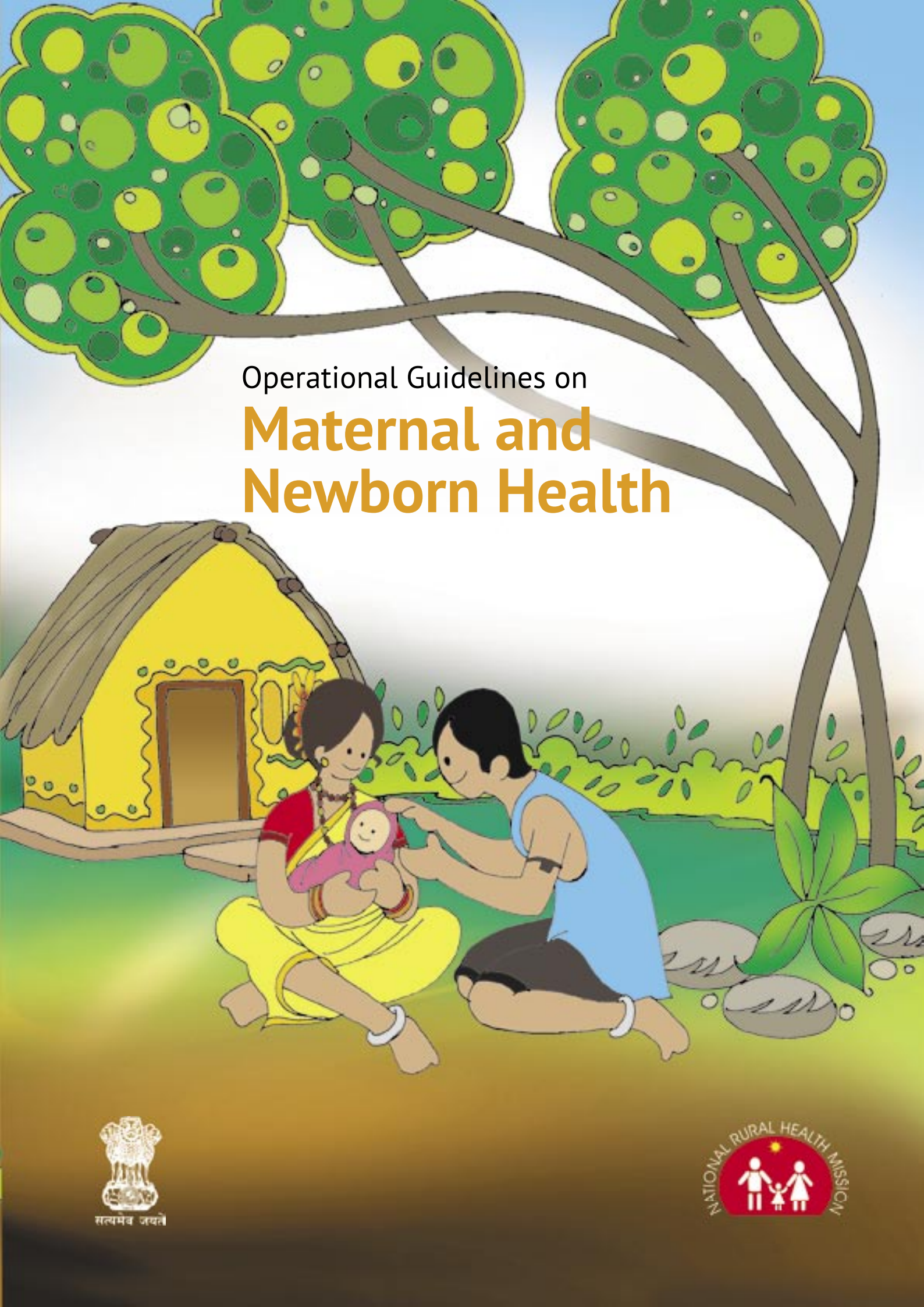


Operational Guidelines on

Maternal and Newborn Health

सत्यमेव जयते

NATIONAL RURAL HEALTH MISSION

Operational Guidelines on

Maternal and Newborn Health

NATIONAL RURAL HEALTH MISSION
राष्ट्रीय ग्रामीण स्वास्थ्य मिशन
गुलाम नबी आज़ाद
GHULAM NABI AZAD

सत्यमेव जयते

भारत सरकार
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
निर्माण भवन, नई दिल्ली - 110108

Government of India
Ministry of Health & Family Welfare
Nirman Bhavan, New Delhi - 110108

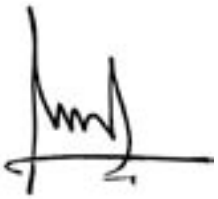
MESSAGE

The National Rural Health Mission (NRHM), has brought a renewed emphasis on strengthening our public health systems and achieving the goal of health for all. Substantial investments have been made in strengthening infrastructure, building capacity of service providers, and ensuring uninterrupted flow of drugs and supplies. These investments are beginning to yield results. Across the country, the Janani Suraksha Yojana has seen unprecedented number of women accessing institutions in the public sector for delivery services.

And yet, we cannot afford to rest. Much remains to be done, if we are to meet our national goals of reducing maternal mortality to 100/100,000 and infant mortality to 30/1000. Despite the encouraging improvements and expansion in infrastructure and human resources, issues of inequity in access and poor quality in health care persist. The challenge before us now is to ensure that all women and newborns, no matter where they live, can demand and obtain the service that the NHRM promises.

I welcome these operational guidelines as another major effort to address the problem of maternal and newborn mortality. These operational guidelines should become the basis for ensuring that every single pregnant woman in the nation has a safe delivery and every new born has the best possible chance for survival. The National Rural Health Mission is committed to providing the funds needed to reach these standards nationwide. I call upon programme managers to use these guidelines to plan access to these basic services for even the poorest household and the most inaccesible areas.

New Delhi
7.4.2010



(Ghulam Nabi Azad)

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GOVERNMENT OF INDIA
MINISTRY OF HEALTH & FAMILY WELFARE
NIRMAN BHAVAN, NEW DELHI - 110108

MESSAGE

The National Rural Health Mission has enabled several innovations to promote people's access to services. One of the most impressive of these is the Janani Suraksha Yojana, which has enabled unprecedented increases in institutional delivery across the country.

However the term "institutional delivery" should not be reduced to mean any delivery taking place in a building. It must mean the availability of a health team with necessary skills, and equipped with the necessary drugs and equipment who are able to manage a certain level of complications as and when they arise, and take responsibility for reaching them to where it can be managed. Unless pregnant women with complications are managed adequately, institutional delivery by itself would fail to lower maternal mortality ratios. All this is true for the prevention of neonatal mortality also.

These Operational Guidelines specify the package of services each level of facility would provide and the quality parameters for these. Further proposed is a supervisory structure and an external system of assessment that would enable the planner to ensure that the services guaranteed are actually being delivered. The institutional linkages and community support needed is also described. This document would help the district planner to prepare a plan that would guarantee every woman a safe delivery. But further it should become a tool for financing the program such that every poor woman gets the support needed to meet her expenses and that every facility and every provider is incentivised in proportion to the work load they are managing.

The Ministry is launching these operational guidelines to enable states and districts to develop outcome based plans to reduce maternal and newborn mortality. As a beginning these guidelines would be used to plan, monitor and support the achievement of NRHM goals in the poorest performing 125 districts of the country. But gradually such planning, based upon well defined service guarantees, clear quality norms, specific local contexts, and differential financing should inform all district health planning in the country.

New Delhi
7.4.2010

(K. Sujatha Rao)

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Government of India
Ministry of Health & Family Welfare
Nirman Bhavan, New Delhi - 110108

MESSAGE

NRHM initiatives over the last five years at community, institution and management levels have enabled high levels of access to public sector facilities. The Janani Suraksha Yojana has played a large part in empowering and enabling pregnant women to access facilities for safe delivery. Despite these gains, issues of quality access and equity are areas of concern that need to be addressed.

The need for care does not cease after childbirth and the emphasis in planning should be on a continuum of care approach that enables care in pregnancy, delivery, for the newborn and post-partum care through a well-planned and effectively executed strategy.

The guidelines are designed so as to translate technical strategies into planning processes. The guidelines span strategic approaches and a service delivery framework based on Indian Public Health Standards, human resource development, quality certification and community linkages including the role of the ASHA. These guidelines are part of a larger set of manuals that the Government of India is developing. These would include the training manuals, the supervisors' manuals, the standard treatment protocols and the quality manual.

I hope that the states and districts are able to effectively use these guidelines in developing specific plans to address the issue of maternal and newborn mortality.

New Delhi
7.4.2010

(P. K. Pradhan)

Abbreviations

ANC	:	Antenatal Care
ANM	:	Auxiliary Nurse Midwife
ASHA	:	Accredited Social Health Activist
AWW	:	Anganwadi Worker
BCC	:	Behaviour Change Communication
BEmONC	:	Basic Emergency Obstetric and Newborn Care
CEmONC	:	Comprehensive Emergency Obstetric and Newborn Care
CHC	:	Community Health Centre
EmOC	:	Emergency Obstetric Care
FRU	:	First Referral Unit
HBNC	:	Home Based Newborn Care
HIV	:	Human Immunodeficiency Virus
HMIS	:	Health Management Information Systems
IMNCI	:	Integrated Management of Neonatal and Childhood Illnesses
IMR	:	Infant Mortality Rate
IUD	:	Intrauterine Device
LBW	:	Low Birth Weight
LSAS	:	Life Saving Anaesthesia Skills
LHV	:	Lady Health Visitor
MO	:	Medical Officer
MoHFW	:	Ministry of Health and Family Welfare
MTP	:	Medical Termination of Pregnancy
MMR	:	Maternal Mortality Ratio
MVA	:	Manual Vacuum Aspiration
NGO	:	Non-Governmental Organisation
NHSRC	:	National Health Systems Resource Centre
NIHFW	:	National Institute of Health and Family Welfare
NRHM	:	National Rural Health Mission
NSSK	:	Navjaat Shishu Suraksha Karyakram
NSV	:	Non-Scalpel Vasectomy
OT	:	Operation Theatre
PIH	:	Pregnancy Induced Hypertension
PHC	:	Primary Health Centre
PPH	:	Post-Partum Haemorrhage
PRI	:	Panchayati Raj Institution
RCH	:	Reproductive and Child Health
SBA	:	Skilled Birth Attendant
SC	:	Scheduled Caste
SHG	:	Self-Help Group
SHSRC	:	State Health Systems Resource Centre
SIHFW	:	State Institute of Health and Family Welfare
SNCU	:	Sick Newborn Care Unit
ST	:	Scheduled Tribe
VHND	:	Village Health and Nutrition Day
VHSC	:	Village Health and Sanitation Committee

Contents

CHAPTER -1

Background, Rationale and Principles of the Guidelines

1.1. Background: Current Status of Maternal and Newborn Health

Maternal health is important to communities, families and the nation due to its profound effects on the health of women, immediate survival of the newborn and long term well-being of children, particularly girls and the well-being of families. Maternal death and illness have cost implications for family and the community because of high direct and indirect costs, the adverse impact on productivity and the tremendous human tragedy that every maternal or child death represents. Maternal mortality and morbidity indicators reflect not only how well the health system is functioning, but also the degree of equity in public service delivery, utilisation of services, and the social status of women.

