A Strategic Approach to Reporoductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A) in India

For Healthy Mother and Child

सत्यमेव जयते

Ministry of Health & Family Welfare
Government of India
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Message

Reducing maternal and child mortality are among the most important goals of the National Rural Health Mission. Huge and strategic investments are being made by Government of India to achieve these goals. At various global platforms, India has reaffirmed its commitment to make every effort towards achieving the Millennium Development Goals 4 and 5. The National Call to Action: Child Survival and Development, 2013, is an iteration of this commitment, where the Government with all its partners will together launch the strategic roadmap for accelerating child survival and improving maternal health in the near future and beyond 2015.

India has made considerable progress over the last two decades in the sector of health, which was further accelerated under NRHM. True to its vision, NRHM improved the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, women and children. However, latest data and trends emerging from the national surveys demand a cohesive approach to manage child and maternal health care.

Clear articulation of the strategic approach to reproductive, maternal, newborn, child and adolescent health (RMNCH+A) is an effort in this direction. I am confident that this strategic approach will prove useful in strengthening efforts and renewing India's commitment towards a compelling vision of improving maternal health and child survival in India. I earnestly hope that this document would be used constructively at the national, state, district and sub-district levels to improve the condition of women and children and fill in the gaps at various life stages leading to reduced maternal and child mortality and better health for women and children across the country.

Shri Ghulam Nabi Azad
Union Minister of Health and Family Welfare
Government of India

Foreword

I am happy to know that the Ministry of Health & Family Welfare is bringing out an integrated approach document for reproductive, maternal, new born, child and adolescent health (RMNCH+A) in India. **RMNCH+A approach** essentially looks to address the major causes of mortality among women and children as well as the delays in accessing and utilising health care and services. The RMNCH+A strategic approach document has been developed to provide an understanding of 'continuum of care' to ensure equal focus on various life stages. Priority interventions for each thematic area have been included in this document to ensure that the linkages between them are contextualised to the same and consecutive life stage. The document also introduces new initiatives like the use of Score Card to track the performance, National Iron + Initiative to address the issue of anaemia across all age groups and the Comprehensive Screening and Early interventions for defects at birth , diseases and deficiencies among children and adolescents. The RMNCH+A document appropriately directs the States to focus their efforts on the most vulnerable population and disadvantaged groups in the country. The document also emphasizes on the need to reinforce efforts in those poor performing districts that have already been identified as the high focus districts. The document will serve as a hands-on guide for Mission Directors and State Program Managers in the planning, implementation and monitoring of the new and existing RMNCH+A interventions.

It is now important that we follow the strategic direction, make use of available resources and set NRHM as a benchmark for sustained and dedicated implementation of national programme. Opportunities like this - to make wide ranging interventions and to invest in quality of services in the field of RMNCH+A - come rarely to be handled through a mission approach. I hope that *A Strategic Approach to Reproductive, Maternal, New-born, Child and Adolescent Health (RMNCH+A) in India* will take India closer to achieving its national health gaols and the Millennium Development Goals 4 & 5.

Mr. P. K. Pradhan
Secretary Health and Family Welfare
Government of India

Preface

At the cusp of the new phase of NRHM, it is my privilege to present *'A strategic Approach to Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A) in India'* that embodies our vision for comprehensive and integrated health services most importantly for the adolescents, mothers and children. In the last seven years the Reproductive and Child Health Programme (RCH II) have provided the flexibility and opportunity to introduce new interventions and to pilot and scale up innovative service delivery mechanisms. This has resulted in an ever-growing and dynamic list of interventions and service packages across the reproductive, maternal and child health spectrum. With the expansion of the health infrastructure, additional managerial capacity and financial resources, it is being felt that the service packages are implemented and managed in independent units and with a focus on achieving a certain health goal or a set of indicators. Somewhere along the way we have lost sight of the fact that these service packages are complementary to each other in terms of achieving the national goals and making an impact. This poses a challenge at the higher level of decision making where the composite picture and the inter-linkages between the various programme components must be understood and addressed through a cohesive approach for achieving a common set of goals and targets that are interdependent.

Increasingly, across the globe, there is emphasis on establishing the 'continuum of care' , which includes integrated service delivery in various life stages including the adolescence, pre-pregnancy , childbirth and postnatal period, childhood and through reproductive age. In addition, services should be available at all levels: in homes and communities, through outpatient services and hospitals with 'inpatient' facilities. This approach is based on the sound premise that health of an individual across the life stages is interlinked. One of the key concerns for us is the number of maternal deaths, which we know can be reduced by bringing down the numbers of unintended pregnancies. This requires increased contraceptive use and in effect, the maternal health and family planning service packages to be linked in terms of service delivery. This integrated approach has been further elaborated in this document, with due emphasis on adolescence as a significant phase of life and referral linkages between community and facility based services.

The purpose of this document is to provide the Health Secretaries, Mission Directors and Programme Managers at National and State level a vision and understanding of the comprehensive approach to improving child survival and safe motherhood and attaining two Millennium Development Goals 4 and 5, to which India is sincerely committed.

As we approach another milestone year (2015), the urgency to accelerate the pace of reduction in maternal and child mortality cannot be overemphasised. The 12th Five Year Plan that coincides with the new phase of NRHM has presented an important opportunity to induce greater momentum into the programme.

I dedicate 'A Strategic Approach to Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A) in India' to the States that have been at the forefront of testing innovations, adopting new models of service delivery and feeding these learning into the programme, and thus shaping the national strategy. How we implement and continuously evaluate the process of implementation adopting this approach is a challenge that we gladly accept today. The approach is sound and inclusive, the document is simple and understandable, the groundwork is already done across the States; what we need is to renew our commitment to change the way we conducted business so far. I am very hopeful that this approach will help the programme to evolve further and maximise the gains achieved so far.

Ms. Anuradha Gupta
Additional Secretary & Mission Director, NRHM
Government of India

Foreword

The Reproductive, Maternal, Child and Adolescent Health programme is at the heart of our flagship programme National Rural Health Mission (NRHM). Central tenets guiding this programme have been equity, universal care, entitlement and accountability. Our aim is to protect the lives and safeguard the health of women, adolescents and children and this has been the driving force for reaching out to the maximum numbers, in the remotest corners of the country through constant innovation and calibration of interventions. Our strategies have yielded rich and quick dividends, evident in improved IMR and MMR. However there is much that needs to be done – the extension of the Mission into a new phase of five years is a strategic opportunity that we must seize and make the most of it in terms of taking forward the agenda of health for all.

One of the most important steps that the Government of India has taken to fulfil its commitment to improving maternal health and child survival is the articulation of a comprehensive approach and linking together a set of initiatives and strategies that address each life stage. This approach is defined with the purpose to guide the States, and especially Programme Managers leading the programme at State level, in evolving specific models, customised to context and requirements. The approach document clearly underscores the shifting focus for programming - from the district to the block and community level. In the context of this shift in levels of programming, our dynamic workforce of 8.7 lakhs ASHA workers would be a key in establishing a continuum of care between communities and health facilities.

The RMNCH+ A approach also reiterates the need to focus on the most vulnerable and underserved sections of the population. Geographic pockets have been identified and singled out for concerted action. The approach is a conscious articulation of our endeavour to tailor programmes for sections of population which till now have been underserved; for instance, adolescents, urban poor and tribals. This focused attention will undoubtedly yield quick and large gains.

I would urge the states to build on our existing strengths while planning the implementation of this approach and use convergence as leverage for achieving overall health and development goals. Linkages within health programmes and programmes of other ministers and departments that share a commonality of the goals and vision must be foster for improved health outcomes.

I am confident that this well-conceived, effective framework for reproductive, maternal, newborn, child and adolescent health services shall go a long way in changing situation at the ground level and will serve as a handy resource for Mission Directors and Programme Mangers.

I wish you success in your endeavours and pledge my unstinting support towards implementation of this approach.

Dr. Rakesh Kumar
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Global Health Strategies

Glossary

AEFI	Adverse Events Following Immunization
AHS	Annual Health Survey
ANC	Ante Natal Care
ANM	Auxiliary Nurse Midwife
ART	Anti Retro-viral Therapy
AWC	Anganwadi Centre
AWW	Anganwadi Worker
BCC	Behaviour Change Communication
CAC	Comprehensive Abortion Care
CHERG	Child Health Expert Review Group
DH	District Hospital
DLHS	District Level Household Survey
EAG	Empowered Action Group
EMOC	Emergency Obstetric Care
FP	Family Planning
FRU	First Referral Unit
GNM	General Nursing Midwives
GOI	Government of India
HIV	Human Immunodeficiency Virus
HMIS	Health Management & Information System
HR	Human Resource
ICDS	Integrated Child Development Services Scheme
IMNCI	Integrated Management of Neonatal and Childhood Illnesses
IPC	Inter Personal Communication
IPHS	Indian Public Health Standards
IUCD	Intra Uterine Contraceptive Device
LBW	Low Birth Weight
LHV	Lady Health Visitor
LSAS	Life Saving Anaesthesia Skills
MCH	Maternal and Child Health
MCIS	Multi Cluster Indicator Survey
MCTS	Mother and Child Tracking System
MMU	Mobile Medical Unit

MO	Medical Officer
MTP	Medical Termination of Pregnancy
MWCD	Ministry of Women and Child Development
NBSU	New Born Stabilisation Unit
NFHS	National Family Health Survey
NRC	Nutrition Rehabilitation Centre
NRHM	National Rural Health Mission
NSSK	Navjaat Shishu Suraksha Karyakram
OCP	Oral Contraceptive Pills
ORS	Oral Rehydration Solution
OT	Operation Theatre
PCPNDT	Pre-Conception & Pre-Natal Diagnostic Test
PHC	Primary Health Centre
PIP	Programme Implementation Plan
PHN	Public Health Nurse
PPIUCD	Post Partum Intra Uterine Contraceptive Device
PPS	Post-Partum Sterilisation
PPTCT	Prevention of Parent to Child Transmission
PRI	Panchayati Raj Institution
RCH	Reproductive Child Health
RGI	Registrar General of India
RKS	Rogi Kalyan Samiti
RPR testing kits	Rapid Plasma Reagin testing kits
RMNCH+A	Reproductive, Maternal,Newborn, Child Health plus Adolescents
RTI	Reproductive Tract Infection
SBA	Skill Birth Attendant
SHC	Sub Health Centre
SNCU	Special Newborn Care Unit
SRS	Sample Registration System
STI	Sexually Transmitted Infection
TFR	Total Fertility Rate
UT	Union Territory
U5M	Under Five Mortality
VHND	Village Health & Nutrition Day
VHNSC	Village Health Nutrition and Sanitation Committees
WHO	World Health Organisation
WIFS	Weekly Iron Folic-acid Supplementation

Contents

CHAPTER 1

Introduction and Rationale

Improving the maternal and child health and their survival are central to the achievement of national health goals under the National Rural Health Mission (NRHM) as well as the Millennium Development Goals (MDG) 4 and 5. In the past seven years, innovative strategies evolved under the national programme to deliver evidence-based interventions to various population groups. A substantial increase in the availability of financial resources for Reproductive and Child Health (RCH), healthcare infrastructure and workforce as also the expansion of programme management capacity since the launch of NRHM in 2005 provides an important opportunity to consolidate all our efforts. As we inch closer to 2015, there is an opportunity to further accelerate progress towards MDG and redefine the national agenda to come up with a coordinated approach to maternal and child health in the next five years.

