 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.

xi. To further accelerate the pace of decline in MMR following activities have been carried out : new operational guidelines for obstetric HDU & ICU have been prepared and disseminated to the States for screening for diagnosis & management of Gestational Diabetes Mellitus, Hypothyroidism during pregnancy, 161 Obstetric HDUs/ICUs have been approved; 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 Post-partum Hemorrhage; training manuals for facilitators and participants for the Daksh Skills Lab for RMNCH+A services are the latest guidelines released.

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	2014-16	1999-01	2001-03	2004-06	2007-09	2010-12	2011-13	2014-16
India	398	327	301	254	212	178	167	130	-7.6	-4.1	-5.5	-5.8	-5.7	-6.2	-8.01
Andhra Pradesh	197	220	195	154	134	110	92	74	4.5	-5.9	-7.6	-4.5	-6.4	-16.4	-7
Assam	568	398	490	480	390	328	300	237	-13.3	11.0	-0.7	-6.7	-5.6	-8.5	-7.56
Bihar/ Jharkhand	531	400	371	312	261	219	208	165	-10.7	-3.7	-5.6	-5.8	-5.7	-5.0	-7.43
Gujarat	46	202	172	160	148	122	112	91	80.7	-7.7	-2.4	-2.6	-6.2	-8.2	-6.69
Haryana	136	176	162	186	153	146	127	101	10.9	-4.1	4.7	-6.3	-1.5	-13.0	-7.35
Karnataka	245	266	228	213	178	144	133	108	3.3	-7.4	-2.2	-5.8	-6.8	-7.6	-6.71
Kerala	150	149	110	95	81	66	61	46	-0.3	-14.1	-4.8	-5.2	-6.6	-7.6	-8.98
Madhya Pradesh/ Chhattisgarh	441	407	379	335	269	230	221	173	-3.2	-3.5	-4.0	-7.1	-5.1	-3.9	-7.84
Maharashtra	166	169	149	130	104	87	68	61	0.7	-6.1	-4.4	-7.2	-5.8	-21.8	-3.56
Odisha	346	424	358	303	258	235	222	180	8.5	-8.1	-5.4	-5.2	-3.1	-5.5	-6.75
Punjab	280	177	178	192	172	155	141	122	-16.8	0.3	2.6	-3.6	-3.4	-9.0	-4.71
Rajasthan	508	501	445	388	318	255	244	199	-0.6	-5.8	-4.5	-6.4	-7.1	-4.3	-6.57
Tamil Nadu	131	167	134	111	97	90	79	66	10.2	-10.4	-6.1	-4.4	-2.5	-12.2	-5.82
Uttar Pradesh/ Uttarakhand	606	539	517	440	359	292	285	201	-4.6	-2.1	-5.2	-6.6	-6.7	-2.4	-10.99
West Bengal	303	218	194	141	145	117	113	101	-12.3	-5.7	-10.1	0.9	-6.9	-3.4	-3.67

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 the National Health Mission (NHM). It is being implemented with the objective of reducing 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 scheme has identified Accredited Social Health Activists (ASHAs) as an effective link between the Government and pregnant women.

3.5.1 Important Features of JSY

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

3.5.2 Eligibility for Cash Assistance

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

LPS	All pregnant women delivering in government health centres, such as Sub 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 JSY Scheme has a provision to hire the services of a private specialist to conduct Caesarean Section or for the management of obstetric complications in 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 JSY 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 through electronic funds transfer.

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 Rs.1835 crores in 2017-18. In the financial year 2018-19, the expenditure reported is Rs.1743.46 crores (provisional).

Year-wise physical and financial progress of JSY is as under:

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	1764.33
2014-15	104.38	1777.04
2015-16	104.16	1708.72
2016-17	104.59	1788.10
2017-18	110.21	1835.06
2018-19*	100.41	1743.46

** Figures are provisional for FY 2018-19*

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

- Increase in institutional deliveries which have gone up from 47% (District Level Household Survey-III, 2007-08) to 78.9% (NFHS-4, 2015-16).
- Maternal Mortality Ratio (MMR) which declined from 254 maternal deaths per 1,00,000 live births in 2004-06 to 130 maternal deaths per 1,00,000 live births during 2014-16.
- IMR has declined from 58 per 1000 live births in 2005 to 34 per 1000 live births in 2017.
- The Neo-Natal Mortality Rate (NMR) has declined from 37 per 1000 live births in 2006 to 24 per 1000 live births in 2016.

3.6 PRADHAN MANTRI SURAKSHIT MATRITVA ABHIYAN(PMSMA)

The Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA) has been launched by the 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. Over 1.89 crore ANC check-ups were conducted by over 5,640 volunteers in over 13,672 Government facilities. Also morethan 9.18 lakh high risk pregnancy cases were identified across the country.