Every year, in India, 28 million pregnancies take place with 67,000 maternal deaths,[1] 1 million women left with chronic ill health, and 1 million neonatal deaths.[2]

Neonatal mortality in India is about 35/1000 live births (SRS-2008) and accounts for 50% of deaths of all children under five.[3] Three quarters of all neonatal deaths occur during the first week of life, and about 20% take place in the first 24 hours.[4] This is also the period when most maternal deaths take place. *Thus, the provision of maternal and newborn care through a continuum of care approach, ensuring care during critical periods of delivery and postnatal period, addresses the needs of the mother and the newborn through a seamless transition from home and village to the facility and back again.*[5] Care for the mother and newborn has to be provided from conception till the first 42 days after delivery at the home/community levels, institutions where delivery takes place and again at home after discharge from the facility.

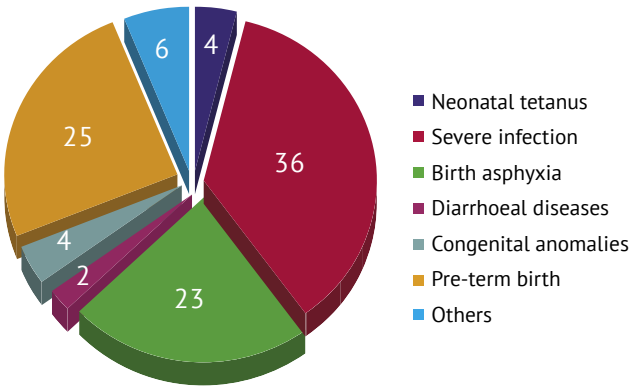
Care for the mother and infant has to be provided from conception to the first 42 days after delivery at the home/community levels, institutions where delivery takes place and again at home after discharge from the facility.

High maternal and neonatal mortality is generally ascribed to medical causes. However maternal deaths are higher among Scheduled Castes (SCs) and Scheduled Tribes (STs),[26] and among less educated and poorer families, indicating the importance of social determinants of high mortality.

[1] Sample Registration Survey, 2004-06, Government of India
[2] State of the World's Children, UNICEF, 2009
[3] National Family Health Survey Phase 3, (2005-2006) International Institute of Population Studies
[4] Indian Council of Medical Research
[5] Source: World Health Organization, 2006, (WHO/FCH/CAH/09.02), "Home visits for the newborn child: A strategy to improve survival", WHO/UNICEF Joint Statement.

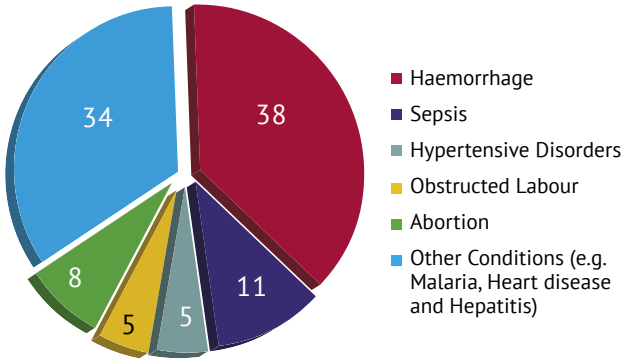
1.2. Causes of Maternal and Neonatal Deaths

Neonatal Deaths (%)



WHO SEARO Mortality Country Fact Sheet, India 2007
Source: World Health Statistics 2007[24]

Maternal Deaths (%)



SRS-2001-03Ref[17]

Social determinants of maternal and neonatal mortality

The underlying social, political and economic conditions also contribute to maternal and neonatal deaths, and these require a wider range of interventions, beyond the direct purview of the health sector.

1. **Economic and Social Status:** Women in poor households have reduced access to nutrition, rest, health education and healthcare – all of which are essential for safe pregnancy. Such women are also likely to be more malnourished and anaemic with greater risk of dying as a result of haemorrhage.

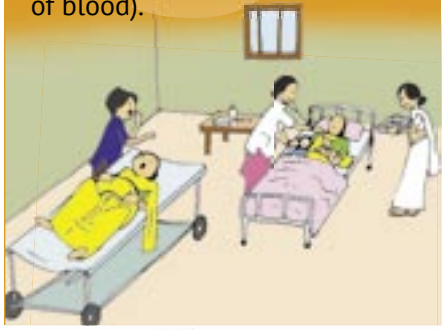
2. **Early Marriage and Childbearing:** Women who get pregnant young tend to develop more complications during pregnancy and delivery and are more likely to die. Neonatal mortality is also higher among young women. Risk of complications is also higher among women whose pregnancies are not adequately spaced, and where there is frequent childbearing.

3. **Public Infrastructure and Access to Care:** The lack of roads and public transport is a barrier to access. In such areas, the development and therefore density and functioning of both public and private health services is poor. This is a major contributor to maternal deaths.

Delay 1: Delay in recognising the problem (lack of awareness of danger signs, low status of women, no control over resources, lack of decision making) and deciding to seek care (health facility inaccessible, fear of costs, fear of poor treatment).

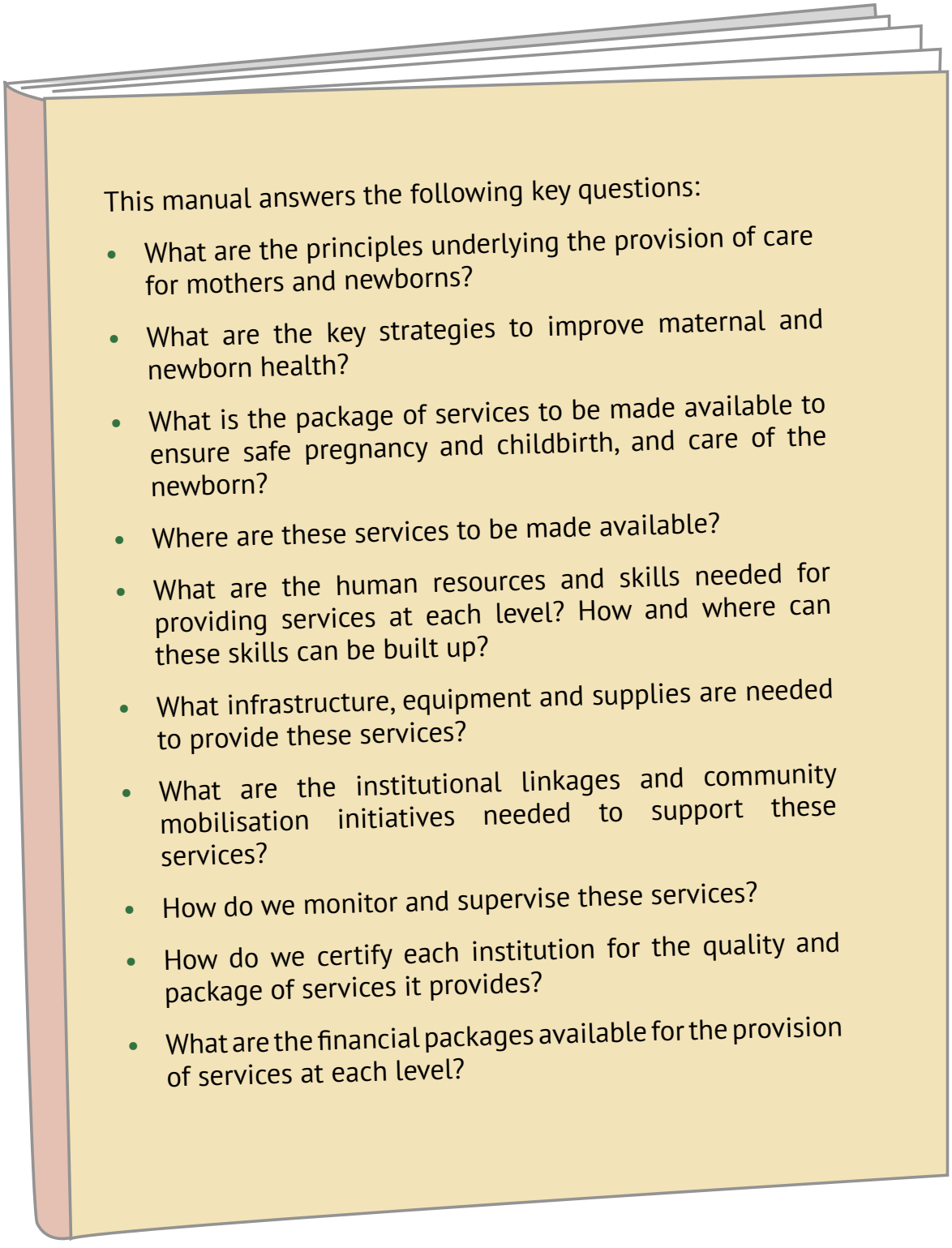
Delay 2: Delay in reaching the health facility (high costs, lack of transportation, poor roads).

Delay 3: Delay in receiving adequate treatment once a woman has arrived at the health facility (poor organisation or lack of skilled doctors and nurses, gaps in supply of equipment, shortfall of blood).



1.3. Rationale for Guidelines

This manual is designed to help programme managers at district and state level, to plan, implement and supervise the delivery of services that would guarantee a safe childbirth for every mother.



This manual answers the following key questions:

- What are the principles underlying the provision of care for mothers and newborns?
- What are the key strategies to improve maternal and newborn health?
- What is the package of services to be made available to ensure safe pregnancy and childbirth, and care of the newborn?
- Where are these services to be made available?
- What are the human resources and skills needed for providing services at each level? How and where can these skills can be built up?
- What infrastructure, equipment and supplies are needed to provide these services?
- What are the institutional linkages and community mobilisation initiatives needed to support these services?
- How do we monitor and supervise these services?
- How do we certify each institution for the quality and package of services it provides?
- What are the financial packages available for the provision of services at each level?

1.4. Principles of Organising Care for Maternal and Newborn Health

1. Every woman must be enabled to have her childbirth with a Skilled Birth Attendant (SBA), in a setting of maximal dignity, comfort, and care.