In order to bring greater impact through the RCH programme, it is important to recognise that reproductive, maternal and child health cannot be addressed in isolation as these are closely linked to the health status of the population in various stages of life cycle. The health of an adolescent girl impacts pregnancy while the health of a pregnant woman impacts the health of the newborn and the child. As such, interventions may be required at various stages of life cycle,which should be mutually linked. The reasons for adopting such a strategy can be understood when the available data is taken into account and the close inter-linkages between different stages of life cycle are recognised.

Birth weight is an important risk factor for child survival as children with low birth weight (LBW) are more likely to have impaired growth, higher mortality and risk of chronic adult diseases. The LBW is also a strong predictor for size in later life as most of these babies have intrauterine growth retardation, and they seldom catch-up with normal size during childhood. In India, 22% babies born each year have LBW, which has been linked to maternal under-nutrition and anaemia among other causes. The mother's condition before pregnancy is a key determinant of its outcome; half of adolescents (boys and girls) have below normal body mass index (BMI) and almost 56% of adolescent girls aged 15–19 years have anaemia.

Therefore, the nutritional status of adolescent girls and young women is inextricably linked to the birth weight of their children and subsequently to child survival. There is evidence to show that adolescent mothers are vulnerable to problems related to pregnancy and childbearing. Of all mothers, adolescent mothers are more likely to have preterm births. According to national surveys, adolescents (15–19 years) contribute about 16% of total fertility in the country and 15–25 years age group contributes 45% of total maternal mortality.

With substantial unmet need of contraception – about 27% among married adolescents (15–19 years) – and low condom use by adolescents in general, adolescent girls are at a high risk of contracting sexually transmitted infections, HIV and unintended and unplanned pregnancies. This in turn contributes to maternal morbidity and mortality due to unsafe abortions and infections.

High maternal and child mortality in adolescent mothers and a smaller but significant contribution of adolescents to total fertility brings the focus back on the need to address adolescents as an integral part of the strategy so as to improve maternal and child health. Another compelling reason to invest in an integrated strategy across life stages is the well-known link between maternal and child survival,and the use of family planning methods. There is evidence to show that in developing countries, the risk of premature delivery and LBW doubles when conception occurs within six months of a previous birth. The use of contraceptive has the potential to improve perinatal outcomes and child survival by widening the interval between successive pregnancies. Increased contraceptive use can also reduce the number of maternal deaths by reducing unintended pregnancies and thereby abating the number of times women face the hazards of pregnancy. Especially in areas with poor health infrastructure, family planning is a cost-effective and feasible way to reduce maternal and child deaths as it does not rely on complex technology. It is estimated that if the current unmet need for family planning could be fulfilled within the next five years, India can avert 35,000 maternal deaths and 12 lakh infant deaths while saving more than 4,450 crore of Indian currency. If safe abortion services are coupled with increase in family planning services, the savings made to the country could be to the tune of Rs 6,500 crore.

Just as different stages in the life cycle are interdependent so are the aspects of where and how healthcare is provided. Household or community education contributes to preventing health complications, quality care provided at the community level helps avoid the need for hospitalisation, and sound referral systems at primary care level support early identification of risks and better treatment for acute and complicated conditions. Essential interventions to improve the health of women and children therefore need to take place at all levels in the health system, that is, from the home to the community level and through all the health facilities.

Thus, there are two dimensions to healthcare: (1) stages of the life cycle and (2) places where the care is provided. These together constitute the 'Continuum of Care.' This Continuum of Care approach of defining and implementing evidence-based packages of services for different stages of the lifecycle, at various levels in the health system,has been adopted under the national health programme. This strategic approach to Reproductive, Maternal, Newborn, Child Plus Adolescent Health (RMNCH+A) is described further in the document. The 'Plus' in the strategic approach denotes the (1) inclusion of adolescence as a distinct 'life stage' in the overall strategy; (2) linking of maternal and child health to reproductive health and other components (like family planning, adolescent health, HIV, gender and Preconception and Prenatal Diagnostic Techniques (PC&PNDT); and (3) linking of community and facility-based care as well as referrals between various levels of health care system to create a continuous care pathway, and to bring an additive /synergistic effect in terms of overall outcomes and impact.

This approach is likely to succeed given that India already has a community-based programme (that has been given a huge fillip by the presence of 8.7 lakh ASHA workers) as well as the three-tiered health system in place. These provide a strong platform for delivery of services across the entire continuum of care, ranging from community to primary health care,as well as first referral level care to higher referral and tertiary level of care. This integrated strategy can potentially promote greater efficiencies while reducing duplication of resources and efforts in the ongoing programme.

By defining integrated packages of services, the Continuum of Care provides an effective framework for seamless delivery of services at state and district levels.

This approach document acknowledges that differences in life chances arise largely due to the wider determinants of health that include the socio-economic conditions in which children are born, and are forced to grow and live. Gender inequalities, illustrated by the skewed child sex ratio, shape women's daily lives while playing a major role in determining their health and well-being as also the health of their children. Achieving MDG 3, the empowerment of women, is therefore key to achieving MDG 4 and 5. A cohesive action by the Government integrating cross-sectoral efforts is needed to tackle these challenges. While recognising the need for wider action, this RMNCH+A strategic approach focuses on what the Health Delivery System can do to help achieve maternal and child health goals.

The RMNCH+A approach document has been especially prepared for Health Secretaries, Mission Directors, Directors of Health Services and senior programme planners and implementers, with the purpose of providing an understanding of the comprehensive approach to improving child survival and safe motherhood, and operational guidance to implement this approach during the next phase of the NRHM (2012–2017).

The document provides the programmers with direction, which when followed in earnest would lead to significant improvement in adolescent, woman and child health over the next five years. Individual states and districts would still need to translate the approach proposed here to specific actions within their own context in order to achieve state-specific targets.

The document mainly refers to the measures taken so far to improve the health of women, mother and children; however, the national health programme is a dynamic and evolving one, hence new measures will be included as more evidence emerges from pilot states and from intervention research and implementation experiences from across the country. Major changes and modifications in the flagship programmes of Ministry of Women and Child Development and other Ministries and sectors are also envisaged in the 12th plan, and these are likely to have an impact on many indicators and social determinants of health and development that affect maternal and child survival.

CHAPTER 2

Problem Statement: Situation of Reproductive, Maternal and Child Health in India

A good place to start addressing the maternal and child health issues is to understand the magnitude of the problem that requires to be addressed.

Globally, an estimated 287,000 maternal deaths occurred in 2010, when the global maternal mortality ratio was 210 maternal deaths per 100,000 live births. Sub-Saharan Africa (56%) and Southern Asia (29%) accounted for 85% (or 245,000 in numbers) of the global burden of maternal deaths in 2010. At the country level, India accounted for 19% (56,000 in numbers) of all global maternal deaths.

In terms of child mortality, globally 76 lakh children died in 2010 before reaching their fifth birthday. Five countries – India, Nigeria, Democratic Republic of the Congo, Pakistan and China – collectively accounted for half or nearly 37.5 lakh of all global deaths in children younger than five years. India presently accounts for nearly 20% of the world's child deaths. In terms of numbers, it is the largest number of child deaths (approximately 15.8 lakh) under the age of five years in any country. The reasons for this are a large birth cohort (2.6 crore) and child population (15.8 crore in the age group 0–6 years) and a relatively high child mortality rate (59 per 1,000 live births).

Despite India being amongst the top five countries in terms of absolute numbers of maternal and child deaths, encouraging progress has been made in terms of reducing maternal and child mortality rates. In 1990, when the global under five mortality rate was 88 per 1,000 live births, India carried a much higher burden of child mortality at 115 per 1,000 live births. In 2010, India's child mortality rate (59 per 1,000 live births) almost equals the global average of 57. As per the report of Maternal Mortality Estimation Inter-Agency Group, maternal mortality has shown an annual decline of 5.7% between the years 2005 and 2010.

At the national level, maternal mortality ratio (MMR) declined from 254 (SRS 2005) to 212 (SRS 2007–09) – a decline of about 14 points per year on an 'All India' basis. In terms of numbers, there are still 56,000 maternal deaths each year. About two-thirds of maternal deaths occur in just a few states – Assam, Uttar Pradesh(including Uttarakhand), Rajasthan, Madhya Pradesh (including Chhattisgarh), Bihar (including Jharkhand) and Odisha. However, these states have also shown the most notable drop in MMR (between Sample Registration System(SRS) 2004–06 and SRS 2007–09) during the initial years of NRHM: Assam (90 points), Uttar Pradesh including Uttarakhand (81 points), Rajasthan (70 points), Madhya Pradesh and Chhattisgarh (66 points). It is likely that more of this success will be evident as and when data from the current period becomes available.

The mortality rate in children below five years is 59 per 1,000 live births (SRS 2010), which translates into 15.8 lakhs deaths in the country per year. Of these, 8.8 lakh (56%) children die in the first month of life; 12.5 lakh (79%) children die in the first year, including the neonatal period. The neonatal mortality rate has remained stagnant, constituting an even larger proportion of the total child deaths (0–5 years) in 2010. A rural-urban differential in under-five mortality is evident and stands at

28 points; however, the encouraging trend is that the decline in rural child mortality has been faster than the urban. There is also a gender differential of 9 points in the under-five category (female: 64; male: 55), underlining the need to address social determinants of health, including the status of women and the girl child, female literacy, and women's economic and social empowerment.

Looking at the national and state averages as the measures of progress can very often mask the inequities in progress in various regions and districts of a large country like India. The Annual Health Survey carried out in eight Empowered Action Group (EAG) states and Assam in 2010–11 provides a more accurate picture of the RCH status within the states with a high burden of maternal and child mortality. Analysis of data from 284 districts across these nine states shows that there is a wide inter-district variation. For example, Madhya Pradesh, a state with high under-five mortality rate has an inter-district variation of 89 points between Indore (51) and Panna (140) while Uttar Pradesh has a 90 point variation between the two districts of Kanpur Nagar (52) and Shrawasti (140).

Therefore, it is clear that the implementation focus has to shift to geographical areas of greatest concern and populations that carry the highest burden of illness and mortality. This must also include a focus on the urban disadvantaged population (the 'urban poor') where barriers to utilization of health services, often due to inequitable distribution of service availability, are well documented.

