

MATERNAL HEALTH PROGRAMME

4.1 INTRODUCTION

Maternal Health is an important aspect for the development of any country in terms of increasing equity & 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 is one of the important indicators of the quality of health services in the 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 contributing to 27 percent of the global maternal deaths. In the year 2010 global MMR was 210. Against this, MMR in India has declined to 178 per hundred thousand live births in 2011 as per latest SRS estimates. India now contributing to only 16 percent of the global maternal deaths. Globally, there has been a 47% decline 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 guarantees in the form of entitlements to pregnant women, sick new-borns 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 2,000 crores have been sanctioned for this scheme in 2013-14.

However, still 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 hemorrhage, 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 & other factors contribute to the delays leading to these deaths.

4.2 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.
- 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.

4.2.1 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 Tamil Nadu (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%).
- 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.

Comparison of MMR (SRS & AHS) for 9 High Focus States

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

4.3 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, post natal 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 are also being done like Coverage Evaluation Surveys (CES) by UNICEF.

4.3.1 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
Mothers who had received any Ante Natal Care (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 checkup (%)	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

4.3.2 Key Maternal Health Strategies

Demand Promotion: Janani Suraksha Yojana (JSY), a demand promotion scheme was launched in April 2005 with the objective of reducing Maternal and Infant Mortality. This is a conditional cash transfer scheme for pregnant women coming into the institutional fold for delivery. It has been lauded as a successful scheme bringing about a surge in institutional deliveries since its launch.

The expenditure under JSY has risen from 38.29 crores in 2005-06 to Rs. 1640.00 crores in 2012-13. The number of JSY beneficiaries has also risen from 7.39 lakhs in 2005-06 to more than 106.00 lakhs in 2012-13. In 2013-14 (uptil Dec.) more than 78.27 lakhs beneficiaries has availed JSY benefits and expenditure under JSY is Rs. 1220.40 crores.

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

To complement JSY, Government of India launched Janani Shishu Suraksha Karyakram (JSSK) on 1st June, 2011 to eliminate out of pocket expenditure for pregnant women and sick new-borns 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 crores have been allocated to the States for the year 2013-14 for providing the free entitlements under JSSK while Rs. 2107 crores was allocated during 2012-13 under Reproductive Child Health (RCH) & National Rural Health Mission (NRHM) Flexipool.

4.3.4 Essential and Emergency Obstetric Care

- *Skilled Attendance at birth (domiciliary & health facilities)* - Nearly 69,760 ANMs, LHV's and Staff Nurses have been trained in SBA, as per State reports.
- Multi-skilling of doctors to overcome shortage of skilled manpower in critical specialities-training on Life Saving Anaesthesia 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 Emergency Obstetric Care (EmOC).
- For placing emergency obstetric care services at the health facilities, once the women have come into the institutional fold, more than 17000

'Delivery Points' fulfilling certain bench marks of performance have been identified across the country. These are being strengthened in terms of infrastructure, equipments, trained manpower for provision of comprehensive Reproductive, Maternal, Newborn Child health services along-with services for Adolescents and Family Planning etc. These are being monitored for service delivery.

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

4.4 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 24x7 PHCs/FRUs (DHs/SDHs/CHCs) with a focus on "Delivery Points" (about 16000 health facilities performing deliveries/ C- sections above 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 counseling 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.
- Print material for IEC/BCC on CAC shared with the States.

4.4.1 Management of Sexually Transmitted 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 24x7 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.

4.4.2 Village Health & Nutrition Days (outreach services for comprehensive Maternal and Child Health care): More than 4.32 crore Village Health and Nutrition Days have been held upto September, 2013 (NRHM-MIS).

4.4.3 Mother and Child Protection (MCP) Card: A joint Mother and Child Protection (MCP) Card of Ministry of Health & Family Welfare 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.

4.5 MATERNAL DEATH REVIEW (MDR)

- The process of 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. This is with

the objective of taking corrective action at appropriate levels and improving the quality of obstetric care.

- The States are being monitored closely on the progress made in the implementation of MDR.

Capacity Building

- Skill Building through training programmes for all categories of service providers e.g. Training of MBBS doctors in Life Saving Anesthesia Skills (LSAS), Emergency Obstetric Care including C-sections; Training of Nurses and ANMs in Skilled Birth Attendance (SBA); Training of MOs in Comprehensive Abortion Care (CAC).
- 1352 doctors have been trained in Emergency Obstetric Care including C-sections and 1862 doctors in LSAS. 69760 SNs/LHVs/ANMs have been trained as SBAs as per State reports.

4.6 MATERNAL AND CHILD HEALTH (MCH) WING

Under NRHM, 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 loads and institutional deliveries at these facilities. 470 dedicated Maternal and Child Health Wings (MCH Wings) with more than 28,500 additional beds have been sanctioned in 18 States.

4.6.1 Skill Labs

To strengthen the quality of capacity building of different cadres of service providers training, Skill Labs are being established in the States.