2. Since life threatening complications may arise in any delivery, every effort must be made for all women to deliver in an institution where most maternal and newborn complications can be promptly and effectively managed, and with the means to transport a patient safely and quickly to an institution where complications that require surgical care and blood transfusion can also be managed.

3. Where a delivery is known to have much higher risk of complications even before the onset of labour, e.g. an adolescent mother or a previous Caesarean, every effort must be made so that the delivery takes place in an institution where surgical care and blood transfusion for managing emergencies is available.

4. Every mother must be provided with postnatal care that ensures support to her in this period, identifies complications and arranges for referral when required. This care is preferably institutional in the first 48 hours, with home based follow-up for a 42 day period thereafter.

5. Every newborn must be provided with appropriate care and support from the moment of birth. This includes initiation of breastfeeding, keeping the baby warm, identifying illnesses or risk including low birth weight, resuscitation where indicated, access to referral care at an institution, and close follow-up at home for 28 days after birth.

6. The public health system must hold itself accountable to provide skilled human resources, infrastructure and equipment, institutional linkages and supervision needed to ensure that these services guarantees for safe maternal and newborn health are realised.

7. A grievance redressal mechanism must be in place which should receive reports of any failure to deliver the services that are certified as available in a particular facility and take appropriate action, and provide feedback to the complainant and public.

8. Every maternal or newborn death must be accounted for and investigated so as to detect system gaps and to increase accountability.

9. The provision of maternal and newborn care should be based on a 'continuum of care' approach that covers the entire period of pregnancy, delivery and postnatal period, and the needs of the newborn, through a seamless transition from home and community to the facility, referral institutional care where needed, and back again to the home.

CHAPTER -2

Strategies for Ensuring Improvements in Maternal and Newborn Health

The key strategy is to ensure care of the pregnant mother and newborn during the period from conception up to 42 days of delivery. A more comprehensive approach to reducing maternal and neonatal mortality also encompasses the period of adolescence among girls to ensure that they are well-equipped for pregnancy and childbirth and the provision of family planning to ensure that no pregnancy occurs before the age of 21 years.

The strategies for maternal and newborn health include:

2.1. Provision of Quality Antenatal Care

All women must have access to a package of antenatal services provided in the community or at the facility by a provider who is skilled and who has the necessary equipment and supplies.

2.2. Ensure Access to a Skilled Birth Attendant

A Skilled Birth Attendant (SBA) is a professionally qualified individual who can handle normal pregnancies and deliveries, equipped with skills to provide essential newborn care, identify obstetric and neonatal emergencies, manage complications as per their defined competencies, and undertake timely referral to a higher centre where comprehensive obstetric care can be provided.

2.3. Functional Facilities to Provide Institutional Delivery

Care for pregnancy, childbirth and newborn can be provided at any of the three facility levels shown in the box:

Definitions

Level 3

Institutional Delivery (Comprehensive Level-FRU): All complications managed including C-Section and blood transfusion, i.e. Comprehensive Emergency Obstetric and Newborn Care **(CEmONC)** provided at equipped public and private hospitals. The public and private hospitals would also be equipped with Neonatal Stabilisation Unit and Sick Newborn Care Unit (SNCU).

Level 2

Institutional Delivery (Basic Level): Delivery conducted by a skilled birth attendant in a 24x7 PHC level (PHC or CHC with Basic Emergency Obstetric and Newborn Care **(BEmONC)** or in a private nursing home with equivalent facilities) having Newborn Corner and Stabilisation Unit.

Level 1

Skilled Birth Attendance: This refers to a delivery conducted by skilled birth attendant in all Sub-Centres and in some Primary Health Centres (PHCs) which have not yet reached the next level of "24 x 7 PHC". Newborn Corner in all facilities. Home deliveries assisted by a skilled birth attendant would also be included under safe deliveries at this level.

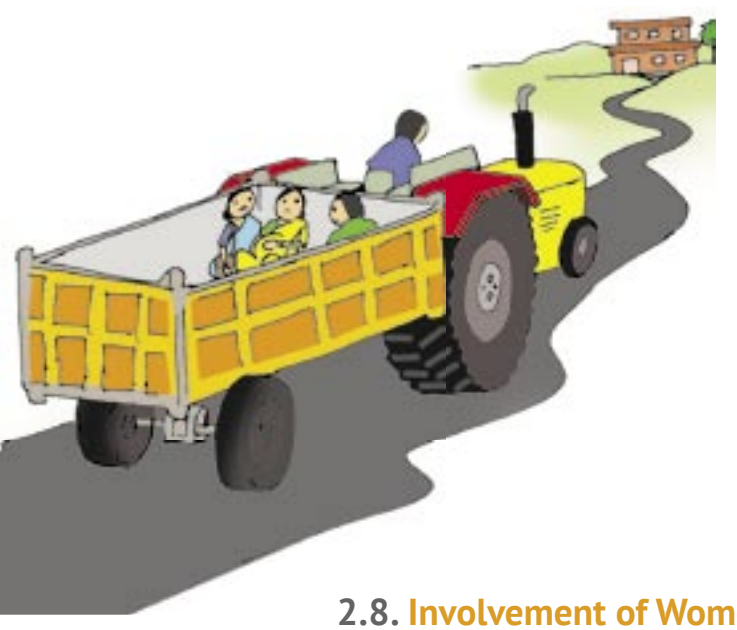
The point is simple – any delivery that happens within the four walls of a health institution is not to be called institutional. It must provide a level of care as specified. Private sector care should also be grouped along these categories.

2.4. Facility Based Newborn Care

This should be given at the time of birth as appropriate to each of the three levels – Sick Neonatal Care Unit at district hospitals, Newborn Stabilisation Units at all institutional delivery facilities, whether comprehensive or basic, and Newborn Care Corner at all facilities.

2.5. Home Based Newborn Care and Postnatal Care

This should be provided through a series of visits. (First two days of care should be given at the facility where institutional delivery took place.) At home, care should be provided within 24 hours of delivery for the newborn by a trained community health volunteer who may be an Accredited Social Health Activist (ASHA) or an Anganwadi Worker (AWW) or other health worker as appropriate to that context and who is a resident of that habitation.



2.6. Referral Linkage and Transport

This is for access to emergency services. The ideal situation is where every mother delivers in an institution with access to a referral centre within one hour, in case of complications requiring surgery and blood transfusion. District health plans must conform to a roadmap to reach this ideal, respecting and supporting the wishes of families at every stage.

2.7. Behaviour Change Communication (BCC)

This is carried out by ASHA and other health workers to ensure care in pregnancy and for the newborn, recognition of complications and their danger signs, birth planning, and choosing a safe site for delivery.

2.8. Involvement of Women's Groups and Community Mobilisation

This is required to promote key messages for delaying age at marriage, spacing, delaying age at first birth, ensuring gap of at least three years between pregnancies and management of unwanted pregnancies.

To ensure delivery of these services, the programme should define a) the package of services to be delivered at each level, b) the quality of standards and protocols for these services, c) the minimum skills the service providers would have to be certified for, d) the process of certification of both facility and of service provider, and e) the institutional linkages and community mobilisation that is needed.

This service delivery framework is given in the next chapter.

The Service Delivery Framework

3.1 Antenatal Care (minimum 4 ANCs including registration)

Level 1 SBA Level	Level 2 Institutional (Basic Level)	Level 3 Institutional (Comprehensive Level)
Delivery by SBAs (Sub-Centre, PHCs not functioning as 24x7 and home deliveries conducted by SBA)	**PHC-Basic Obstetric and Neonatal Care (24X7 PHCs, CHCs other than FRUs)**	**FRU-Comprehensive Obstetric and Neonatal Care (DH, SDH, RH, selected CHCs)**
ANC session should include:- • Registration (within 12 weeks) • Physical examination + weight+ BP + abdominal examination • Identification and referral for danger signs • Ensuring consumption of at least 100 IFA tablets (for all pregnant women)/200 (for anaemic women). Severe anaemia needs referral. • Essential lab investigations (HB%, urine for albumin/sugar, pregnancy test) • TT immunisation (two doses at interval of one month) • Counselling on nutrition, birth preparedness, safe abortion, Family Planning and institutional delivery Assured referral linkages for complicated pregnancies and deliveries	**All in Level 1** + blood grouping & Rh typing, Wet mount (saline/KOH), RPR/VDRL Management and provision of all basic obstetric & newborn care including management of complications other than those requiring blood transfusion or surgery   • Linkages with nearest ICTC/ PPTCT centre for voluntary counselling and testing for HIV and PPTCT services	**All in Level 1** + blood cross matching + management of severe anaemia Management of complications in pregnancy referred from **Levels 1 and 2** 

3.2 Intranatal Care

Level 1 SBA Level	Level 2 Institutional (Basic Level)	Level 3 Institutional (Comprehensive Level)
Delivery by SBAs (Sub-Centre, PHCs not functioning as 24x7 and home deliveries conducted by SBA)	**PHC-Basic Obstetric and Neonatal Care (24X7 PHCs, CHCs other than FRUs)**	**FRU-Comprehensive Obstetric and Neonatal Care (DH, SDH, RH, selected CHCs)**
• Normal delivery with use of partograph • Active management of third stage of labour • Infection prevention • Identification and referral for danger signs • Pre-referral management for obstetric emergencies, e.g. eclampsia, PPH, shock • Assured referral linkages with higher facilities **Essential newborn care will include:** • Neonatal resuscitation • Warmth • Infection prevention • Support for initiation of breastfeeding within an hour of birth • Screening for congenital anomalies • Weighing of newborns	**All in Level 1 +** Availability of following services round the clock • Episiotomy and suturing cervical tear • Assisted vaginal deliveries like outlet forceps, vacuum • Stabilisation of patients with obstetric emergencies, e.g. eclampsia, PPH, sepsis, shock • Referral linkages with higher facilities **Essential newborn care as in Level 1+** • Antenatal Corticosteroids to the mother in case of pre-term babies to prevent Respiratory Distress Syndrome (RDS) • Immediate care of LBW newborns (>1800 gm) • Vitamin K for premature babies	**All in Level 2 +** availability of following services round the clock: • Management of obstructed labour • Surgical interventions like Caesarean section • Comprehensive management of all obstetric emergencies, e.g. PIH/Eclampsia, Sepsis, PPH retained placenta, shock etc. • In-house blood bank/blood storage centre • Referral linkages with higher facilities including medical colleges **Essential newborn care as in Level 2 +** • Care of LBW newborns <1800 gm • Care of sick newborns • Vitamin K for premature babies