One of the key indicators of good reproductive health of the community is the Total Fertility Rate (TFR). As described earlier, TFR is linked to maternal health and child survival. The TFR is defined as the average number of children that would be born to a woman over her reproductive life span. As TFR decreases, maternal mortality rate also declines. Low TFR impacts child survival by bringing optimum spacing between successive pregnancies. Currently India's TFR is 2.5 (SRS 2010). Although India has not achieved the replacement level of fertility (i.e. 2.1), the rate of decline in TFR has accelerated since the implementation of the NRHM and this trend is expected to continue further. Currently, twenty-one states/union territories have already achieved the replacement level of fertility (i.e. 2.1) or less, while seven more states are on the verge of achieving replacement level fertility. Concern remains with seven high focus states, which have the TFR of 3.0 or more as these are (predictably so) also the states with the highest burden of maternal and child mortality.

Before the change can be seen in terms of programme impact (maternal and child mortality, total fertility), intermediate outcomes or results may become evident. These could be in terms of services made available, change in community knowledge and behaviour, adoption of safe practices or utilisation of available health services.

CHAPTER 3

Problem Analysis: Causes for Maternal and Child Deaths in India

Considering the large number of maternal and child deaths taking place in the country, it is important to understand why these deaths occur. This chapter provides a brief overview of the most common causes for maternal and child mortality in India. The analysis forms the basis for planning and identification of thrust areas for intervention.

Maternal mortality is a key indicator for maternal health and reveals inequalities between and also within states that cannot be attributed to biological differences alone. Maternal mortality results from multiple reasons, which can broadly be classified as medical, socio-economic and health system-related factors.

The medical causes can be direct or indirect. The most common direct medical causes of maternal death as per SRS (2001–03) are haemorrhage, mainly postpartum (37%), sepsis because of infection during pregnancy, labour and postpartum period (11%), unsafe abortions (8%), hypertensive disorders (5%) and obstructed labour (5%). These conditions are largely preventable and once detected, they are treatable. A significant proportion of maternal deaths are also attributed to 'indirect causes', the most common of which are anaemia and malaria.

Among children who die before their fifth birthday, almost one third of them die of infectious causes, nearly all of which are preventable. As per WHO-CHERG 2012 estimates, the causes of child mortality in the age group 0–5 years in India are (a) neonatal causes (52%), (b) pneumonia (15%), (c) diarrhoeal disease (11%), (d) measles (3%), (e) injuries (4%) and (f) others (15%).

The major causes of neonatal deaths are prematurity (18%), that is, birth of a child before 37 weeks of gestation, infections (16%) such as pneumonia and septicaemia and asphyxia (10%), that is, inability to establish breathing immediately after birth and congenital causes (5%).

Preterm birth has emerged as the leading cause of neonatal death, underlying the need for rapid scale-up of maternal health interventions in order to improve neonatal health outcomes.

Figure 1

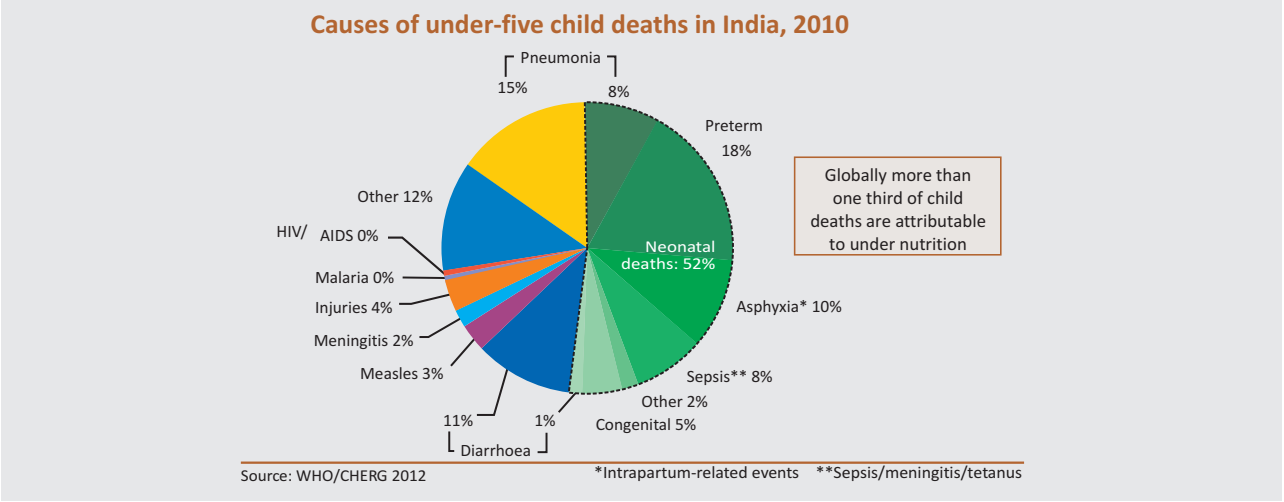
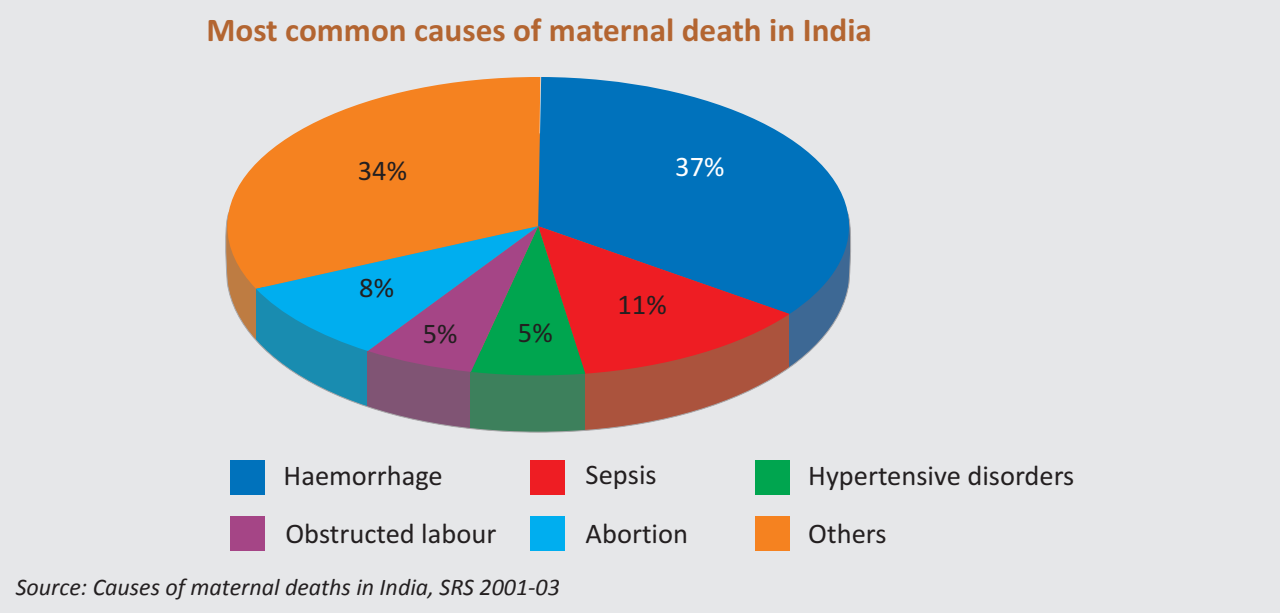


Figure 2



Source: Causes of maternal deaths in India, SRS 2001-03

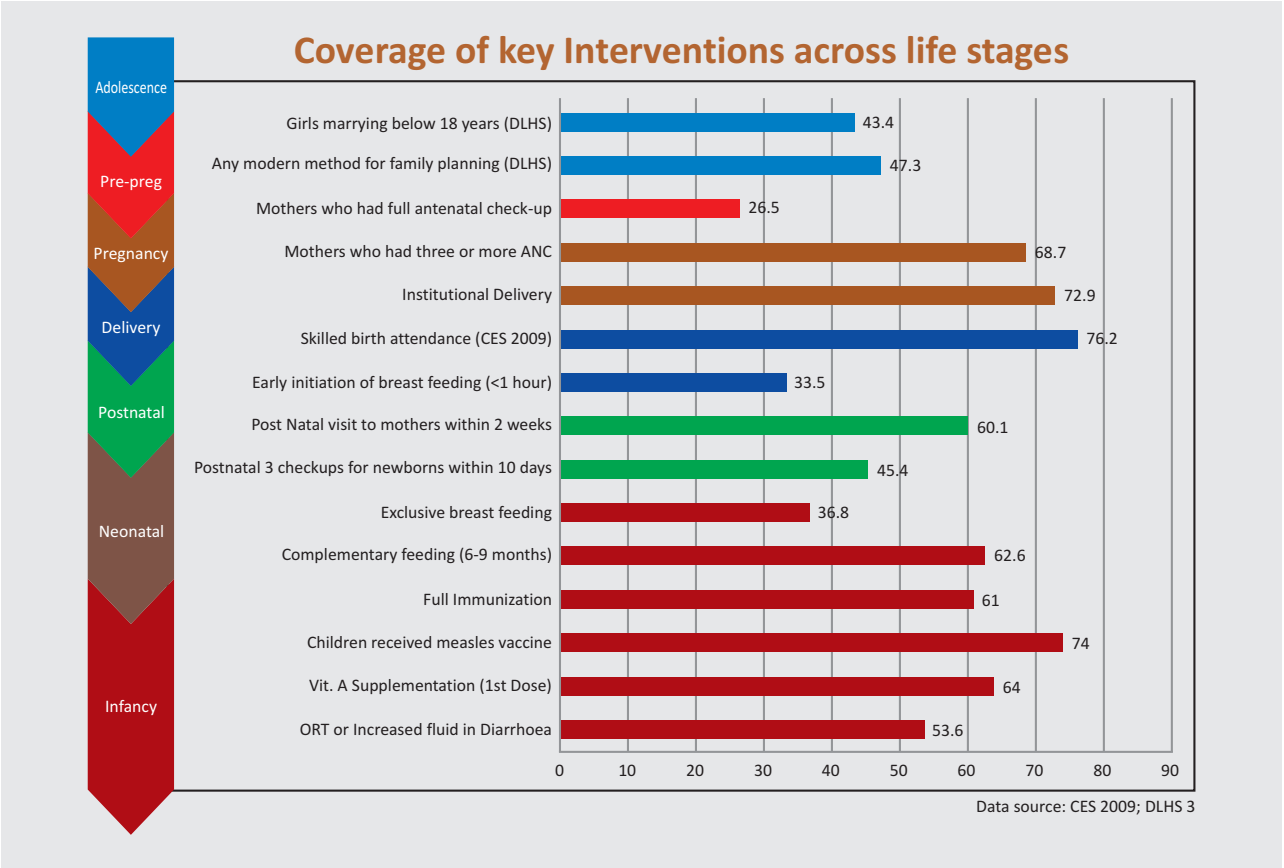
Social determinants for maternal and child mortality include marriage and childbirth at a very young age, less spacing between births and low literacy level among women, in particular those belonging to the urban poor and rural settings, and socially-disadvantaged groups (such as scheduled castes and tribes). Access to and use of contraceptives, particularly modern, non-permanent contraceptives, and access to safe abortion services are also factors that influence maternal health and child survival. It has been reported in SRS 2010 that TFR for those women who have no education is 3.4 compared to 2.2 for those who are literate. Furthermore, there is a gradual decline of TFR with the increase in the level of education. Low level of education is itself linked to the low status of women, and associated risks such as violence against women, emotional and physical abuse and malnutrition. In addition, high unmet need of contraceptives due to non-availability of services at the community outreach and primary healthcare level is another factor that needs to be addressed.