AWARDS FOR REDUCTION IN MMR &
HONOURING PMSMA 'IPledgeFor9' ACHIEVERS
29 June 2018 I Hyatt Regency, New Delhi
#IPledgeFor9
PRADHAN MANTRI SURAKSHIT MATRITVA ABHIYAN
ACHIEVERS AWARDS


AWARDS FOR REDUCTION IN MMR &


CHILD DEV. PROJECT OFFICER
ICDS PROJECT CHENANI
PRADHAN MANTRI SURAKSHIT MATRITVA ABHIYAN
(PMSMA)

3.7 RASHTRIYA KISHOR SWASTHYA KARYAKRAM (RKSK)

In order to ensure holistic development of adolescent population, the MoHFW launched Rashtriya Kishor Swasthya Karyakram (RKSK) in January, 2014 to reach out to 253 million adolescents; male and female, rural and urban, married and unmarried, in and out-of- school. The programme expands the scope of adolescent health programme in India from being limited to sexual and reproductive health to now including in its ambit - nutrition, injuries and violence (including gender based violence), non-communicable diseases, mental health and substance misuse. It is a paradigm shift from the clinic-based services to promotion and prevention and reaching adolescents in their own environment, such as in schools, families and communities.

3.7.1 The interventions under RKSK can be broadly grouped as:

A. Community based interventions

B. Facility based interventions

C. School based interventions

(A) Community based interventions:

- **Peer Education (PE) Programme**

The PE programme aims to ensure that adolescents or young people between the ages of 10-19 years benefit from regular and sustained peer education covering nutrition, sexual and reproductive health, conditions for NCDs, substance misuse, injuries and violence (including GBV) and mental health. Under the PE programme, four Peer Educators (two boys and two girls) are selected per village/1000 population/ASHA habitation to reach out to adolescents.

Peer Educators form a group of 15-20 boys and girls in the community and conduct weekly one to two hours participatory sessions on adolescent health.

Adolescent Health Day (AHD) is conducted at the village level on quarterly basis to increase awareness among adolescents, parents, families and stakeholders about issues and needs related to adolescent health and the services available. PEs facilitate organization of AHD and also refers adolescents to Adolescent Friendly Health Clinics (AFHCs).

Current Status: As on March, 2019, 2.53 lakh Peer Educators have been selected of which 1.79 lakh have been trained. Across the States, 53,949 AHDs were celebrated during the FY 2018-19.

➢ **Weekly Iron Folic Acid Supplementation (WIFS) Programme**

WIFS entails provision of weekly supervised IFA tablets to in-school adolescent boys and girls and out-of-school adolescent girls for prevention of iron and folic acid deficiency anaemia, and biannual albendazole tablets for helminthic control. The programme is being implemented across the country in both rural and urban areas, covering Government and Government aided schools and Anganwadi centres. Screening of targeted adolescents population for moderate/ severe anaemia and referral of cases to an appropriate health facility; and information and counselling for prevention of nutritional anaemia are also included in the programme.

The programme is implemented through convergence with key stakeholder Ministries i.e. the Ministry of Women and Child Development and Department and the Ministry of Human Resource Development, with joint programme planning, capacity building and communication activities. The programme aims to cover a total of 11.9 crore beneficiaries including 9.4 crore in-school and 2.5 crore out-of-school beneficiaries.

Current Status: During the FY 2018-19, 4.17 crore beneficiaries (3.59 crores in-school adolescents and 58 lakh out of school adolescent girls) were covered under WIFS programme which was carried out every month.

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

Scheme for Promotion of Menstrual Hygiene was launched by MoHFW, GoI to promote Menstrual Hygiene among adolescent girls in the age group of 10-19 years in rural areas as part of the Adolescent Reproductive Sexual Health (ARSH) in RCH II, with specific reference to ensuring health for adolescent girls.

The major objectives of the scheme are:

- To increase awareness among adolescent girls on Menstrual Hygiene.
- To increase access to and use of high quality sanitary napkins to adolescent girls in rural areas.
- To ensure safe disposal of sanitary napkins in an environmentally friendly manner.

Since 2015-16, the scheme had been decentralized and funds are approved in the State Programme Implementation Plans for decentralized procurement of sanitary napkin packs, for safe storage and disposal and for training of ASHA and nodal teachers. The States have been instructed to undertake procurement of sanitary napkins packs at prices decided through competitive bidding.