3.3 Postnatal and Newborn Care

Level 1 SBA Level	Level 2 Institutional (Basic Level)	Level 3 Institutional (Comprehensive Level)
Delivery by SBAs (Sub-Centre, PHCs not functioning as 24x7 and home deliveries conducted by SBA)	**PHC-Basic Obstetric and Neonatal Care (24X7 PHCs, CHCs other than FRUs)**	**FRU-Comprehensive Obstetric and Neonatal Care (DH, SDH, RH, selected CHCs)**
• Minimum 6 hrs stay post delivery • Counselling for Feeding, Nutrition, Family Planning, Hygiene, Immunisation and postnatal check-up • Home visits on 3rd, 7th and 42nd day, for both mother and baby. Additional visits are needed for the newborn on day 14, 21 and 28. Further visits may be necessary for LBW and sick newborns. • Timely identification of danger signs and complications, and referral of mother and baby **Newborn Care** • Warmth • Hygiene and cord care • Exclusive breastfeeding for 6 months • Identification, management and referral of sick neonates, low birth weight (LBW) and pre-term newborns • Referral linkages for management of complications • Care of LBW newborns <2500 gm • Zero day immunisation OPV, BCG, Hepatitis B	**All in Level 1 +** • 48 hours stay post delivery and all the postnatal services for zero and third day to mother and baby • Timely referral of women with postnatal complications • Stabilisation of mother with postnatal emergencies, e.g. PPH, sepsis, shock, retained placenta • Referral linkages with higher facilities **Newborn Care as in Level 1 +** • Stabilisation of complications and referral • Care of LBW newborns >1800 gm • Referral services for newborns <1800 gm and other newborn complications • Management of sepsis	**All in Level 2 +** • Clinical management of all maternal emergencies such as PPH, Puerperal Sepsis, Eclampsia, Breast Abscess, post surgical complication, shock and any other postnatal complications such as RH incompatibility etc. **Newborn Care as in Level 2 +** in district hospitals through Sick Newborn Care Unit (SNCU) • Management of complications • Care of LBW newborns <1800 gm • Establish referral linkages with higher facilities 

3.4 Safe Abortion Services as per MTP Act

Level 1 SBA Level	Level 2 Institutional (Basic Level)	Level 3 Institutional (Comprehensive Level)
Delivery by SBAs (Sub-Centre, PHCs not functioning as 24x7 and home deliveries conducted by SBA)	**PHC-Basic Obstetric and Neonatal Care (24X7 PHCs, CHCs other than FRUs)**	**FRU-Comprehensive Obstetric and Neonatal Care (DH, SDH, RH, selected CHCs)**
Counselling and facilitation for safe abortion services 	**Same as in Level 1 +** • Essential – MVA up to 8 weeks • Desirable first trimester services (up to 8 weeks) as per MTP Act and Guidelines • Post abortion contraceptive counselling • Referral linkages with higher centre for cases beyond 8 weeks of pregnancy up to 20 weeks • Treatment of incomplete/inevitable/ spontaneous abortions • Medical methods of abortion (up to 7 weeks of pregnancy) with referral linkages	**Same as in Level 2 +** • Second trimester MTP as per MTP Act and Guidelines • Management of all post abortion complications

3.5 Management of RTI/STIs

Counselling, prevention and referral	**All in Level 1 +** • Identification and management of RTI/STIs • Referral linkages with ICTC	**All in Level 2** + ICTC (desirable) • PPTCT at district hospitals

3.6 Family Planning Services as per the FP Guidelines

• Emergency contraception pills • Counselling, motivation for small family norm, distribution of condom, oral contraceptive pills, IUD insertion • Follow-up services for contraceptive acceptors, including post sterilisation acceptors	**All in Level 1 +** • Desirable - Male Sterilisation including Non-Scalpel Vasectomy + Tubectomy • Referral linkages for sterilisation	**All in Level 2 +** • Male Sterilisation including Non-Scalpel Vasectomy • Female Sterilisation (Mini-Lap and Laparoscopic Tubectomy) • Management of all complications

3.7 Making Home Deliveries Safer

Even while we continue to promote institutional delivery, we have a "responsibility to help families choosing to give birth at home to have a safe and clean labour, delivery, and post-partum experience". The single most important component of making a home delivery safe is ensuring that a SBA attends the delivery. The second most important component is to have a plan for referral if complications arise.

A birth preparedness plan must be made during the antenatal care visit. In the Maternal and Child Health card, the birth plan includes contact information, knowledge of danger signs, transport arrangement, financial arrangements, telephone numbers for potential last minute access to the referral facility etc.

I. Symptoms or signs that identify a woman at risk who should not deliver at home

Danger signs – Any bleeding in pregnancy, generalised swelling of the body and seizures, high fever.

During previous pregnancy – Caesarean delivery, poor obstetric history with previous foetal loss; in this pregnancy, premature labour or malpresenting foetus, severe anaemia, medical disorders such as heart disease, diabetes, tuberculosis, hepatitis or jaundice.

II. Checklists for preparation of home birth

i) **Checklist for Family:** Families of women who have made up their mind on a home delivery should be given a checklist (Annexe I-B), at least a month before the due date, to help ensure they have everything ready for a safe home birth. The nurse/midwife or ASHA should visit the home with the checklist at least two weeks before the expected date of delivery to make sure that the family is prepared. The family/ASHA should call the ANM at the onset of labour. ☑

ii) **Checklist for the ANM:** The ANM must be informed and be present with her kit (Annex 1-B) during labour and delivery to provide skilled attendance at birth, and ASHA to help provide care for the newborn. ☑

iii) **The Safe Home Delivery Protocol:** Is described in the MoHFW Guidelines for ANM, LHV, Staff Nurses[6] ☑

3.8 The Infrastructure and Support Services

Level 1 SBA Level	Level 2 Institutional (Basic Level)	Level 3 Institutional (Comprehensive Level)
Delivery by SBAs (Sub-Centre, PHCs not functioning as 24x7 and home deliveries conducted by SBA)	**PHC - Basic Obstetric and Neonatal Care (24X7 PHCs, CHCs other than FRUs**	**FRU-Comprehensive Obstetric and Neonatal Care (DH, SDH, RH, selected CHCs)**
i) Minimum number of beds		
Facility for staying at least 6 hrs: In home deliveries, SBA should be available for 2 hours after child birth.	Minimum 6 beds, stay - 48 hrs (uncomplicated delivery)	Minimum 30 beds, stay - 48 hrs (uncomplicated delivery), 3-7 days (complicated)
ii) Human resource		
Minimum two ANMs (trained as SBA) of which one is available at the headquarters most of the time. (In PHC, it could be trained nurses) ***For home delivery, the SBA would need assistance of a team of two or three women of which at least one could be ASHA, dai, AWW or any community level health worker and another could be a Self-Help Group (SHG) member or any community volunteer, to help with ancillary functions.***	• 1-2 MO with BEmOC training, trained in F.IMNCI • 3-5 Staff Nurses/ANM with SBA training and NSSK (round-the-clock presence) • Other supportive staff	**As in Level 2 +** • Obstetrician (degree/diploma/ MBBS with EmOC training) • An anaesthetist (degree/ diploma/MBBS with LSAS training) • Paediatrician (degree/diploma/ MBBS trained in F.IMNCI) • For blood transfusion services: A lab technician with skills in blood transfusion or a MO trained to provide these services • Nursing Care – At least 9 more nurses to work on 8 hour shift duties and provide quality nursing care, in labour room (3), neonatal stabilisation unit (3), OT and other areas of these hospitals (3). DH-SNCU would require even more.
iii) Labour room		
Labour table and newborn care corner to provide immediate care for all newborns. For drugs, equipment and essential drugs (see Annexe 1-A) At home – clean surface and surroundings	**All in Level 1 +** Vacuum extractor + newborn corner + stabilisation unit where most sick and LBW newborns are stabilised. For drugs, equipment and essential drugs (see Annexe 1-C)	**Same as in Level 2 +** Sick Newborn Care Unit. For drugs, equipment and essential drugs (see Annexe 1-E)

	Level 1 SBA Level	Level 2 Institutional (Basic Level)	Level 3 Institutional (Comprehensive Level)
	Delivery by SBAs (Sub-Centre, PHCs not functioning as 24x7 and home deliveries conducted by SBA)	**PHC - Basic Obstetric and Neonatal Care (24X7 PHCs, CHCs other than FRUs**	**FRU-Comprehensive Obstetric and Neonatal Care (DH, SDH, RH, selected CHCs)**
	iv) Functional Operation Theatre (OT) and Blood Transfusion Facility		
	Not required	OT for minor procedures including for sterilisation and MVA	• 24x7 functional OT with facility for Caesarean section • Blood Bank/Blood Storage Unit
	v) Drugs and equipment		
	See Annexe 1-A and 1-B	See Annexe 1-C	See Annexe 1-D and 1-E
	vi) Diet provision		
	None: Clean safe drinking water. Boiled and cooled water. Home food brought by patient's family	Diet provided by facility – hot cooked meals	Diet provided by facility – hot cooked meals
	vii) Transport		
	• Should be linked to a transport service that reaches within 30 minutes and transports patient to referral centre. • Transport may be needed for ANM to reach the home of pregnant women.	• Should have an ambulance that could transfer patient to referral centre within an hour. • Should be able to pick up patient from the village. • Should drop patient back home in specific category of cases.	Should be able to pick up and drop patient as required. Should be available on 24x7 call basis.
	viii) Water and electricity		
	Assured water supply that can be drawn and stored locally. Electricity supply linked to main lines or adequate solar source, inverter or back-up generator as appropriate.	Piped 24 hour water supply and 24x7 electricity link with generator back-up	**Same as in Level 2**
	ix) Lighting, warmth and ventilation		
	No drafts; some simple ways of keeping room warm and ventilated. Insect proofing required.	Minimum required ventilation, lighting and warmth. Minimum lighting measured in lux. Insect proofing mandatory.	**Same as in Level 2+** Controlled temperature in intensive setting such as SNCU and OT.