A large number of maternal and child deaths are attributable to the 'three delays': (1) the delay in deciding to seek care, (2) the delay in reaching the appropriate health facility, and (3) the delay in receiving quality care once inside an institution. The delay in deciding to seek care can occur due to inadequate resources, poor access to high-quality health care and lack of awareness of the importance of maternal and newborn health careat the household level. The unavailability of basic reproductive health services, including contraceptives, pre- and postnatal care and emergency obstetric and neonatal care, as well as delays in seeking institutional care and the poor quality of care provided in the health facility can potentially contribute to maternal and child deaths.

The interventions included in the RMNCH+A approach document essentially look to address the major causes of death as well as the three delays in accessing and utilising healthcare services. These interventions are described in the later sections of this document.

The reproductive, maternal, neonatal and child health packages that are currently being implemented under the NRHM address the most common causes of maternal and child deaths. However, the coverage of key interventions, such as antenatal care, deliveries by skilled birth attendants, and use of oral rehydration solution (ORS) for the management of childhood diarrhoea during the NRHM period has been slow and of variable quality across states.

Figure 3



In order to understand the bottlenecks in improving coverage of the key RMNCH+A interventions at national level, and to identify strategic directions for further acceleration, a Bottleneck Analysis was conducted in December 2012, using the Tanahashi framework. Using this framework, systemic bottlenecks are identified at five levels, which are (1) Availability (of quality essential commodities: drugs, supplies and equipment); (2) Geographical access (physical access to services that are equipped and adequately staffed); (3) Utilization of services (initial contact and social acceptability of services); (4) Adequate coverage (continued utilization of services) and (5) Effective coverage (coverage with quality/compliance). Representative interventions are selected from each of the service delivery platforms along the 'continuum of care' for example community outreach and facility based interventions.

The key observations from the Bottleneck Analysis (for national level), carried out using specific indicators for each intervention and latest data sources[1], are:

1. Limited availability of skilled human resources, especially nurses.
2. Low coverage of services and of skilled staff posting among marginalised communities.
3. Inadequate supportive supervision of front-line service providers.
4. Low quality of training and skill building.
5. Lack of focus on improving quality of services.
6. Insufficient information, education and communication on key family practices.

In addition, in select states, gaps in infrastructure (for instance,need for sub centres adequately staffed by skilled personnel) also need to be addressed in order to improve access and coverage of quality services. The gaps in information (regarding the availability of essential commodities or quality of care) affect the monitoring of services, identification of bottlenecks and also in taking corrective actions.

The implementation constraints are very likely to vary across states and districts, as is evident from the significant variation in the key indicators in the Annual Health Survey 2010–11. Therefore, it is important that obstacles to application of high impact intervention packages are identified locally, underlying causes are examined jointly by the Programme managers as also the service providers who are informed by the data that is locally generated and where feasible, facility specific. The District Action Plans and State Programme Implementation Plans (PIP) should reflect promising strategies to overcome the bottlenecks and achieving higher coverage levels of key interventions.

The strategic approach document outlines some of the approaches and strategies to overcome the bottlenecks mentioned above, which could be applied generally across the states. However, as stated earlier, each state needs to conduct a similar state and district specific exercise at regular intervals to identify the major bottlenecks and their underlying causes that should guide the inclusion of corrective strategies in the implementation plans.

[1] Coverage Evaluation Survey 2009, Rural Health Statistics 2011, Concurrent Evaluation of NRHM and NRHM progress reports

CHAPTER 4

Goals & Targets

Taking into account the progress made so far in maternal and child health, it is pertinent to establish the goals and targets for the implementation phase 2012–2017, after considering the main reasons for mortality and interventions proven to have an impact on them.

The 12th Five Year Plan has defined the national health outcomes and the three goals that are relevant to RMNCH+A strategic approach as follows:

Health Outcome Goals established in the 12th Fiver Year Plan

- Reduction of Infant Mortality Rate (IMR) to 25 per 1,000 live births by 2017
- Reduction in Maternal Mortality Ratio (MMR) to 100 per 100,000 live births by 2017
- Reduction in Total Fertility Rate(TFR) to 2.1 by 2017

In order to achieve these goals, that are ambitious, yet potentially feasible Lives Saved Tool (LiST), a computer based application was used to estimate the coverage targets for key child health interventions. A sub-committee and an expert group were constituted to review the application of LiST in Indian context. The expert group ensured that the inputs to LiST are adapted to the Indian context and by undertaking an in-depth review of the impact of various newborn and child survival interventions. The assumptions for the tool were developed based on the best available evidence and, wherever required, through expert consensus.

For achieving the under-five mortality are of 33 per 1000 live births , corresponding to infant mortality rate of 25 per 1000 live births in 2017 (as articulated in 12th Five Year Plan), variable increases in the coverage levels for key interventions are required. These have been defined in the table below.

Coverage targets for key RMNCH+A interventions for 2017

- Increase facilities equipped for perinatal care (designated as 'delivery points') by 100%
- Increase proportion of all births in government and accredited private institutions at annual rate of 5.6 % from the baseline of 61% (SRS 2010)
- Increase proportion of pregnant women receiving antenatal care at annual rate of 6% from the baseline of 53% (CES 2009)
- Increase proportion of mothers and newborns receiving postnatal care at annual rate of 7.5% from the baseline of 45% (CES 2009)
- Increase proportion of deliveries conducted by skilled birth attendants at annual rate of 2% from the baseline of 76% (CES 2009)

- Increase exclusive breast feeding rates at annual rate of 9.6% from the baseline of 36% (CES 2009)
- Reduce prevalence of under-five children who are underweight at annual rate of 5.5% from the baseline of 45% (NFHS 3)
- Increase coverage of three doses of combined diphtheria-tetanus-pertussis (DTP3) (12–23 months) at annual rate of 3.5% from the baseline of 7% (CES 2009)
- Increase ORS use in under-five children with diarrhoea at annual rate of 7.2% from the baseline of 43% (CES 2009)
- Reduce unmet need for family planning methods among eligible couples, married and unmarried, at annual rate of 8.8% from the baseline of 21% (DLHS 3)
- Increase met need for modern family planning methods among eligible couples at annual rate of 4.5% from the baseline of 47% (DLHS 3)
- Reduce anaemia in adolescent girls and boys (15–19 years) at annual rate of 6% from the baseline of 56% and 30%, respectively(NFHS 3)
- Decrease the proportion of total fertility contributed by adolescents (15–19 years) at annual rate of 3.8% per year from the baseline of 16% (NFHS 3)
- Raise child sex ratio in the 0–6 years age group at annual rate of 0.6% per year from the baseline of 914 (Census 2011)

While the country aims to set one collective goal towards reducing preventable maternal, newborn and child deaths by 2017, it is increasingly becoming apparent that there is varied and unequal rate of progress within the states and districts. Therefore state specific coverage targets should be established against existing baselines. The national & state 'scorecard' is being introduced as a tool to increase transparency and track progress against reproductive and maternal health & child survival indicators related with intervention coverage. More details about the score cards are presented in Chapter 8.

CHAPTER 5

Strategic RMNCH+A Interventions Across Life Stages

The overview of the key RMNCH+A interventions as a 'continuum of care' is provided in the table below. A more detailed table is presented for reference in the Annexure. Delivery of these key interventions through various packages under NRHM is described in this section.

It must be recognised that the set of interventions described in this document are those that are shown to have high impact on reducing mortality and improving survival, and most of them have been part of the previous phase of NRHM. The effectiveness of these interventions is determined by the coverage achieved among the affected fraction of population as also the availability, accessibility, actual utilisation of services and quality of service delivered. Therefore, it is important that 'Bottleneck Analysis' be carried out at various levels of planning, including the state and district level in order to prioritise attention to address specific gaps in the delivery of a particular intervention or a set of interventions.

Table 1: Continuum of care across life cycle and different levels of health system

	Reproductive care	Pregnancy and child birth care	Newborn and childcare	
Clinical	• Comprehensive abortion care • RTI/STI case management, • Postpartum IUCD and sterilisation; interval IUCD procedures • Adolescent friendly health services	• Skilled obstetric care and immediate newborn care and resuscitation • Emergency obstetric care • Preventing Parent to Child Transmission (PPTCT)of HIV • Postpartum sterilisation	• Essential newborn care • Care of sick newborn (SNCU, NBSU) • Facility-based care of childhood illnesses (IMNCI) • Care of children with severe acute malnutrition (NRC) • Immunisation	
	Reproductive health care	**Antenatal care**	**Postnatal care**	**Child health care**
Outreach/Sub centre	• Family planning (including IUCD insertion, OCP and condoms) • Prevention and management of STIs • Peri-conception Folic acid supplementation	• Full antenatal care package • PPTCT	• Early detection and management of illnesses in mother and newborn • Immunisation	• First level assessment and care for newborn and childhood illnesses • Immunisaton • Micro-nutrient supplementation
Family & Community	• Weekly IFA supplementation • Information and counselling on sexual reproductive health and family planning • Community based promotion and delivery of contraceptives • Menstrual hygiene	• Counselling and preparation for newborn care,breast feeding, birth preparedness • Demand generation for pregnancy care and institutional delivery (JSY, JSSK)	• Home-based newborn care and prompt referral (HBNC scheme) • Antibiotic for suspected case of newborn sepsis • Infant and Young Child Feeding (IYCF), including exclusive breast feeding and complementary feeding, • Child health screening and early intervention services (0–18 years) • Early childhood development • Danger sign recognition and care-seeking for illness • Use of ORS and Zinc in case of diarrhoea	
	Intersectoral: Water, sanitation, hygiene, nutrition, education, empowerment			

Adolescence/ Pre-pregnancy	Pregnancy	Birth	Newborn /postnatal	Childhood

Adolescence

Adolescent health and nutrition status has an inter-generational effect. Therefore, adolescence is one of the important stages of the life cycle in terms of health interventions. Although adolescence is considered to be a healthy phase, more than 33% of the disease burden and almost 60% of premature deaths among adults can be associated with behaviours or conditions that begin or occur during adolescence – for example, tobacco and alcohol use, poor eating habits, sexual abuse and risky sex (WHO 2002). Within the age group of 10 to 19 years, the profile of disease burden is significantly different for younger and older adolescents. While injuries and communicable diseases are prominent causes of disability and death in the 10 to 14 age group, outcomes of sexual behaviours and mental health become significant for the 15 to 19 years age group.

The data shows that adolescents and youth have limited awareness about sexual and reproductive health matters. For instance, only 15% of young men and women (15–24 years) reported receiving any family life or sex education[2].