The 6th meeting of MSG held on 2nd March 2019 has recommended expansion of Menstrual Hygiene Scheme in urban slums in all cities of India in a phased manner starting with 25% of adolescent girls in slums in 15 States where the number of Urban ASHAs is sufficient viz. Andhra Pradesh, Assam, Chhattisgarh, Delhi, Gujarat, Haryana, Jharkhand, Kerala, Madhya Pradesh, Manipur, Odisha, Punjab, Tripura, Uttar Pradesh and Uttarakhand. In the first phase 7.98 lakh girls and 15,000 Urban ASHAs will be reached.

Current Status: Rs. 4254 lakhs have been allocated to 16 States in ROP 2018-19 for decentralized procurement of sanitary napkins under MHS. The programme has been rolled out in 9 States/ UTs and in 6 States/ UTs the procurement of sanitary napkins is under process.

(B) Facility based interventions :

➢ **Adolescent Friendly Health Clinics (AFHC)**

AFHCs act as the first level of contact of primary health care services with adolescents. The broad objectives of AFHCs is provision of counselling and clinical services to adolescents. AFHCs are established at Medical Colleges, District Hospitals, Sub – Divisional Hospitals, Community Health Centres, Primary Health Centres and Urban Health Centres to cater to diversified health and counselling need of adolescent girls and boys.

Dedicated space, trained Medical Officer, ANMs and Counsellors, availability of equipment, commodities and comprehensive IEC material are prerequisites for the establishment of AFHCs.

Current status: Total 7,464 AFHCs have been established across the country. 70.71 lakh adolescents availed counselling and clinical services from AFHCs during FY 2018-19.

(C) School based interventions :

School based health promotion activities have been incorporated as a part of the Health and Wellness component of the Ayushman Bharat Program of the Government of India. These activities will combine health education, health promotion, disease prevention and improve access to health services in an integrated, systemic manner at the school level. The School Health Promotion Activities under Ayushman Bharat Program is a joint initiative of MoHFW, Department of School Education & Literacy and Ministry of Human Resource & Development.

Two teachers, preferably one male and one female, from every school is designated as "Health and Wellness Ambassadors" and will be trained to transact health promotion and disease prevention information in the form of interesting activities for one hour every week. These health promotion messages will also have bearing on improving health practices in the country as students will act as Health and Wellness Messengers in the society. Every Tuesday may be dedicated as Health and Wellness Day in the schools.

Current status: With finalization of the training curriculum, the programme will be implemented in 85 districts across 28 States to begin with.

Other Activities

RKSK Regional Review Workshop: Five 2 days RKSK Regional Review Workshops were conducted between November, 2018 to January 2019 in Tamil Nadu, Odisha, Meghalaya, Punjab and Chhattisgarh for all States/UTs for reorientation of State Officials and State wise review of RKSK implementation.

The State participants included State RKSK Nodal Officer, State RKSK consultants some District RKSK Officials. Representatives from WCD and Education Departments of the host State were also actively involved.

The process adopted for the workshop was; presentations on current status of activities, discussion on achievements and challenges, orientation on newer initiatives and collaborative decision making regarding the further interventions.

The review reports comprising of actionable points with timelines have been shared with the States/ UTs.

3.8 LAQSHYA PROGRAMME

MoHFW launched "LaQshya" programme in December 2017 to improve the quality of care in Labour room and Maternity operation theatres. It will ensure that pregnant women receive respectful and the best quality of care during delivery and immediate post-partum. Total 2,257 facilities are selected with 180 medical colleges. State orientation is complete in all States and UTs. Baseline assessment is complete in 2,214 (98%) facilities.

Till date, 179 Labour rooms and 158 Maternity Operation Theatres are State certified. 54 Labour rooms and 38 Maternity Operation Theatres are National LaQshya certified. Ist Medical College Training of Trainers was held in Delhi from September 17th -18th, 2018. National level Training of Trainers was conducted in Delhi from October 15th-16th, 2018. 2nd Medical College Training of Trainers was conducted in Delhi on 21-22 January, 2019. 1st and 2nd Regional Training of Trainers were conducted in Bhopal (15-16th November, 2018) and Lucknow (Jan 16th -17th, 2019) while 3rd Regional Training of Trainers have been conducted in Jaipur from March 26-27, 2019. 4th Regional Training of Trainers was conducted in Hyderabad from April 25-26, 2019. Standard Operating Procedures for District Hospital and Medical College Hospital have been disseminated for implementation. To fast track certification process, structured Quality Improvement cycles have been implemented in LaQshya facilities. Digitization of LaQshya related data has been initiated through LaQshya Portal.