	Level 1 SBA Level	Level 2 Institutional (Basic Level)	Level 3 Institutional (Comprehensive Level)
	Delivery by SBAs (Sub-Centre, PHCs not functioning as 24x7 and home deliveries conducted by SBA)	**PHC - Basic Obstetric and Neonatal Care (24X7 PHCs, CHCs other than FRUs**	**FRU-Comprehensive Obstetric and Neonatal Care (DH, SDH, RH, selected CHCs)**
	x) Security		
	Provided by family and attenders	One person on security duty at all times. No stray animals allowed in premises. Compound wall mandatory*.	Security round-the-clock through an outsourced or adequately staffed internal arrangement. Compound wall mandatory.*
	xi) Sanitation and hygiene		
	One toilet for patient use that is kept clean at all times. Fresh sheet for every patient, fresh sheet for every day for every bed in use and as needed.	• At least two toilets for patient use and two bathing and washing spaces. • Separate spaces for women • Fresh sheet for every patient. Laundry service desired.	• At least six toilets and three bathing spaces for patient use. • Rest same as in Level 2, but assured laundry service must be in place.
	xii) Infection prevention[6]		
	Hand washing as per protocol. Use of disposable gloves, use of disinfectants, clean sheet, new blade for cord cutting, sterilised cord ties, In facility – autoclaving/ boiling of instruments and colour coded bins.	**Same as in Level 1 +** Autoclave, colour coded bins	**Same as in Level 2**
	xiii) Waste management[25]		
	Hub-cutter, puncture proof boxes for needle disposal, deep burial of placenta	**Same as in Level 1** Deep burial of placenta and all blood and tissue fluid stained	**Same as in Level 1**
	xiv) Rest facilities		
	Not needed	Relative/companion waiting and utility space needed	For ASHAs, birth companion and relatives; separate toilets/kitchen, needed.
		Birth waiting homes in institutions for families residing in remote areas with poor road connectivity	

* Overcrowding of wards to be prevented.

CHAPTER -4

Supervision and Monitoring

In addition to the supervisory structure that exists in the state government system, the following additional supervision mechanisms need to be put in place, organised at three levels: Block, District and State levels.

4.1. Block Level Supervision

Designation	Responsibilities	Profile
Skills Supervisor	• Ensures that all nurse-midwife service providers have the necessary skills through on-the-job mentoring. • Ensures that protocols of care built up for the services at each level are followed, and all service providers have necessary skills. • Guides and ensures that all existing Lady Health Visitors (LHVs) undertake clinical supervision in accordance with protocols.	• A nurse-practitioner • Or a nurse recruited and trained for the necessary competencies.
Quality Supervisor	• Ensures that all facilities and institutions in the block are certified for quality which includes security, safety and comfort of pregnant women and newborns. • Provides the necessary logistic and organisational support to improve facility level quality and management processes. • Builds up community level linkages to ensure demand generation. • Trains all existing supervisors.	• The existing supervisors (male or female), could be selected for this purpose. • Alternatively, a fresh management graduate willing to be trained for the position could be selected.
Block Level Accounts Manager	• Ensures that all payments made at block and sub-block levels are accounted for in a timely manner and open to public scrutiny. • Ensures that all facilities and providers making payments maintain proper accounts.	• Existing block accounts manager if in place. • Alternatively, a contractual accountant could be recruited for this purpose.

Supervisors would have a handbook with both checklists and protocols. A dynamic supervisory team would play a key role in changing the current work ethics and institutional culture.

Main Indicators at Block and District Level

Pregnant Woman

- % of pregnancies registered as against expected
- % of deliveries attended by SBA at each level
- % of ANCs registered within 12 weeks
- % of complicated deliveries attended
- % of complications identified and appropriately treated by diagnosis: severe anaemia, haemorrhage, prolonged/obstructed labour, hypertension in pregnancy, puerperal sepsis
- % complication referred
- Caesarean section rates

Newborn

- % of newborns weighed
- % of newborns who were LBW
- % of newborns admitted and managed for complications
- % of newborns breastfed within the first hour
- % newborns resuscitated
- % of stillbirths and neonatal deaths

Family Planning

Appropriate family planning indicators as per the HMIS

Deaths

- Reports of still births, neonatal deaths, maternal deaths and causes
- Maternal and neonatal death autopsy reports

Note: Only those indicators required by the national level based on HMIS guidelines would be reported up. The remaining indicators are to be used for planning and management purposes.

Processes of Supervision

- Periodic review meetings
- Monthly analysis, validation and feedback of HMIS data
- Facility visits: using supervisory protocols
- Training: on-the-job, refresher and supplementary

4.2. District Level Supervision

The number of supervisors needed at the block and district levels depends on the number of facilities providing delivery services. One skill supervisor and one quality supervisor for 10 facilities is adequate. If there are more than 50 facilities in a district, including sub- centres where institutional deliveries take place, then another set of district level supervisors will be required. This could be one full time nurse tutor or one full time quality supervisor. In addition, the Assistant Chief Medical Officer or RCH officers could provide support.

The quality supervisors and programme officers would be responsible for the facility support and quality certification of each of these facilities. They would also manage the grievance redressal cell which would include non-official members.

4.3. State Level Supervision

Quarterly review meetings would be held by the state Secretary or the Mission Director, with representative of Ministry of Health and Family Welfare (MoHFW) invited.

A quality certification body of five persons would organise and supervise the process of quality certification of facilities. This could be located in a Quality Assurance Cell, wherein professional bodies are represented.

The Training and Skills Coordination team located in the State Institute of Health and Family Welfare (SIHFW) or other suitable bodies with guidance from NIHFW would monitor, support and ensure the performance and outcomes of the nurse-supervisors in terms of skills in place and use of protocols.

CHAPTER -5

Quality and its Certification

5.1. Components

- Standards of care for each service that meet quality requirements.
- An authorised certifying team charged with making the visit and certifying the institution.
- A process of verification of the facilities so certified.
- A process of withdrawal of certification if standards fall below the acceptable norms.
- A process of public announcement of certification or its withdrawal.

5.2. Standards of Care

The areas that should be covered are given in the service delivery framework. The details of these would be given in the supervisor's handbook. Supportive supervision would be able to grade every facility in terms of the package of services it provides, the quantity of services it provides and the quality of each service provided. Once the service is ready for inspection and certification, the supervisors should inform the certifying authority.

5.3. Authorised Certification Team

The current quality assurance body could be the certification team with one consultant added in by the Mission Director of the state and another nominated by the Mission Director at the national level. In the district quality assurance team, the district would specify three persons selected as per guidelines that are available and train them for this purpose. A checklist and guide manual for certification should be made available. The members of this team should be paid on a per visit basis.

5.4. Verifying Process

About 5% of facilities in each district should be verified by a second body. In case of gross errors in certification, the composition and conduct of the certification team should be re-assessed and changed where needed.

5.5. Withdrawal

Withdrawal can be initiated in response to a report from the facility itself, or from the supervisor, or the certifying or verifying team or in response to a public grievance of denial which was investigated and found to be valid. The same authority as signs the certification would sign its withdrawal.

5.6. Public Announcement

Notices would be put up in the facility and panchayat offices. Information must be passed on to the ASHAs and service providers of the facilities below the institution level who refer cases to it. In addition, it could be announced as a news item or advertisement in the local newspaper with the largest circulation in that district.

Making Choices for Safe Delivery

6.1. Choices Before the District Planner

Given below is an example of district planning for safe delivery for all pregnant women, applying the principles and strategies discussed earlier. This focuses on prioritising delivery of good quality reproductive and child health services, while progressively moving towards full Indian Public Health Standards (IPHS).

District Population: 20,00,000: Birth rate: 27/1000
Expected Annual deliveries: 54,000: Monthly Deliveries: 4,500
Blocks: 10 - One with DH, two with a CHC and seven with a block PHC
District Plan Target: 100% safe deliveries in a three year time period

Institutional Comprehensive Level (providing CEmONC services)

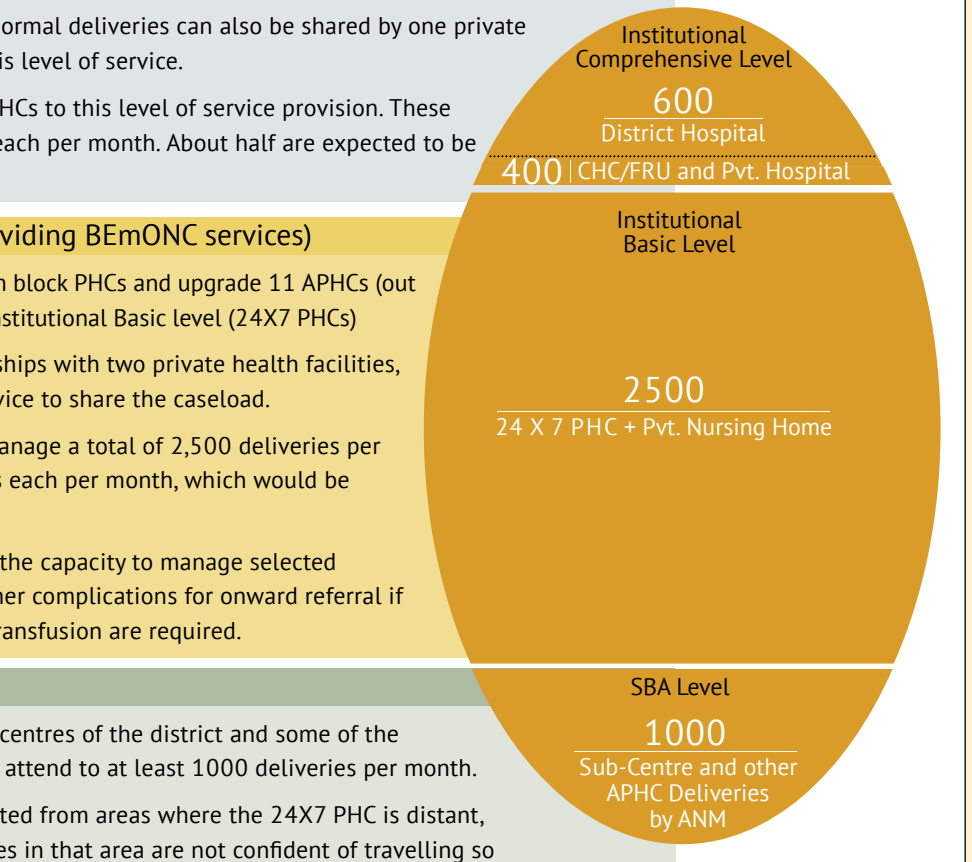
- Strengthen the District hospital, to manage 600 deliveries per month, of which at least half are expected to be complicated, referred from lower level institutions. The majority of the normal deliveries would come from the nearby peri-urban areas.
- This load of complicated and normal deliveries can also be shared by one private health facility that provides this level of service.
- Strengthen and upgrade two CHCs to this level of service provision. These could manage 200 deliveries each per month. About half are expected to be complicated cases.

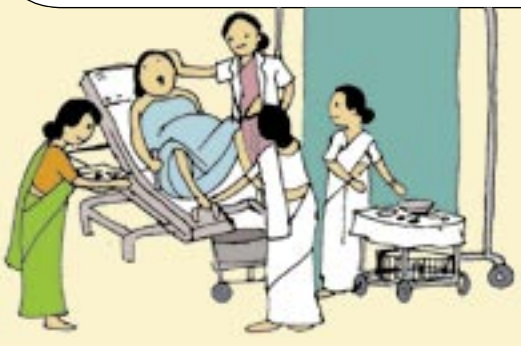
Institutional Basic Level (providing BEmONC services)

- Strengthen the remaining seven block PHCs and upgrade 11 APHCs (out of about 40 in the district) to Institutional Basic level (24X7 PHCs)
- Potential to enter into partnerships with two private health facilities, which provide this level of service to share the caseload.
- These 20 institutions would manage a total of 2,500 deliveries per month, or about 125 deliveries each per month, which would be mostly normal deliveries.
- These institutions would have the capacity to manage selected complications and stabilise other complications for onward referral if Caesarean section and blood transfusion are required.