The psychological disorders such as depression and anxiety start becoming evident in early adolescence with the onset of puberty. The findings from a recent study (Patel et al, 2012) shows that 13% of suicides in the country occur in the age group of 1529 years. This data also indicates that almost 14% of young men and women report symptoms or behaviours indicative of mental health disorders.

Gender-based violence is another area of concern, especially for female adolescents. As per NFHS 3, nearly one out of every three (31%) ever-married female adolescents, in 15–19 age group, reported having experienced physical, sexual or emotional violence perpetrated by their spouse.

The use of alcohol and drugs by adolescents is associated with physical violence, risky sexual activity, depression and suicide as well as irregular school or work attendance and other negative outcomes. In particular, tobacco, alcohol, cigarette/bidis, gutka and other intoxicants are used by young people in both rural and urban areas.

An emerging public health challenge is the rising occurrence of non-communicable diseases (NCD). According to Non-communicable Diseases Country Profiles, WHO 2011, these are estimated to account for 53% of all deaths in India. The non-communicable diseases also cause significant morbidity among both urban and rural population, with a considerable loss to potentially productive years of life. Since the main risk factors for non-communicable diseases – tobacco and alcohol consumption, poor dietary habits, sedentary life style and stress– are preventable, it is imperative that a healthy life style is promoted from a young age. The adolescent period provides an opportune time for positive behaviour modification in order to mitigate emergence of risk factors that lead to non-communicable diseases.

Taking cognisance of the diverse nature of adolescent health needs, a comprehensive adolescent health strategy has been developed. The priority under adolescent health include nutrition, sexual and reproductive health, mental health, addressing gender-based violence, non-communicable diseases and substance use. The strategy proposes a set of interventions (health promotion, prevention, diagnosis, treatment and referral) across levels of care. These interventions and approaches work toward building protective factors that can help adolescents and young people develop 'resilience' to resist negative behaviours and operate at four major levels: individual, family, school and community by providing a comprehensive package of information, commodities and services.

[2]International Institute for Population Sciences (IIPS) and Population Council. 2010. Youth in India: Situation and Needs 2006–2007.

Priority interventions

1. Adolescent nutrition; iron and folic acid supplementation
2. Facility-based adolescent reproductive and sexual health services (Adolescent health clinics)
3. Information and counselling on adolescent sexual reproductive health and other health issues
4. Menstrual hygiene
5. Preventive health checkups

1. Adolescent Nutrition and Folic Acid Supplementation

Adequate nutrition in adolescence is important for growth and sexual maturation. Inadequate nutrition in adolescence can enhance the risk of chronic diseases, particularly if combined with other adverse lifestyle behaviours. India, which is typically known for a high prevalence of under-nutrition, now has increasing numbers of overweight and obese children and adolescents, posing a dual challenge for the country.

As part of the new adolescent health strategy, in order to generate awareness, communication on consumption of balanced diet, nutritious food and inter-generational effects of malnutrition is deemed essential. It is proposed that nutrition education sessions be held at the community level using existing platforms like VHND, Kishori Diwas, school setting, Anaganwadi Centres (AWC) and Nehru Yuva Kendra Sangathan (NYKS). Nutritional counselling on a dedicated quarterly Adolescent Health Day (to coincide with Kishori Diwas in SABLA districts) is also proposed. To make deeper inroads, nutrition education is to be included in school curriculum, establishing working linkages with 'Sakshar Bharat' Abhiyan.

Since the National Health Programme does not include the component of direct nutrition supplementation, linkages with MWCD (SABLA scheme) and MoHRD (Mid-Day Meal Programme) for supplementary nutrition, fortification and nutritional assessment is to be prioritised. Under the child health screening and early intervention services, screening of adolescents for low Body Mass Index proposed and this will be followed by counselling at adolescent health clinics.

National Iron + Initiative

Following the principle of 'continuum of care', the National Iron + Initiative provides a minimum service package for the management of anaemia across life stages and at different levels of care. This initiative brings together existing programmes for iron and folic acid (IFA) supplementation among pregnant and lactating women and children in the age group of 6–60 months, and proposes to include new age groups (adolescents ; women in reproductive age group). It is well known that iron deficiency in adolescent girls influences the entire life cycle since anaemic girls have lower pre-pregnancy stores of iron and therefore pregnancy becomes too short a period to build iron stores to meet the requirements of the growing foetus. Iron-deficient adolescent girls have a higher risk of preterm delivery and of having babies with low birth weight. In addition, both adolescent boys and girls benefit in multiple ways with improvement in their iron status: improved physical growth, cognitive development, physical fitness, improved work performance and capacity, and concentration in daily tasks and school performance.

National Iron + Initiative will include, interalia, adolescents (10–19 years), both in and out of school. Those in school will be reached through Weekly Iron and Folic Acid Supplementation (WIFS) described below, while 'out of school' adolescents will be reached through AWCs.

Since anaemia prevention requires not just medical intervention, but also behaviour change (both in terms of dietary habits and compliance with the intake of iron supplements), an extensive communication campaign will be developed. A conscious effort has already been made to position the iron supplement differently. The iron and folic acid (IFA) tablet for adolescents is coloured blue (*'Iron ki nili goli'*) to distinguish it from the red IFA tablet for pregnant and lactating women. The campaign is built around benefits of IFA supplementation and healthy eating habits. The scope of this communication campaign will eventually be enhanced to address all segments of the population covered under the National Iron + initiative.

Weekly iron and folic acid supplementation scheme

The Weekly Iron and Folic Acid Supplementation (WIFS) scheme is a community-based intervention that addresses nutritional (iron deficiency) anaemia amongst adolescents (boys and girls) in both rural and urban areas. It aims to cover adolescents enrolled in class VI–XII of government, government-aided and municipal schools as well as 'out of school' girls. The key features of the scheme are (1) Supervised administration of weekly iron and folic acid supplements of 100 mg elemental iron and 500 mcg folic acid; (2) Screening of target groups for moderate and severe anaemia and referral to an appropriate health facility; (3) Bi-annual de-worming (Albendazole 400 mg) and (4)Information and counselling for improving dietary intake and preventive actions for intestinal worm infestation.

2. Adolescent Friendly Health Services (Adolescent Health Clinics)

Access to reproductive and sexual health information and services, including access to contraceptives and safe abortion services, delivered in an adolescent-friendly environment are critical to reducing incidences of STIs, unplanned and unwanted pregnancies and unsafe abortions.

In an effort to provide adolescent reproductive and sexual health information and services along the continuum of care, community-based intervention and demand generation initiatives will be linked to facility-based services across all levels of health system. Services at sub centre level will be provided by the ANM while an Adolescent Information and Counselling Centre will be made functional by the Medical Officer and ANM at the Primary Health Centre on a weekly basis. At the Community Health Centre, District Hospital/Sub District Hospital/Taluk/Area Hospital and Medical College, Adolescent Health Clinics will provide services on a daily basis. A dedicated counsellor will be available on all days at higher-level facilities (Community Health Centre onwards).

Services in adolescent health clinics will be available to all adolescents: married and unmarried, girls and boys, and will be further expanded and strengthened.

Special focus will be given to establishing linkages with Integrated Counselling and Testing Centres (ICTCs) and making appropriate referrals for HIV testing and RTI/STI management; providing comprehensive abortion care; and provision of information, counselling and services for contraception to both married and unmarried adolescents. The provision of contraceptives is to be made through this clinic, while ensuring continuous contraceptive supplies and services. These services will be linked to a strong community-based component for generating demand and mobilizing adolescents to the Adolescent Health Clinics.

3. Information and counselling on adolescent sexual reproductive health and other health issues

In order to improve knowledge, attitude and behaviours regarding sexual and reproductive health (including gender-based violence) and to address a host of health issues (mental health, substance use, non-communicable diseases) that can have immediate and long germ implications for health, Life Skills Education will be imparted both through educational institutions and in community settings.

The life-skills-based adolescence education programme implemented through schools provides an important opportunity to inform and educate adolescents on relevant health issues. While awareness and skill building through Life Skills Education will be the mechanism to counter pressure to experiment with addictions such as tobacco, alcohol or drugs, the health service providers will be trained to screen and make appropriate referrals and linkages with de-addiction centres. To promote favourable attitudes against gender-based violence, awareness and skills to challenge gender stereotypes, discrimination and violence shall be incorporated in adolescence education programme.

To promote healthy lifestyle (physical activity, healthy diet) and generate awareness on risk factors for NCDs (for example, tobacco and alcohol use, junk food), school setting will serve as the platform to educate and counsel adolescents on behaviour risk modification (avoidance of junk foods with high carbohydrates, sedentary life style, tobacco and alcohol). It is recommended that schools should incorporate at least 60 minutes of physical activity per day for every working day.

Under the Child Health Screening and Early Intervention Services, screening for diabetes and other non-communicable diseases is proposed, following which, if required, children will be referred for treatment and management to an appropriate health facility.

The community settings for informing adolescents are the Adolescent Health Day, 'Kishori Samooh' under SABLA scheme (Ministry of Women and Child Development) and Teen Clubs (Nehru Yuva Kendra Sangathan, under the Ministry of Sports & Youth Affairs).

In order to reach out more effectively to adolescents, 'peer education' approach at the community/ village level will be adopted. States like Gujarat, Maharashtra, Haryana and Uttarakhand have implemented this approach successfully. The peer educators will be selected, trained and mentored by teachers to provide information on common health concerns in this age group. Also, the community level functionaries like teachers, Anganwadi workers (AWW) and volunteers will be trained to counsel adolescents with age appropriate content and to make appropriate referrals to Adolescent Health Clinics.

In order to address mental health issues, the adolescent health strategy envisages promotion of protective factors such as self-esteem, healthy relationships, and the ability to deal with stress and conflicts positively. The peer educators will be trained to counsel adolescents on these issues and service providers (teachers, AWW ANMs and Preraks etc.) will be trained to screen for anxiety, stress, depression, suicidal tendencies and refer them to appropriate facility for counselling and management of mental health disorders through linkage with the National Mental Health Programme.

In order to reduce adolescent pregnancy, focused messaging to individuals, families and communities (including men) will be reinforced through the Life Skills Education sessions that are delivered from various adolescent centric platforms including community outreach sessions and Anganwadi centres. All newly-married couples and influencers will be informed about risks of early conception and importance of spacing between children. Pregnancy testing kits and contraceptives such as condoms and oral contraceptive pills (OCPs) are already being made available at the doorstep through home visits by ASHAs and male health workers.

A new scheme for delaying the first birth after marriage and ensuring spacing between the first and second child was launched in May 2012 and has provision for incentivising ASHAs for their efforts.