4.6.2 Quality Assurance Guidelines

Quality Assurance Guidelines are on the anvil with the objective of providing standard guidelines to be uniformly adopted by all States. These Guidelines indicate the steps and processes and defines minimum standards to be followed to ensure quality of service provision.

4.7 MOTHER AND CHILD TRACKING SYSTEM (MCTS)

To catch every pregnant women and every neonates and infants for quality ANC, INC, PNC, FP, Immunization

services, the pregnant women and neonates are being tracked by name. **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. As on March, 2014 more than 6.20 crores women and 5.17 crores children have been registered under MCTS.

A new initiative of prevention of PPH through Community Based Advanced distribution of Misoprostol by ASHAs/ANMs has been launched in the districts with high home delivery rates.

4.8 JANANI SURAKSHA YOJANA (JSY)

Janani Suraksha Yojana (JSY) was launched in April 2005 to enable women especially from the vulnerable sections of the society to access institutional delivery and thereby effect reductions in maternal and neonatal mortality. The scheme provides conditional cash assistance to pregnant women for giving birth in a government health facility by providing access to skilled birth attendance and emergency obstetric care.

The scheme is under implementation in all States and Union Territories (UTs) with a special focus on Low Performing States (LPS). Around 9 lakh Accredited Social Health Activists (ASHAs) are working as an effective link between the government and poor pregnant women who get financial incentive to promote institutional delivery.

The scheme focuses on poor 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 and Kashmir. While these states have been named Low Performing States (LPS), the remaining States have been named High Performing States (HPS).

The number of beneficiaries under the scheme has increased manifold i.e. from 7.38 lakhs in 2005-06 to 1.05 crores in 2013-14. Similarly, expenditure has increased from Rs. 38.29 crores in 2005-06 to Rs. 1748 crores in 2013-14.

4.8.1 Eligibility for Cash Assistance for Pregnant Women

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

Low Performing States (LPS)	All pregnant women delivering in government health centres or accredited private institutions.
High Performing States (HPS)	All BPL/Scheduled Caste (SC)/Scheduled Tribe (ST) women delivering in a government health centre or accredited private institutions.

4.8.2 Cash Assistance for Institutional (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**	
Low Performing States (LPS)	1400	600	2000	1000	400	1400
High Performing States (HPS)	700	600	1300	600	400	1000

*ASHA incentive of Rs. 600/- in rural area includes Rs. 300/- for ANC component and Rs. 300/- for accompanying pregnant woman for institutional delivery.

**ASHA incentive of Rs. 400/- in urban area includes Rs. 200/- for ANC component and Rs. 200/- for accompanying pregnant woman for institutional delivery.

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 regardless of age and number of children preferring to delivery at home are entitled to financial assistance of Rs. 500/- per delivery in all the States/UTs.

4.8.3 Janani Shishu Suraksha Karyakaram (JSSK)

Free Service Guarantees at Public Health Facilities: Janani Shishu Suraksha Karyakaram (JSSK):

- Capitalizing on the surge in institutional deliveries brought about by JSY to provide service guarantees at health facilities, Government of India has launched Janani Shishu Suraksha Karyakaram

(JSSK) in 1st June, 2011 to eliminate out of pocket expenditure for pregnant women and sick new-borns 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. Under this scheme, pregnant women are entitled to free drugs and consumables, free diagnostics, free blood wherever required, and free diet up to 3 days for normal delivery and 7 days for C-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 new-borns accessing public health institutions for treatment till 30 days after birth. This has now been expanded to cover the complications during ANC, PNC and also sick infants.

- To implement this scheme, more than Rs. 2107 crores have been allocated during the year

2012-13 and more than Rs. 2000 crores have been sanctioned up till now in 2013-14 under RCH and Mission Flexipool.

4.9 ADOLESCENT HEALTH PROGRAMME

Adolescents (10-19 years) constitute about one-fifth of India's population and represent a huge opportunity that can transform the social and economic fortunes of the country. The large and increasingly relative share and absolute numbers of adolescent population in India make it necessary that the nation ensures they become a vibrant, constructive force that can contribute to sustainable and inclusive growth. Investments in adolescent health will have an immediate, direct and positive impact on India's health goals and on the achievements of the Millennium Development Goals (MDGs).

Under Adolescent Health following three programmes are currently being implemented:

- Adolescent Reproductive and Sexual Health (ARSH);
- Scheme for Promotion of Menstrual Hygiene (MHS) and
- Weekly Iron Folic Acid Supplementation programme (WIFS).