SBA Level

- Strengthen 50 of the 400 sub-centres of the district and some of the remaining APHCs to be able to attend to at least 1000 deliveries per month.
- These facilities would be selected from areas where the 24X7 PHC is distant, or overcrowded, or poor families in that area are not confident of travelling so far and would prefer the delivery to be nearer home.
- While a majority of the deliveries would take place in the facility, the alternative of the ANM attending the delivery at the house could be planned for under appropriate circumstances.

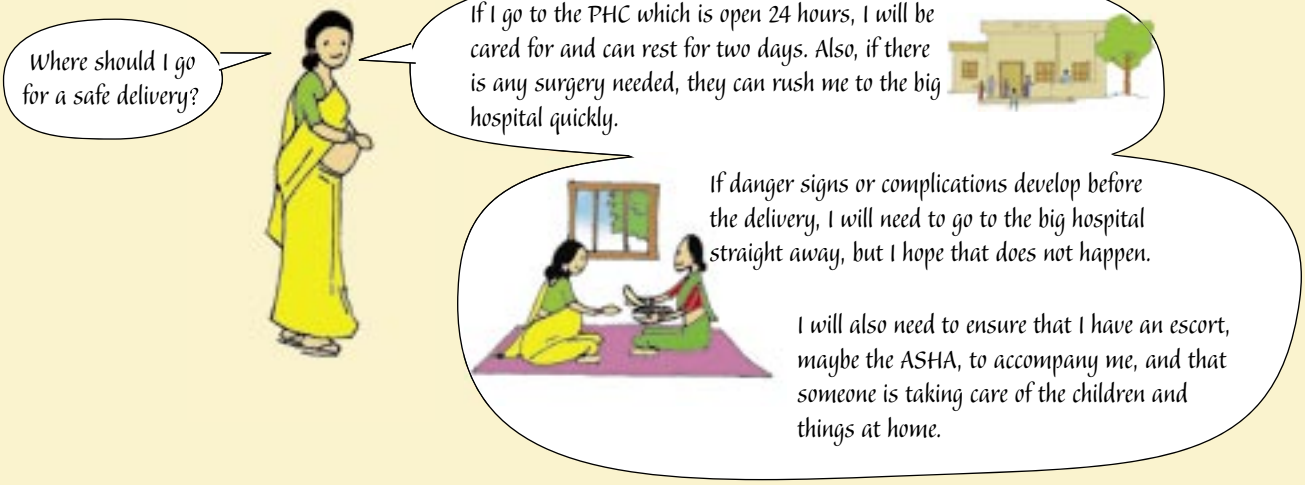




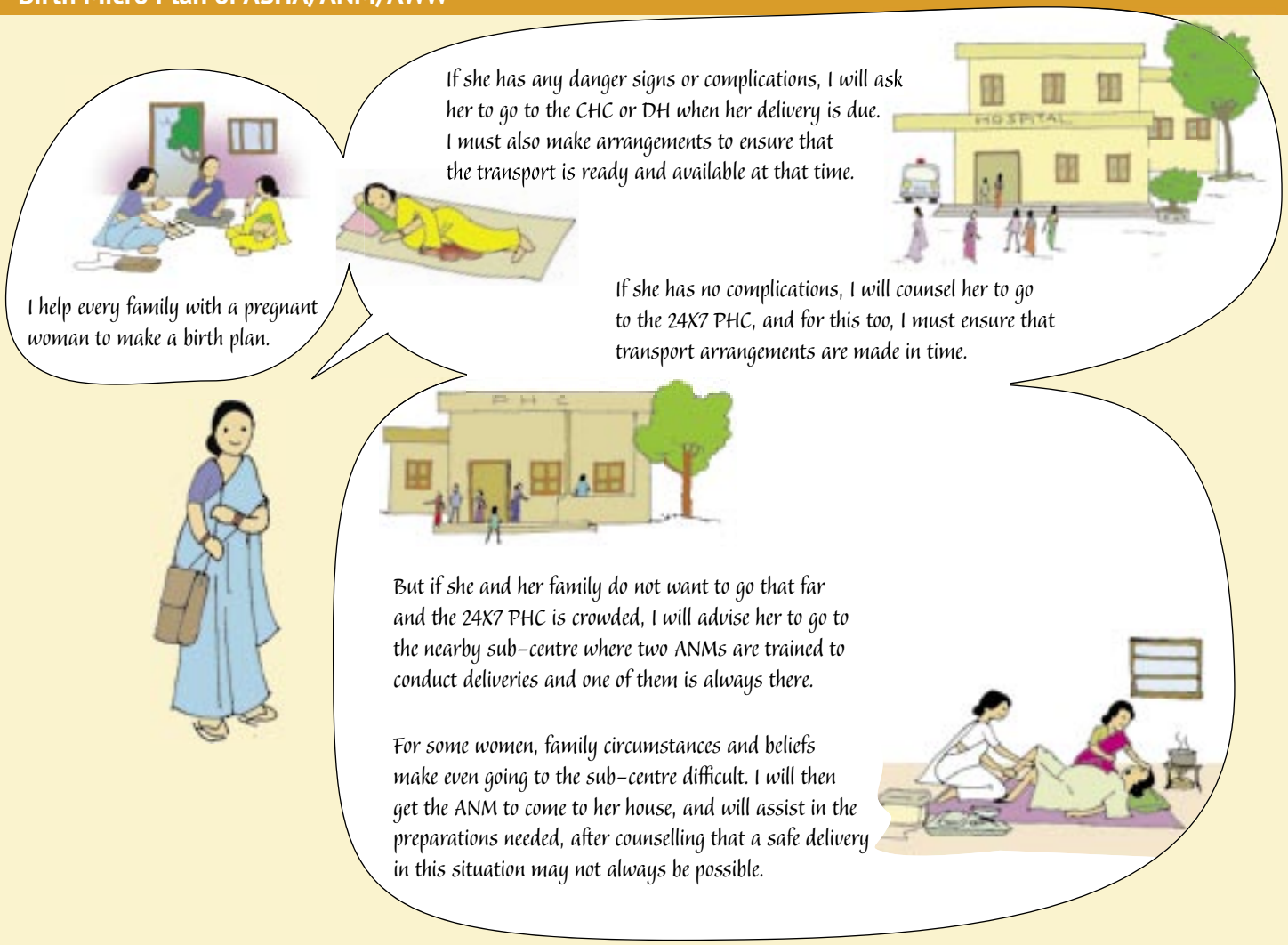
Depending upon the specific context in each district, the number of deliveries in each category and the choice of facilities to upgrade would differ.

6.2. Decisions People Make

Woman's choice



Birth Micro Plan of ASHA/ANM/AWW



Human Resource Development

CHAPTER -7

7.1. The Key Issues

- Getting adequate number of skilled providers in place including leveraging of partnerships.
- Ensuring that the skills of the providers are adequate to deliver quality services.
- Ensuring that there is a positive workforce environment and supportive supervision.
- Ensuring that there is human resource planning for managers and supervisors.

The service delivery framework specifies the numbers and qualifications of the service providers.

7.2. Human Resource Requirements, Skill Requirements and Training

The table below specifies the skill level required and the training that has been prescribed to achieve this level.

Facility	Minimum human resource requirements	Skill requirements	Training required
Sub-Centre	Minimum two ANMs (trained as SBA) of which one is available at the headquarters most of the time.	ANM should have the skills of a SBA	21-day SBA training module. May be integrated with: • IUD insertion training • NSSK training • HBNC supervision • Management of Childhood Illnesses In which case, training period would be of 25 days or longer.
Institutional - Basic	Two medical officers Three staff nurses or ANMs	The SN/ANMs should have skill levels at least of SBA and trained in NSSK. In addition, medical officers and any other staff involved in service provision should have skills of basic emergency obstetric care and essential and sick newborn care.	For SN/ANMs: As above Post basic nurse practitioner training. For Medical Officers: • Basic Emergency Obstetric Care (10 days BEmONC training) • F.IMNCI + NSSK (11+2 days) ◆ Safe abortion/MTP training ◆ NSV skills ◆ Conventional/mini-lap training +

Facility	Minimum human resource requirements	Skill requirements	Training required
Institutional - Comprehensive	One Obstetrician/ Gynaecologist One Anaesthetist One Paediatrician or MBBS doctor trained in above skills + four other doctors and nine nurses. One lab tech trained for blood transfusion support	Skills to manage surgical obstetric emergencies, blood transfusion and neonatal emergencies. If specialists are not available, medical officers in these specialist skills can be trained.	16 weeks short-term training courses for medical officers on emergency obstetrics (EmOC), 18 weeks for life saving anaesthesia skills (LSAS) and 4 weeks course for paediatric skills. Integrate/add on with: • Safe abortion/MTP training • Mini-lap and NSV training Nurses trained as described earlier.
Home Based Level	ASHA or other community health volunteer	Skills to make a difference in home visits in the neonatal/post-partum period	15 days on home based care– assuming induction is over. Otherwise 25 days.

7.3. Positive Workforce Environment and Supportive Supervision

- Service providers should feel supported to stretch themselves and take the risks that are necessary to save lives. An environment where there are rewards and incentives for good performance and extra work helps. Social recognition and recognition from peers and superiors also helps.
- Periodic on-the-job visits and opportunities to learn provided by a team of supervisors is also central to improved performance. During supportive supervision visits, the supervisor assists the service provider in her tasks, follows up to see that gaps in supplies or infrastructure are bridged, provides training and encouragement as needed. The supervisor follows a checklist to ensure that every skill is rehearsed, every protocol is understood and followed, all the inputs are in place, and all processes and outputs recorded appropriately.

7.4. District Plan and the RCH Programme Manager

The district needs to have one senior programme manager at the second level to the CMO and one contractual programme manager to ensure that this programme is run according to the plan.

The programme manager should be trained and certified in every aspect of training and planning for this programme. He/She should ensure that every facility follows appropriate protocols of care and is monitored and supported to do so.

7.5. The State PIP and the State RCH Officer

The State PIP must aggregate district human resource needs and training plans, include plans for fulfilling staff shortages and address other related areas such as incentives for retention and good performance, for developing additional training sites.