4. Scheme for promotion of menstrual hygiene among adolescent girls in rural India:

Menstruation is a normal body function. Despite this, generations of women have had to endure ill health, discomfort, lack of hygiene and even personal risk in trying to manage this normal function. The above-mentioned scheme promotes better health and hygiene among adolescent girls (aged 10 to 19 years) in rural areas by ensuring that they have adequate knowledge and information about the use of sanitary napkins. Through the scheme, high quality and safe products are made available to the girls and environmentally safe disposal mechanisms are made accessible. The sanitary napkins are provided under NRHM's brand 'Free days'. These napkins are being sold to adolescent girls by ASHAs.

The scheme should also be seen as an opportunity to inform adolescent girls about sexual and reproductive health issues, nutrition, non-communicable diseases and mental well being, and guide them to community-based counsellors and/or adolescent clinics in case of any queries or problems that need to be addressed.

5. Preventive health checkups and screening for diseases, deficiency and disability

The School Health Programme addresses the need for preventive health checkups amongst school going children and adolescents. Bi-annual health screening is undertaken for students (6–18 years age group) enrolled in government and government-aided schools for disease, deficiency and disability, with referrals and linkages to secondary and tertiary health facilities, as required. The components of the School Health Programme include screening, basic health services and referral; immunization; micronutrient supplementation (IFA, Vitamin A) and de-worming.

The new approach in the implementation of the School Health Programme is to establish dedicated mobile health teams at block level. These teams will include two Medical Officers (MBBS/Dental/AYUSH qualified) and two paramedics (one ANM and any one of the following: Pharmacist/Ophthalmic Assistant/Dental assistant). These teams will be provided mobility support (dedicated hired vehicle) as per the approved norm of the state, equipment and medicines. School-going children and adolescents in need of secondary and tertiary care will be entitled to free treatment through Rastriya Swasthya Bima Yojona or State Health Insurance Scheme or NRHM.

The School Health Programme also requires a strong convergence with the Department of Education (Sarva Siksha Abhiyaan for classes I to VIII; Rastriya Madhyamik Shiksha Abhiyaan for classes IX to XII).

Pregnancy and Childbirth

Pregnancy and childbirth are physiological events in the life of a woman. Though most pregnancies result in normal birth, it is estimated that about 15% may develop complications, which cannot be predicted. Majority of these complications can be averted by preventive care (such as antenatal check-ups, birth preparedness), skilled care at birth, early detection of risk (like with use of partographs), appropriate and timely management of obstetric complications and postnatal care. The essential package of interventions needed for averting maternal mortality is well known. The challenge lies in ensuring that this package is delivered at a sufficient scale and with sufficient quality to have a significant impact.

Most obstetric complications and maternal deaths occur during delivery and in the first 48 hours after childbirth. This makes the intra-partum period (defined as labour, delivery and the following 24 hours) a particularly critical time for recognising and responding to obstetric complications and seeking emergency care to prevent maternal deaths. The best way to do so is to maximise facility-based deliveries or skilled attendance during home births in 'difficult to reach areas', and referring women to emergency care in case of complications, and also monitoring postpartum mothers.

Addressing the 'three delays' in seeking and receiving skilled care is an important aspect of maternal health interventions. Sensitising the community and family for making timely decisions and timely referral through pre-identified transport can address the first two delays. Simultaneously, skill-building (technical and managerial) of service providers and adequately equipping the facilities to provide quality services is important for addressing the third delay. This will ensure the provision of skilled attendance to all women during pregnancy and childbirth.

Care during pregnancy also requires reproductive health services to be provided along the continuum of care. These services are needed to treat underlying conditions like STIs, including HIV, and support women following the birth of a child for timely adoption of contraception to prevent another pregnancy spaced too close to the previous one. The back-up safe abortion services within the framework of the MTP Act (1971) are required for cases of unintended pregnancies and spontaneous or induced abortions.

Another key concern related to this period is that of sex selective abortions resulting in declining sex ratio at birth across most Indian states. Preventing illegal sex determination and sex selective abortions requires implementation of PC & PNDT Act while sensitising the community, service providers and other stakeholders (media, judiciary, policy makers) on this issue. It is important to sensitise these groups on different objectives of the Medical Termination of Pregnancy (MTP) Act and the PC&PNDT Act,so as to safeguard the rights of women to access safe and comprehensive abortion care services.

Linkages with PPTCT services is another essential intervention in the maternal health package as it has a bearing on the health of mothers and children both in the short and long term.

The delivery of services during pregnancy and childbirth requires a strong element of continuum of care from community to facility level and vice versa. While the antenatal package, counselling and preparation for newborn care, breast feeding, birth and emergency preparedness will mainly be delivered through community outreach; skilled birth attendance will be provided at health facilities, primarily 24 X 7 Primary Health Centres (PHC) and First Referral Units (FRU). These facilities are most

likely to be the ones that have been designated as 'delivery points' and therefore have provision for full complement of RMNCH services. Further, linkage between 'delivery points' at different levels of health facilities is critical to provide emergency obstetric and neonatal care, and requires an efficient and effective referral system and referral transport mechanism.

Following discharge from the health facility, mothers and newborns will be provided postanatal care through home visits. Most of the services in this continuum are already in place; what is required is a stronger linkage between various levels, and tracking women and newborn to ensure the delivery of this package of services.

Priority interventions

1. Delivery of antenatal care package and tracking of high-risk pregnancies
2. Skilled obstetric care
3. Immediate essential newborn care and resuscitation
4. Emergency obstetric and new born care
5. Postpartum care for mother and newborn
6. Postpartum IUCD and sterilisation
7. Implementation of PC&PNDT Act

1. Preventive use of folic acid in peri-conception period

Pre-conception health status and behaviours have an impact on pregnancy outcomes. All women of childbearing age should receive pre-conception care services that will enable them to enter pregnancy in optimal health. The aim is to increase the likelihood of a good pregnancy outcome by encouraging positive behaviours and controlling for or preventing health problems before pregnancy.

Promoting use of folic acid in planned pregnancies during the peri-conception phase (three months before and three months after conception) for the prevention of neural tube defects and other congenital anomalies is a community-based intervention that can be undertaken by frontline workers and facility-based service providers. As the ASHAs are now incentivised for delaying the birth of the first child and for spacing between births, the identification of couples who will have a planned pregnancy becomes much easier. In addition, pre-pregnancy check-ups can be offered as a component of maternity care, with one pre-pregnancy visit for couples planning pregnancy. In states where a larger number of pregnancies are 'planned', this intervention should be included in the package of RMNCH+A services.

2. Antenatal care package and tracking of high risk pregnancies

To monitor the progress of foetal growth and to ascertain the wellbeing of the mother, the antenatal care package is available through the public health system, delivered both at community outreach and health facility level. Timely identification of complications enables service providers to make timely referrals to health facilities equipped to provide emergency obstetric and newborn care. Currently the number of women accessing the complete antenatal package is quite low. As a result, many women reach the healthcare facilities for the first time only during labour and face increased risk of complications during childbirth.

Pregnancy testing to detect pregnancy at an early stage is the first step towards early registration, and timely and quality antenatal care. Pregnancy Testing Kits are supplied under the brand name Nishchay to all the sub centres and through ASHAs. The provision for testing for early pregnancy should be made accessible to all adolescent girls (unmarried and married), as it is to the women, that is, across the reproductive age group.

Universal access to full antenatal package that includes counselling and preparation for newborn care, breast feeding, birth and emergency preparedness should be the focus of service delivery both at community outreach and facility level. Mother and Child Tracking system (MCTS) is one mechanism that enables service providers to follow up women and programme managers to monitor service delivery.

Birth preparedness in the antenatal period should include discussion with the mother/family members regarding the health facilities where skilled obstetric care is available as well as the transport facilities that are now available free of charge in the public health system.

With anaemia emerging as one of the major contributing factors for maternal deaths, line listing of severely anaemic women, tracking pregnant women with severe anaemia for treatment and tracking these women during pregnancy and childbirth must receive high priority. The ANMs and PHC In-charges have been identified as the nodal officers for this purpose and must ensure timely and appropriate management of severely anaemic women. In malaria endemic areas, provision of insecticidal bed nets and timely checkup of anaemia is required.

Parent-to-child transmission of HIV is a major route of new and emerging HIV infections in children. Children born to women living with HIV acquire HIV infection from their mother, either during pregnancy, delivery or through breast feeding. In pregnant women, early initiation of Anti Retroviral Therapy significantly reduces HIV transmission from mother-to-child. To enhance the coverage of PPTCT services, universal confidential HIV screening should be included as an integral component of routine antenatal check-up. The objective is to ensure that pregnant women who are diagnosed with HIV get linked with HIV services for their own health, as well as to ensure prevention of HIV transmission to newborn babies under the PPTCT programme. Currently, single dose Nevirapine (Sd NVP) is being given as prophylaxis at the onset of labour pains or during delivery followed by Syrup Nevirapine to the baby soon after birth. The new PPTCT Guidelines 2012 recommend moving from the single-drug prophylaxis to multi-drug prophylaxis in a phased manner.

3. Skilled obstetric care and essential newborn care and resuscitation

Operationalizing delivery points: Health facilities located across the health system are now assessed against a minimum benchmark of performance (number of deliveries conducted per month as one of the parameters of service utilisation) and designated as ‘delivery points’. As a policy decision, the delivery points are to be prioritised for the allocation of resources (infrastructure and human resources, drugs and supplies, referral transport etc.) in order to ensure quality of services and provision of comprehensive RMNCH services at these health facilities. This approach has helped to direct resources and focus attention on those facilities that already have higher footfalls. These facilities will be branded and positioned as quality RMNCH+A 24 X 7 service centres within the public health system.

Demand generation for skilled obstetric care: In order to motivate women to deliver at health facilities, Janani Suraksha Yojana (JSY) was launched as a scheme with the provision of conditional cash transfer to a pregnant woman for institutional care during delivery and the immediate postpartum period. One of the objectives is to reach the unreached pregnant women (nearly 7.5 million a year) who still deliver at home. The increasing number of institutional births demands that quality of antenatal care with identification and timely referral of complicated cases, delivery care and immediate postpartum care be improved in order to capitalise on this opportunity and reduce maternal morbidity and mortality. The forty-eight hours stay at the health facility should be promoted for the well-being and survival of the mother and the newborn. Additional focus is required for motivating mother/family for the adoption of postpartum family planning method and counselling on exclusive breast feeding, immunisation and child care practices.

A new development under JSY is the decision to make direct cash payments through AADHAR enabled payment system and this has been introduced in forty-three districts to begin with. This requires enrolment of all potential JSY beneficiaries on the MCTS portal, facilitating registration for AADHAR and opening/linking bank accounts to AADHAR for all potential JSY beneficiaries that do not have AADHAR number, entering AADHAR details and bank account numbers on the portal for regular reviewing and monitoring.

Service guarantees and elimination of out-of-pocket expenses: Janani Shishu Suraksha Karyakram (JSSK) is an initiative under the overall umbrella of NRHM that aims to reduce out-of-pocket expenses related to maternal and newborn care. The scheme implemented across the country entitles all pregnant women delivering in public health institutions to absolutely free and no expense delivery, including caesarean section. Similar entitlements are in place for all sick newborn (first 30 days of life) accessing public health institutions for treatment. While the scheme addresses one of the bottlenecks in terms of accessing services (by eliminating/reducing out-of-pocket expenses), utilisation may still be a bottleneck due to issues related with hygiene, sanitation and staff behaviour.