A. Adolescent Reproductive and Sexual Health Programme (ARSH)

Adolescent Reproductive and Sexual Health programme (ARSH) focuses on reorganizing the existing public health system in order to meet service needs of adolescents. Steps are being taken to ensure improved service delivery for adolescents during routine sub-centre clinics and also to ensure service availability on fixed days and timings at the Primary Health Centre and Community Health Centre & District Hospital levels. Core package of services includes promotive, preventive, curative and counselling services being made available for all adolescents - married and unmarried, girls and boys through Adolescent Friendly Health Clinics. ARSH programme envisage creating an enabling environment for adolescent to seek health care services through a spectrum of programmatic approaches:

- Facility based health services- Adolescent Friendly Health Clinics;

- Counselling- Dedicated ARSH and ICTC counsellors;
- Community based interventions- Outreach activities and
- Capacity Building for service providers.

i. Adolescent Friendly Health Clinics (AFHC): Through Adolescent Friendly Health Clinics, routine check-up at primary, secondary and tertiary levels of care is provided on fixed day clinics. At present 6,302 AFHCs are functional across the country providing services, information and commodities to more than 2.5 million adolescents for varied health related needs such as contraceptives provision, management of menstrual problems, RTI/STI management, antenatal care and anaemia.

ii. Facility based Counselling services: Counselling services for adolescent on important issues such as nutrition, puberty, RTI/STI prevention and contraception and delaying marriage and child bearing & concerns related to contraception, abortion services, pre-marital concerns, substance misuse, sexual abuse and mental health problems are being provided through recruitment and training of dedicated counsellors. At present 881 dedicated ARSH counsellors are providing comprehensive counselling services to adolescent across country. In 23 States/UTs, 1439 ICTC counsellors have been enrolled to provide sexual and reproductive health counselling to adolescents.

iii. Outreach activities: Outreach activities are being conducted in schools, colleges, Teen clubs, vocational training centres, during Village Health Nutrition Day (VHND), Health melas and in collaboration with Self Help Groups to provide adequate and appropriate information to adolescents in spaces where they normally congregate.

To further strengthen the outreach component of ARSH programme, Peer Educators at village level have been enrolled in States and Union Territories. Across country 83,360 peer educators have been selected and trained in the last three years.

- iv. **Capacity building through ARSH trainings:** The capacity building of health functionaries in Adolescent Friendly Health Services is undertaken through a systematic ARSH training module (5 days for Auxiliary Nurse Midwife/Staff Nurse and 3 days for Medical Officer) to enhance their skills in addressing health needs of the adolescents. Till date, a total number of 7,224 MOs and 19,112 SN/ANM/LHV have been trained on ARSH.

B. Weekly Iron and Folic Acid Supplementation (WIFS)

Ministry of Health and Family Welfare has launched the Weekly Iron and Folic Acid Supplementation (WIFS) Programme to meet the challenge of high prevalence and incidence of 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. The programme, implemented across the country both (rural and urban areas) will cover 10.25 crore adolescents. The key interventions under this programme are as follows:

- Administration of supervised Weekly Iron-Folic Acid Supplements of 100mg elemental iron and 500ug Folic acid using a fixed day approach.
- Screening of target groups for moderate/severe anaemia and referring these cases to an appropriate health facility.
- Biannual de-worming (Albendazole 400mg), six months apart, for control of helminthes infestation.
- Information and counselling for improving dietary intake and for taking actions for prevention of intestinal worm infestation.

Convergence with key stakeholder ministries like the Ministry of Women and Child Development and Ministry of Human Resource Development is an essential part of implantation plan of the WIFS programme.

Till date the programme has been launched in 32 States/UTs which are: Odisha, Tripura, Andhra Pradesh, West Bengal, Maharashtra, Chandigarh, D&N Haveli, Uttarakhand, Haryana, Andaman & Nicobar, Daman and Diu, Puducherry, Kerala, Mizoram, UP, Gujarat, Jharkhand, Himachal Pradesh, Arunachal Pradesh, Sikkim, Nagaland, Punjab, Meghalaya, Goa, Chhattisgarh, Delhi, Karnataka,

Rajasthan, Lakshadweep, Assam, Manipur and Madhya Pradesh. Total number of beneficiaries covered under this programme including both in-school adolescents and out of school girls is around 3 crore.

C. Menstrual Hygiene Scheme

The Ministry of Health and Family Welfare has launched **Scheme for Promotion of Menstrual Hygiene** among adolescent girls in the age group of 10-19 years in rural areas. This programme aims at ensuring that girls 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:

- Community based Health education and outreach in the target population to promote menstrual health;
- Ensuring regular availability of sanitary napkins to the adolescents;
- Sourcing and procurement of sanitary napkins
- Storage and distribution of sanitary napkins to the adolescent girls;
- Training of ASHA and nodal teachers in Menstrual Health and
- Safe disposal of sanitary napkins.

In the first phase, the scheme is covering 25% of the population i.e. 1.5 crore girls in the age group of 10-19 years in 115 districts of 17 States. The scheme has envisaged providing a pack of 6 sanitary napkins under the NRHM's brand 'Freedays'. These napkins are sold to the adolescents girls at Rs. 6 for a pack of 6 napkins in the village by the Accredited Social Health Activist (ASHA). On sale of each pack, the ASHA gets an incentive of Rs. 1 per pack besides a free pack of sanitary napkins per month.

D. Current Status

The scheme has been rolled out in all the 17 States through Central supply. 1092 blocks in 115 districts are under Central supply wherein Sanitary Napkins are being supplied by Government of India. Till end December 2013, total consumption of sanitary napkins is 4 crore packs of sanitary napkins with a coverage of over 1.9 crore girls.