Institutional Support Systems and Linkages

8.1. Referral Transport and Referral Facility Linkage

All health facilities accredited for safe delivery or institutional delivery should necessarily have an assured referral transport linkage and an assured referral facility linkage.

8.2. What is an Assured Referral Transport?

I

A transport service that could become available within 30 minutes and be able to take the woman or newborn to a referral site within one hour.

II

This may be:
a) an ambulance with the facility,
b) an ambulance called from the higher facility,
c) an ambulance service, or
d) a private or commercial transport vehicle.

III

Communication contact with the vehicle driver directly or routed through a call centre.

IV

The ambulance service should be free of cost at the time of need.

8.3. What is an Assured Referral Facility Linkage?

- An assured referral facility linkage is a facility which provides management of complications including surgical emergencies and blood transfusion (what is termed comprehensive emergency obstetric and newborn care) and which agrees to provide these services on a cashless basis to any patient referred from the referring facility. This may be a public hospital or an accredited private hospital through a public-private partnership arrangement.
- The effort should be to have a network of referral centres within one or two hours of any facility providing institutional delivery or any sort of skilled birth assistance.
- The facility referred to has been intimated by phone about the referral with a brief history of the patient, so that on arrival the women is received and treatment started immediately.

8.4. Improved Logistics on Drugs and Supplies

- All the drugs and supplies needed for provision of care in pregnancy, whether antenatal, intranatal or postnatal, and whatever the level of care, should be available as per the approved drugs and supplies list, without interruption in each and every facility.

- Warehouse: This primarily requires a district warehouse with a minimum stock of three months of all the drugs and supplies mentioned for each facility. The warehouse should have an adequate inventory management system. Minor equipment required for these facilities like blood pressure instruments and Sahle's haemoglobinometers should also be stocked at the district warehouse at a level of 25% of all the facilities requiring it, so that as and when they break or under repair, the facility has the required supplies.
- Every facility should indent when their stocks fall below an estimated three months requirement. Transport of supplies to the periphery should be assured by the district for Sub-Centres and all facilities without a vehicle to transport the stocks immediately.
- Procurement systems must ensure that drugs and supplies and minor equipment at the district level are replenished as and when the stocks fall below a three month threshold.

8.5. Family Planning Programme Linkages

All maternal healthcare providers should be able to counsel the new mothers and the families on how to plan their family size and the advantages of a small family. Spacing should be advocated for its beneficial effect on the health of the mother and child and also on reduction of MMR and IMR.

There is also a need to counsel for delaying the first child where the woman is in her teens or still young, and to space between children. Counselling should also address contraceptive choices so that the family can make the most appropriate contraceptive choice for their context and need.

There is also a need to counsel against son preference.

Since specialised service providers are few, SBAs must have adequate skills in family planning methods, especially for Intrauterine Device (IUD) insertion to space between children and while waiting for sterilisation. IUD quality and effectiveness has now improved such that it could be the only contraception opted for.

Similarly, doctors in institutional delivery settings must also be able to do female sterilisation post-partum or by mini-lap procedure, or a non-scalpel vasectomy.

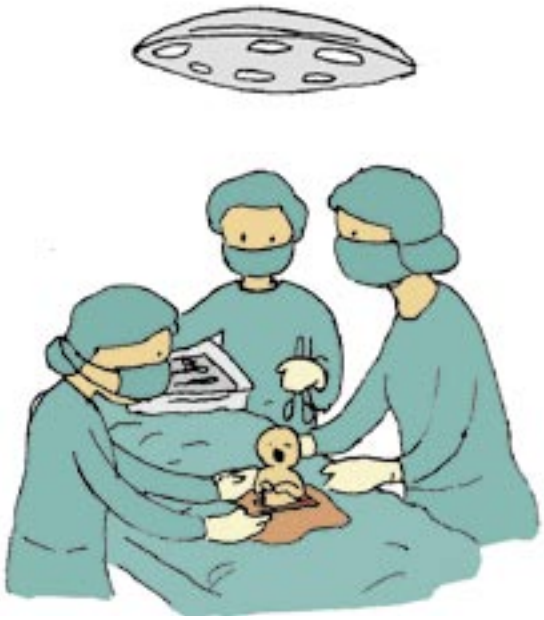
To the extent that the service provider has won the confidence of the mother and her family, and established her credibility, her advice on family planning should be taken seriously and acted on.

Private Sector Partners

CHAPTER -9

Wherever suitable private providers of care in pregnancy and for the newborn exist, effort should be made to engage with them based on the following principles:

- The standards of care should be the same for private providers as they are for the public facilities. The certification process should also be similar.
- Mapping should be done of all private providers in a district. Where there are public sector gaps at a given level of service delivery, available private sector partners could be recruited and utilised to fill in service provider gaps.
- Where public-private partnerships are opted for, care must be taken to draft a contract where the costs and quality are specified and monitored, and access to the poor is ensured. There are GoI guidelines that specifically cover all these inputs and include the process of accreditation of such facilities.
- Not only signing the contract but the supervisory structure and programme managers specified earlier should be charged with effective contract management. It also needs a state level policy and guidelines for the same.
- Payment must be prompt and made with dignity so as to be able to attract and retain the most service oriented and sincere partners.
- Special preference may be given to mission hospitals, philanthropic hospitals, public sector undertaking hospitals, NGO run or worker managed hospitals.



CHAPTER -10

Community Support Systems and Linkages

10.1. Why Community Mobilisation?

- Positive outcomes for maternal, newborn and child health programmes require active community participation and support.
- Community mobilisation is the process by which the community feels enthused and empowered to act. It is the process by which the community gains the knowledge, optimism and organisation needed for action and change.
- Marginalised and vulnerable sections require more intensive effort in the process of mobilisation and service delivery.
- For certain services, like replacing unsafe abortion with safe abortion services, or male sterilisation, demand generation is also required.
- Behaviour change on critical aspects like delaying age of marriage and age of mothers at first child birth also requires community mobilisation.

10.2. Who/What are the modalities of community mobilisation?

Five mechanisms critical to enabling the continuum of care for mother and newborn are:

- ASHA
- Village Health and Nutrition Day
- Village Health and Sanitation Committee
- Women's groups of different types – Self-Help Groups (SHGs), mother's groups etc.
- The elected representatives of local panchayats.

10.2.1. The ASHA

Role of the ASHA: At the village level, the ASHA plays a major role in building the community's awareness of their healthcare entitlements, in providing health education, in facilitating the community's access to essential health services, and in delivering preventive, promotive and first contact curative care.

Service Provider Skills: ASHA would be trained in skills to provide a limited package of first contact care for mothers and newborns, in addition to preventive and promotive services. This actually enables a better realisation of the continuum of care. Provision of essential newborn care for the normal baby whether delivered in an institution or home is well within the purview of a trained and skilled ASHA.

Measurable Tasks for the care of the mother and newborn: The role of the ASHA in maternal and newborn health is to:

1.	Track and mobilise pregnant mothers to attend monthly clinics, such as the VHND and facilitate access to antenatal care services provided by the ANM.
2.	Prepare birth preparedness plans for pregnant women with support from family members and ANM.
3.	Conduct home visits to the pregnant woman to counsel the family on antenatal care- especially related to nutrition and rest, protection from malaria, alertness to danger signs and complications, and for making the birth plan.
4.	Support institutional delivery, including arranging for transport and escort to the facility and act as the birth companion if that is needed and possible.
5.	Make home visits in the postnatal period to diagnose and refer in case of complications such as bleeding or infection.
6.	Make newborn care visits (five visits on Days 3, 7, 14, 21, and 28, in addition to the delivery visit) to promote early and exclusive breastfeeding, ensure that the baby is kept warm, weigh the baby, counsel mother on recognition of danger signs to enable rapid referral in case of illness in the newborn.
7.	Counsel on and facilitate family planning measures as appropriate for the couple.
8.	Support the ANM in updating the Maternal and Child Health card, jointly issued by MoHFW & MWCD.








(List of ASHA competencies is annexed in Annexe 2-D).

10.2.2. The Village Health and Nutrition Day (VHND)

An ANM may have anywhere from 4 to 10 anganwadi centres in her area. On one fixed day, every month she visits each of these anganwadis which cater to one or more habitations/hamlets or a part of the village. This is referred to as the Village Health and Nutrition Day (VHND), and serves as a platform for the ANM to provide all outreach services such as ANC, PNC, family planning, immunisation, treatment for sick children and making of blood slides in fever cases. Both the AWW and ASHA support the ANM by mobilising those children, pregnant women and sick persons in need of care, to attend the VHND. In VHND, the provision of immunisation and antenatal care is also undertaken. The ASHA should also help to make it a community event, and make a special effort to ensure that women living in hamlets and those from marginalised communities are reached with services.

10.2.3. The Village Health and Sanitation Committee (VHSC) and the Panchayati Raj Institutions (PRIs)

The Village Health and Sanitation Committees (VHSCs) are village level bodies comprised of key stakeholders in a village and which serve as a forum for village planning and monitoring. Elected representatives (Members of the PRIs) are generally office bearers of the committee. The main functions of the VHSC and PRI are to ensure that:

- No section of the village community is excluded from these services.
- Service providers are available and are able to alert authorities in case of unscheduled cancellations of the immunisation day/VHND.
- Local transport arrangements are available for pregnant women, especially for those with complications and sick newborn to reach the referral facility, and that in an emergency, this transport is available on a cashless basis with reimbursement later.
- Nutrition supplement and food security programmes reach the pregnant and lactating woman.

Focus on the marginalised

There are some pregnant women who are too poor or too marginalised to seek even free care. Often they are single women without male support and perhaps with children to look after. This means that their circumstances are straitened by poverty and pregnancy. Lack of child care also limits their access to the facility. Other vulnerable women could belong to recent migrant communities who are not registered in the Sub-Centre and do not speak the local language. They could also belong to a SC or ST group which has historically been excluded from services. The ASHA and the VHSC must bring the knowledge of such gaps to the PRI and the health department. A substantial part of the problem is in recognising the existence of such marginalised sub-groups within the village.

10.2.4. Behaviour Change Communication (BCC)

Behaviour Change Communication (BCC) is needed to promote positive health practices for maternal and newborn health, and to discourage harmful practices. At the national and state level, this is undertaken through mass media, to build an enabling environment and create societal acceptance for change. Village level interpersonal communication and community mobilisation, are however the major forms of BCC which lead to changed behaviour. Some of the main areas for a BCC strategy to target include:

B

- Reducing the number of adolescent pregnancies, increasing age at marriage, delaying first child birth and increase spacing between pregnancies.
- Improving nutritional status before and during pregnancy: Ensuring good nutrition during adolescence to improve inter-generational malnutrition, increasing caloric intake, ensuring weight gain of 8- 10 kg, and correcting iron deficiency (anaemia) through proper dietary intake and iron supplementation.