Free assured transport (ambulance service) from home to health facility, inter-facility transfer in case of referral and drop back is an entitlement under JSSK. This provision of the scheme addresses level II delays on account of transport availability. Vehicles with provision for advanced life support, trained staff and equipment are made available with the ambulance to manage emergencies during transit. Ambulances with basic life support are in place to transport non-complicated cases of pregnant women. JSSK is being implemented in all states and union territories across the country.

In 'hard-to-reach areas' the 'last mile' connectivity requires innovations and use of informal transport methods to reach the health facility or to an access point from where ambulances can transport pregnant women to the health facility. For routine drop back facilities, a low-cost transport network is being established working either through the government mechanism or through outsourcing.

The establishment of a centralised call centre along-with a toll free number is a mandatory requirement for providing referral transport services to pregnant women and neonates. The decision regarding the kind of vehicle to use for an individual request is to be taken at the call centre for efficient utilisation of vehicles. Call centre numbers are to be widely publicised.

Mechanisms are also being put in place for grievance redressal. Help desks and suggestion/complaint boxes can be established at government health facilities or helplines can be made functional at district or state level. Names, addresses, emails, telephones, mobiles and fax numbers of grievance

redressal authorities at health facility level, district level and state level are to be disseminated widely in the public domain. Action is to be taken on grievances within a suitable timeframe, and communicated to the complainants.

Essential newborn care and resuscitation: Recognizing that events at the time of birth are critical to newborn survival, Newborn Care Corners are established at delivery points and providers are trained in basic newborn care and resuscitation through Navjaat Shishu Suraksha Karyakram (NSSK). The saturation of all delivery points with Skilled Birth Attendance and NSSK trained personnel and functional Newborn Care Corners are the topmost priority under the national programme. Linkages with sick Newborn Care Units at health facilities (FRU and District Hospital) must be in place to refer newborns requiring special or advanced newborn care. The immediate routine newborn care, comprising drying, warming, skin to skin contact and initiation of breast feeding within one hour of life, will be promoted in all health facilities providing delivery care.

4. Emergency obstetric and new born care

Sub centres and Primary Health Centres designated as delivery points, Community Health Centres (FRUs) and District Hospitals have been made functional 24 X 7 to provide basic and comprehensive obstetric and newborn care services. Only those health facilities can be designated as FRUs that have the facilities and manpower to conduct a Caesarian section. A holistic planning for operationalisation of FRUs is required as per the guidelines, making provision for infrastructure, equipment, drugs and other commodities, quality improvement system and skilled human resources.

Under NRHM, dedicated 'Maternal and Child Health (MCH)Wing' is being established at high case load facilities in order to expand the health infrastructure for maternal and newborn care, and thus overcome the constraints of limited numbers of beds at health facilities. The MCH Wing, with integrated facilities for advanced obstetric and neonatal care, will not only create scope for quality services but also ensure forty-eight hours stay for the mother and newborn at the hospital. The postnatal period being crucial to survival of the newborn, as also the establishment of breast feeding, contraceptive counselling and postnatal care of the mother, a comprehensive postnatal package of maternal, newborn and reproductive (family planning) services will thus be made possible.

In order to overcome the shortage of specialist doctors who can provide emergency obstetric care, multi skilling of doctors in the public health system is being undertaken. This includes an eighteen-week-long training programme of MBBS qualified doctors in Life Saving Anaesthetic Skills (LSAS);a sixteen-week-long training programme in Obstetric Management Skills including Caesarean section; a ten-day-long training for Medical Officers in Basic Emergency Obstetric Care (BEmOC) and a three-week-long Skilled Birth Attendance training for ANMs/LHVs /Staff Nurses. Mentoring support and post-training follow up should further be ensured so that these service providers gain confidence and are thus able to practice newly acquired skills.

5. Postpartum care for mother and baby

To ensure postpartum care for mothers and newborns, forty-eight hours of stay at the health facility is mandated in case of institutional delivery. MCH wings are being established in high case load facilities to provide quality postnatal care to mothers and newborns.

The postnatal home visits are made by frontline workers irrespective of the place of delivery. In case

of home delivery, the first visit takes place within twenty-four hours of birth. In all other cases, at least three postnatal visits to the mother and six postnatal visits to the newborn are to be made within six weeks of delivery/birth.

6. Postpartum IUCD insertion and sterilisation

In order to capitalise on the opportunity provided by increased institutional deliveries, postpartum family planning becomes another priority area for action. Currently the focus is on placement of trained providers for post-partum IUCD (PPIUCD) insertion at district and sub-district hospital level only, considering the high institutional delivery load at these facilities. However, it would be essential to have PPIUCD trained providers at all those health facilities up to the sub centres, which are currently providing delivery services. Training of Medical Officers in 'Minilap' for provision of Post-Partum Sterilisation in high case load facilities is another such step in this direction.

A dedicated RMNCH counsellor is being placed at public sector health facilities under the NRHM. It is envisioned that the counsellor will play a key role in increasing awareness and generating demand for the various RMNCH services being provided at the facilities. The counsellor will provide counselling services and motivate women to adopt modern or terminal family planning methods, wherever deemed appropriate, for ensuring healthy timing and spacing between pregnancies. In addition, he/she will provide counselling on breast feeding and other infant and young child feeding and childcare practices.

7. Implementation of preconception and prenatal diagnostic techniques (PC&PNDT) Act:

The Census 2011 results indicate skewed sex ratios in 0–6 years age group. The declining ratio is related both to declining sex ratio at birth due to sex-selective abortions and to continued neglect and poor care-seeking for the girl child.

Addressing the challenge of skewed sex ratio through stricter implementation of PC&PNDT is one key intervention under NRHM. The mission is to improve the sex ratio at birth by regulating the pre-conception and pre-natal diagnostic techniques misused for sex selection. The key areas for action include: formation of dedicated PC&PNDT cells at state/district level, strengthening of human resources as well as trainings and establishing appropriate infrastructure at all levels. States should have a comprehensive communication strategy to address the concerns of the girl child and publicise the provisions of PC&PNDT Act. Establishment of statutory bodies under the PC&PNDT Act (State Supervisory Board, State & District Appropriate Authority, State & District Advisory Committee), strengthening of monitoring mechanisms, including the State Inspection and Monitoring Committee, online maintenance, analysis and scrutiny of records mandated under the Act and digitalisation of registration records with periodic evaluations are some of the important steps to be taken by the states. Building community opinion against sex selective abortion and foeticide can be undertaken by sensitising and mobilising self-help groups and empowering women through these agencies.

However, utmost care must be taken to ensure that measures to address the objectives of the PC&PNDT Act do not become a barrier to women's rights to access safe abortion services, particularly the vulnerable women such as adolescents, rape survivors and poor women from rural and marginalised population.

Newborn and Childcare

The interventions in this phase of life mainly focus on children under 5 years of age and address the most common causes of mortality in this period, described in Chapter III, with some interventions extending to children older than 5 years. The thrust are as for newborn and child health under the NRHM are (1) immediate, routine newborn care and care of sick newborns (2) child nutrition including essential micronutrients supplementation (3) immunization against common childhood diseases and (4) management of common neonatal and childhood illnesses. Besides this a new initiative of Child Health Screening and Early Intervention Services offering comprehensive care to children (0–5; 6–9; 10–18 years) is being introduced.

Given below are the priority child health interventions that should be implemented across the country. In states that have achieved the national targets for reducing child mortality or are close to reaching this target, there will be a shift in priorities, with increasing focus on interventions that address residual causes of mortality and morbidity. However, the mortality trends across the country demonstrate the need to accord priority to newborn interventions in all states.

Even in those states that have low infant and child mortality rates, the main cause of remaining deaths is on account of mortality in the newborn period. These states have already shown a shift towards interventions like neonatal screening for metabolic and genetic disorders, early detection and management of congenital defects and disabilities, and establishment of tertiary care units (paediatric and neonatal) that have a scope for a wider range of medical interventions.

As newer health challenges emerge, it will be important to set up a surveillance programme to provide estimates and trends of the NCD burden such as childhood epilepsy, juvenile diabetes, childhood injuries, birth defects, sickle cell anaemia and thalassemia for future programming and policy direction. The relative disease burden in states must be taken into account for identifying a rational mix of interventions that reflect the changing health needs of this population. The Child Death Review and the other systems of monitoring should guide this planning and prioritisation process as also the evidence base, depicting that the intervention is known to have an impact on child mortality.

Priority interventions

1. Home-based newborn care and prompt referral
2. Facility-based care of the sick newborn
3. Integrated management of common childhood illnesses (diarrhoea, pneumonia and malaria)
4. Child nutrition and essential micronutrients supplementation
5. Immunisation
6. Early detection and management of defects at birth, deficiencies, diseases and disability in children (0–18 years)

1. Home based newborn care and prompt referral

Reducing mortality in the neonatal period is paramount if the infant mortality rate is to be impacted. Neonatal deaths account for 59% of under-five mortality at the national level, most of which occurs in the first week of life. About 25% of total deaths in the neonatal period take place in second

to fourth week of life. Global evidence shows that home visits by community health workers to provide neonatal care in settings where access to facility-based care is limited or not available is associated with reduced neonatal mortality. The home-based newborn care scheme, launched in 2011, provides for immediate postnatal care (especially in the cases of home delivery) and essential newborn care to all newborns up to the age of 42 days. Frontline workers (ASHAs) are trained and incentivised to provide special care to preterms and newborns; they are also trained in identification of illnesses, appropriate care and referral through home visits.

Home-based newborn care as a component of continuum of care for newborns and linkages with facility-based care for prompt referral of sick newborns is critical to improving survival in this age group. In the same way, newborns discharged from the Special Newborn Care Units must be followed up at home by frontline workers.

2. Facility-based care of the sick newborns

In order to strengthen the care of sick, premature and low birth weight newborns, Special Newborn Care Units (SNCU) have been established at District Hospitals and tertiary care hospitals. SNCUs, with provision of advanced care for sick newborns, must serve as the referral centre for the entire district and for their optimum utilisation this information must be available at all peripheral health facilities. Referrals from peripheral units and admission of 'out born' sick newborns to SNCUs should be monitored closely.

Presently SNCUs are available across half of the districts in the country and more are in the process of being established. The goal is to have one SNCU in each district of the country. Additionally, health facilities with more than 3,000 deliveries per year can be considered for establishing an SNCU.

Another smaller unit known as the Newborn Stabilisation Unit (NBSU), which is a four-bedded unit providing basic level of sick newborn care, is being established at Community Health Centres/First Referral Units. Provision of newborn care at these units increases the chances of survival for babies with health conditions requiring observation and stabilisation soon after birth or in the period thereafter.