Status of LaQshya

	State	No of facilities identified for LaQshya	Number of Facilities applied for National Certification (MCH-Medical College Hospital; Others - DH, SDH, CHC, FRU)				Number of Facilities State Certified				Number of Facilities National Certified			
			LR		OT		LR		OT		LR		OT	
			MCH	Others	MCH	Others	MCH	Others	MCH	Others	MCH	Others	MCH	Others
1	Andaman Nicobar Islands	6	0	0	0	0	0	0	0	0	0	0	0	0
2	Andhra Pradesh	69	0	3	0	3	0	3	0	3	0	1	0	0
3	Arunachal Pradesh	6	0	0	0	0	0	0	0	0	0	0	0	0
4	Assam	128	0	6	0	5	3	15	3	15	0	4	0	4
5	Bihar	426	0	3	0	3	0	3	0	3	0	2	0	1
6	Chandigarh	4	0	0	0	0	0	0	0	0	0	0	0	0
7	Chhattisgarh	38	0	9	0	6	0	9	0	7	0	6	0	3
8	Dadra N Haveli	4	0	2	0	0	0	2	0	0	0	2	0	0

	State	No of facilities identified for LaQshya	Number of Facilities applied for National Certification (MCH-Medical College Hospital; Others - DH, SDH, CHC, FRU)				Number of Facilities State Certified				Number of Facilities National Certified			
			LR		OT		LR		OT		LR		OT	
			MCH	Others	MCH	Others	MCH	Others	MCH	Others	MCH	Others	MCH	Others
9	Daman & Diu	2	0	0	0	0	0	0	0	0	0	0	0	0
10	Delhi	18	0	0	0	0	0	0	0	0	0	0	0	0
11	Goa	5	0	0	0	0	0	0	0	0	0	0	0	0
12	Gujarat	153	10	23	10	20	12	33	12	33	5	7	5	8
13	Haryana	48	0	7	0	0	0	9	0	0	0	6	0	0
14	Himachal Pradesh	20	0	2	0	2	0	2	0	2	0	2	0	1
15	Jammu & Kashmir	23	0	0	0	0	0	1	0	1	0	0	0	0
16	Jharkhand	74	0	2	0	2	0	4	0	4	0	1	0	1
17	Karnataka	123	0	0	0	0	0	0	0	0	0	0	0	0
18	Kerala	41	0	3	0	3	0	3	0	3	0	2	0	2
19	Lakshdweep	1	0	0	0	0	0	0	0	0	0	0	0	0
20	Madhya Pradesh	25	0	14	0	14	0	14	0	15	0	5	0	5
21	Maharashtra	123	0	6	0	8	0	22	0	20	0	0	0	0
22	Manipur	6	0	0	0	0	0	1	0	1	0	0	0	0
23	Meghalaya	4	0	0	0	0	0	0	0	0	0	0	0	0
24	Mizoram	9	0	0	0	0	0	0	0	0	0	0	0	0
25	Nagaland	4	0	0	0	0	0	1	0	0	0	0	0	0
26	Odisha	98	0	6	0	6	0	6	0	6	0	0	0	0
27	Pudducherry	3	2	1	2	1	2	1	2	1	0	0	0	0
28	Punjab	25	0	4	0	2	0	4	0	1	0	1	0	1
29	Rajasthan	72	0	9	0	9	0	11	0	8	0	1	0	0
30	Sikkim	1	0	0	0	0	0	0	0	0	0	0	0	0
31	Tamil Nadu	188	0	9	0	13	0	4	0	4	0	4	0	4
32	Telangana	76	0	7	0	7	0	7	0	7	0	2	0	2
33	Tripura	12	0	0	0	0	0	0	0	0	0	0	0	0
34	Uttar Pradesh	277	0	6	0	6	0	6	0	6	0	2	0	1
35	Uttarakhand	35	0	1	0	1	0	1	0	1	0	1	0	0
36	West Bengal	110	0	0	0	0	0	0	0	0	0	0	0	0
	Total	**2257**	**12**	**123**	**12**	**111**	**17**	**162**	**17**	**141**	**5**	**49**	**5**	**33**

Midwifery Initiative

The Government of India has taken a landmark policy decision to roll out midwifery services in the country in order to improve the quality of care and ensure respectful care to pregnant women and newborns. The initiative was launched during the Partners Forum held at New Delhi in December, 2018.

The initiative aims to create a cadre of Nurse Practitioners in Midwifery who are skilled in accordance to competencies prescribed by the International Confederation of Midwives (ICM) and are knowledgeable and capable of providing compassionate women-centered, reproductive, maternal and newborn health care services. In order to create a cadre of Nurse Practitioner Midwives, 18 months training would be provided to GNM/BSc nurses having 2 years' experience in conducting deliveries. Training Curriculum would be based on the 'Essential Competencies for Midwifery Practice defined by International Confederation of Midwife.