C

- Reducing the risk of Human Immunodeficiency Virus (HIV) and HIV related complications: Promoting safe sexual behaviours.
- Making informed choices regarding use of family planning methods, including the use of spacing method.
- Improving infant and young child feeding.

C

- Importance of early initiation and exclusive breastfeeding.
- Information on danger signs in the mother and newborn .
- Appropriate choices to be made if there are any signs needing referral care.

A BCC strategy would require the following:

- Knowledge of the determinants of key behaviours listed above.
- Audience segmentation and the choice of appropriate message, medium and communicator to reach mothers, their families and community influencers.
- Measures to monitor and evaluate effectiveness of the BCC components.

CHAPTER -11

Janani Suraksha Yojana

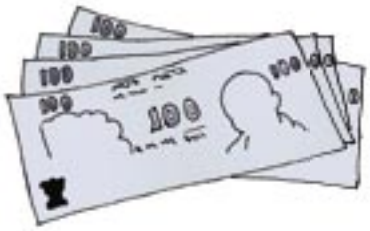
Janani Suraksha Yojana is a central scheme that provides cash to the pregnant woman from poor and marginalised families, to encourage and empower her to be able to give birth to her child in the safety, comfort and care of an institution. There are costs involved in transport, diet and medical care that poor families have to meet in order to avail of delivery in health facilities. The JSY provides these costs in the form of a cash transfer to such families. The scheme also provides incentives for ASHA to promote institutional delivery and guide and support the pregnant woman to seek appropriate care. The scheme also provides payments for contracting in specialist services in the facilities at Rs. 1500 per case.

The JSY also provides a smaller sum as support for those poor women who opt for home delivery for reasons ranging from lack of access, confidence in institutional delivery services or their own cultural beliefs.

11.1. JSY benefit packages at a glance

Place of delivery	**Rural**		**Urban**	
Institutional deliveries in	Package for mothers	ASHA package	Package for mothers	ASHA package
• Low Performing States	1400	600 (200+250+150)	1000	200
• High Performing States	700	200	600	200
Home deliveries	500	Nil	500	Nil

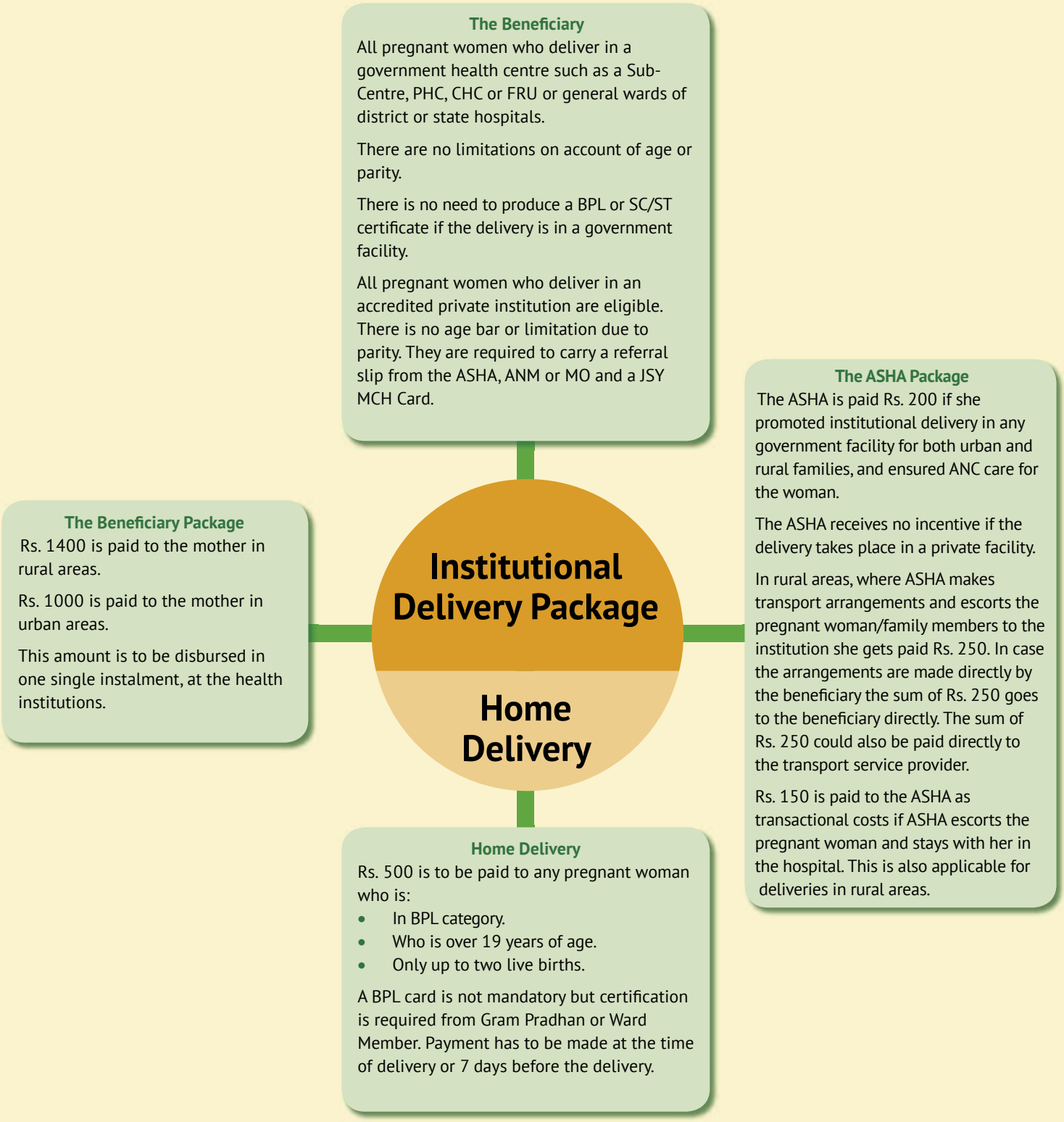
Note: ASHA package is applicable only for deliveries in the public sector.



Rs. 1400 given as incentive for institutional delivery

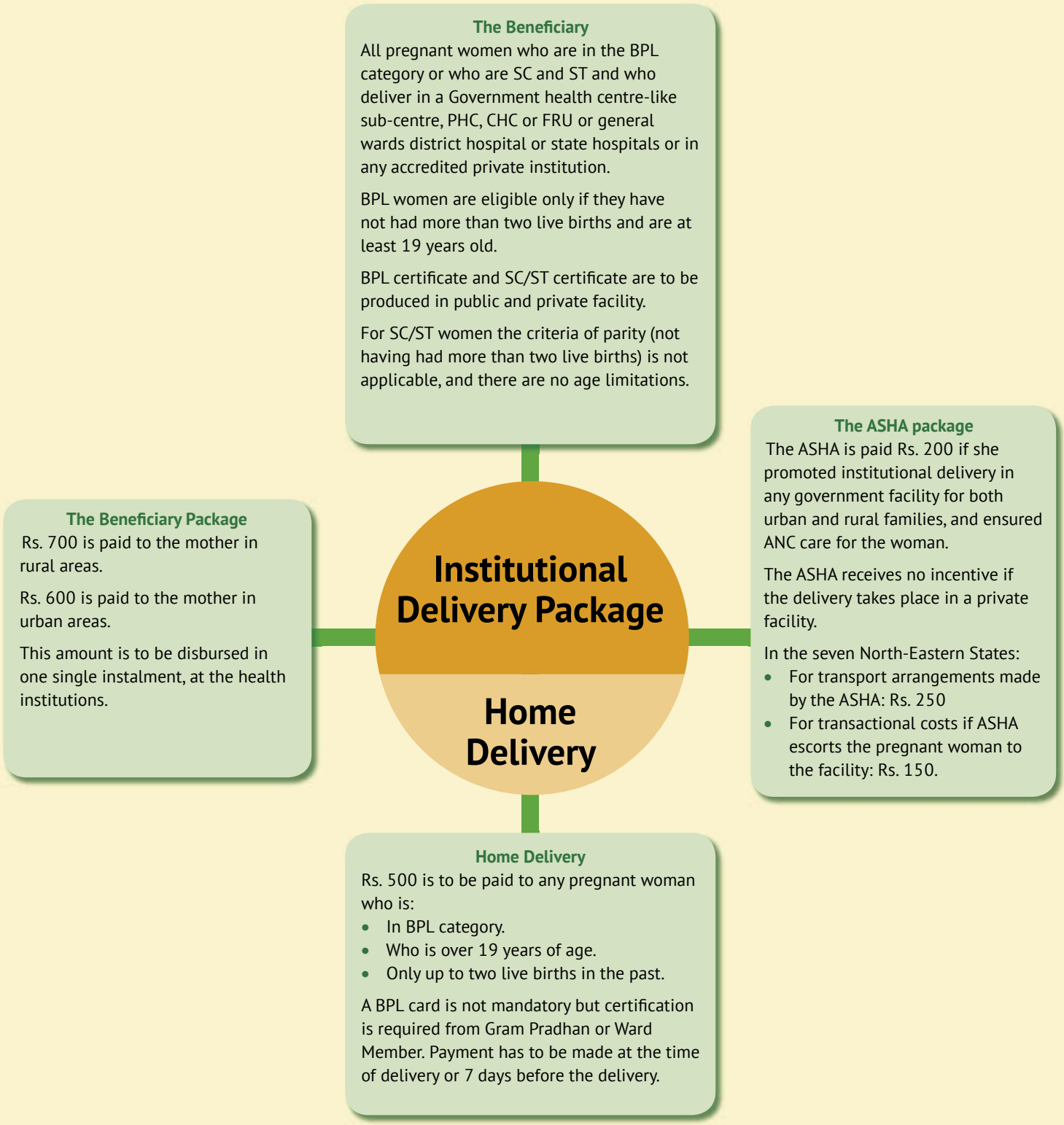
11.2. JSY Financial Package for Low Performing States

This includes Assam, Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Orissa, Rajasthan, Uttar Pradesh, Uttarakhand, Jammu and Kashmir.



11.3. JSY Financial Package For High Performing States, including UTs and the Seven North-Eastern States

This includes Andhra Pradesh, Goa, Gujarat, Haryana, Himachal Pradesh, Karnataka, Kerala, Maharashtra, Punjab, Tamil Nadu, West Bengal, Andaman and Nicobar Islands, Chandigarh, Delhi, Dadra and Nagar Haveli, Daman and Diu, Lakshadweep, Puducherry and the north-eastern states of Arunachal Pradesh, Manipur, Meghalaya, Mizoram, Nagaland, Sikkim and Tripura.



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