As part of the Janani Shishu Suraksha Karyakram, all newborns requiring facility-based newborn care up to thirty days receive diagnostics, drugs and treatment free of charge at these newborn care facilities. Free Emergency Referral Transport is also to be provided for transport from home/community to the health facility and between health facilities in case a referral is made. In under/unserved areas where public health facilities are not equipped to provide basic and /or advanced obstetric and neonatal care, credible private institutions can be accredited for providing these services till the time the public health facilities are strengthened.

Follow up of the sick newborn after discharge from the newborn facilities should be an integral component of neonatal care. These newborns are not only at increased risk of mortality but also of developing long term sequelae as a result of insult to the brain and other body organs during the neonatal period. Sick newborns discharged from health facilities should be followed up for Developmental Screening and Early Intervention and also provided special care or treatment required by them (for instance, for Retinopathy of Prematurity). During these follow ups, counselling on exclusive breastfeeding, complementary feeding, monitoring of survival, growth monitoring, and screening for neuro-developmental disorders (such as visual, hearing) must be included.

3. Child nutrition and essential micronutrients supplementation

Given the magnitude of child under-nutrition in India, one of the key preventive interventions is the promotion of 'infant and young child feeding practices'.

The first two years of life are considered a 'critical window of opportunity' for prevention of growth faltering. Optimal breast feeding and complementary feeding practices together allow children to reach their full growth potential. The various opportunities for maternal and child health contacts now available in the health system, both at the health facility and community level, must be leveraged to reinforce the key messages around infant and young child feeding, growth monitoring and promotion.

Line listing of babies born with low birth weight must be maintained by the frontline workers (ANMs and ASHAs) and their follow up should be ensured so that mothers are supported for optimum feeding and child care practices, and growth faltering is detected early on before it progresses to a more serious condition of moderate or severe under-nutrition.

In order to reduce the prevalence of anaemia among children, all children between the ages of 6 months to 5 years must receive iron and folic acid tablets or syrup (IFA) (as appropriate) for 100 days in a year as a preventive measure. Taking cognizance of ground realities, a policy decision has been to provide bi-weekly iron and folic acid supplementation for preschool children of 6 months to 5 years as part of the National Iron + initiative. ASHAs will be incentivised to make home visits and to provide at least one dose per week under direct observation and educate the mothers about benefits of iron supplements and also how to administer it.

In addition, there is a provision for (1) weekly supplementation of iron and folic acid for children from 1st to 5th grades in government and government-aided schools and (2) weekly supplementation for 'out of school' children (6–10 years) at Anganwadi Centres.

Accordingly, appropriate formulation (syrups and tablets) and logistics must be ensured and proper implementation and monitoring should be emphasised through tracking of stocks using HMIS. Deworming (using Albendazole syrup or tablet in single dose) can be carried out every 6 months in order to reduce the intestinal parasite load. To simplify administration of deworming tablets/syrup, this intervention can be combined with Vitamin A supplementation during biannual rounds.

As part of the Government's policy for Vitamin A supplementation, children between nine months to five years are given six monthly doses of vitamin A. A child must receive nine doses of Vitamin A by the 5th birthday. A biannual approach is being used in many states where two specific months in a year are designated for carrying out the supplementation, sometimes offering other child health services (such as screening for under nutrition, deworming etc.) as a package.

Currently, the programme provides care to children with severe acute malnutrition (SAM) and this is mainly through facility-based care. Given the magnitude of this problem in India, it is not the most viable approach. Community-based programmes for the management of children with SAM are urgently required. A comprehensive strategy, including promotion of optimal infant and young child feeding practices, growth monitoring and promotion, care of children with severe acute malnutrition in community care centres and of complicated cases at facility-based care will be implemented in partnership with MWCD (ICDS).

In order to reduce the risk of mortality in children with severe acute malnutrition, Nutritional Rehabilitation Centres(NRCs) have been established for providing medical and nutritional care. NRCs play a crucial role in promoting physical and psychosocial growth of children with severe under-nutrition. These units can be established at the District Hospitals or FRUs, depending upon the availability of infrastructure and human resources as well as the accessibility of the facility to the surrounding areas. Tribal areas and high focus districts must be prioritised for setting up these units. The NRCs should be linked to community-based programmes and to the Integrated Child Development Scheme (ICDS) for identification and referral of severely undernourished children.

4. Integrated management of common childhood illnesses (pneumonia, diarrhoea and malaria)

In order to address the most common causes of neonatal and child deaths in India, an integrated strategy that includes both preventive and curative interventions has been adopted. This is known as the Integrated Management of Neonatal and Childhood Illnesses (or IMNCI) and is provided at all levels of care: at community (ASHA package), first level care (IMNCI) and referral level care (F-IMNCI). IMNCI addresses various aspects of child nutrition, immunization, and elements of disease prevention and health promotion. Its three main components include: improvements in the case-management skills of health staff, improvements in the overall health system required for effective management of neonatal and childhood illnesses, and improvements in family and community healthcare practices.

Considering that the leading causes of death beyond the neonatal period are diarrhoea and pneumonia, priority attention must be given to the management of these two illnesses. Availability of ORS and Zinc should be ensured at all sub-centres and with all frontline workers. Use of Zinc should be actively promoted along with use of ORS in the case of diarrhoea in children.

Use of recommended antibiotics (based on national guidelines) in children aged 2 months to 5 years with non-severe pneumonia must be ensured through frontline workers (ASHA, ANM) and at all levels of health facilities. Timely and prompt referral of children with fast breathing and/or lower chest in-drawing should be made to higher level of facilities. Emergency management of children with pneumonia is included in the facility-based IMNCI trainings which should be conducted with greater urgency across the states.

The prevention and treatment of malaria as per the guidelines in the National Malaria Control Programme should be emphasised as part of the child health interventions. The child health programme managers should closely liaise with managers of communicable disease control programmes in endemic districts to track progress.

Hospital-based care and management of children with severe diarrhoea and pneumonia is another important aspect of preventing deaths due to these two causes. This includes training of health service providers (doctors and nurses), especially those at FRUs and District Hospitals in F-IMNCI, which is the organisation of emergency care area to receive a sick child, ensuring availability of essential equipment and drugs, and application of management protocols.

5. Immunisation

India has one of the largest immunisation programmes in the world targeting 2.6 crore newborns for vaccination each year. Universal Immunisation Programme includes vaccines to prevent seven vaccine preventable diseases (Tuberculosis, Polio, Diphtheria, Pertussis, Tetanus, Measles, Hepatitis B).

Japanese Encephalitis (JE vaccine) vaccine has been introduced in endemic districts in a campaign mode and also incorporated into the Routine Immunization Programme. The second dose of measles has been introduced and Hepatitis B vaccine is now available in the entire country. Pentavalent vaccine, a combination vaccine(DPT + Hep-B + Hib),first introduced in two states (Kerala and Tamil Nadu), is now being expanded to six states and will eventually be scaled up to cover the entire country. New vaccines would be introduced in the course of the next phase, depending upon the available evidence for efficacy studies, cost effectiveness and programmatic considerations.

To strengthen routine immunization, newer initiatives include provision for Auto Disable (AD) Syringes to ensure injection safety, support for alternate vaccine delivery from PHC to sub centres as well as outreach sessions and mobilization of children to immunization session sites by ASHA. MCTS assists in tracking service delivery by generating due lists for ANMs, sending SMS alerts to beneficiaries and maintaining records for actual services delivered.

The cold chain must be further strengthened through improved procurement, supply and maintenance of equipment. Also, vaccine management assessment should be conducted and corrective actions instituted.

As the coverage of DPT first booster and the second Measles dose given at the age of 18 months is less than 50% across the country, the coverage of vaccine beyond the first year of life must be emphasised and monitored.

The district AEFI Committees must be in place and an investigation report of every serious 'adverse event following immunisation' (AEFI) case must be submitted within 15 days of occurrence.

India has been declared 'polio free' since January 2011. However, a high level of vigilance has to be maintained in the light of a constant threat of the import of polio virus from neighbouring countries. This includes maintaining high vaccination coverage levels among children with at least three doses of oral polio vaccine (OPV); administering supplementary doses of OPV to all children younger than 5 years during National Immunisation Days; mopping up vaccination campaigns if a polio case occurs and maintaining a good surveillance system.

6. Child Health Screening and Early Intervention Services (Rashtriya Bal Swasthya Karyakram)

Expanding focus from child survival to a more comprehensive approach of improving child development and quality of life is the guiding principle for the launch of a new initiative called the Child Screening and Early Intervention Services. The objective of the child health screening is to detect medical conditions at an early stage, thus enabling early intervention and management, ultimately leading to reduction in mortality, morbidity and lifelong disability. This initiative aims to reach 27 crore children annually in the age group 0-18 years, when fully implemented across the country.

The burden of birth defects, development delays in children, deficiencies and diseases is significant in children and this is one of the important factors for child mortality, poor quality of life and financial stress. The 'March of Dimes' Report (2006) estimates that out of every 100 babies born in India annually, 6 to 7 have a birth defect. This would translate into an estimated 17 lakhs birth defects annually, and account for 9.6% of all newborn deaths. Various nutritional deficiencies affecting preschool children range from 4 to 70% while developmental delays are common in early childhood, affecting at least 10% of the children and can potentially lead to permanent disabilities.

Under NRHM, child health screening and early interventions services will be provided by expanding the reach of mobile health teams at block level. These teams will include at least two doctors (MBBS /AYUSH qualified) and two paramedics who will be adequately trained and provided necessary tools for screening. These teams will carry out screening of all the children in the age group 0–6 years enrolled at AWC at least twice a year for 30 identified health conditions.

The health screening will be conducted to detect 4Ds: defects, deficiencies, diseases, development delays including disabilities, and arrangements will be made to provide free management of these children at District Early Interventions Centres or identified tertiary level institutions.

Through early identification and link to care, support and treatment, screening will help in providing a comprehensive package of services at Early Intervention Centres established at district hospitals.

Detailed guidelines for operationalisation of this initiative and relevant tools for training of mobile health teams and personnel at District Early Intervention Centres have been developed.

Through the Reproductive Years

Reproductive health needs exist across the reproductive years and therefore access to these services is required in various life stages starting from the adolescence phase. Reproductive health services include the provision for contraceptives, access to comprehensive and safe abortion services, diagnosis and management of sexually transmitted infections, including HIV.

A new strategic direction has been developed for the family planning programme, wherein it has been repositioned to not only achieve population stabilisation but also to reduce maternal mortality as also infant and child mortality. A target-free approach based on unmet needs for contraception; equal emphasis on spacing and limiting methods; and promoting 'children by choice' in the context of reproductive health are the key approaches to be adopted for the promotion of family planning and improving reproductive health.

These services will be delivered at home, through community outreach and at all levels of health facilities and include adolescents and adults in the reproductive age group.

Priority interventions

1. Community-based promotion and delivery of contraceptives
2. Promotion of spacing methods (interval IUCD)
3. Sterilisation services (vasectomies and tubectomies)
4. Comprehensive abortion care (includes MTP Act)
5. Prevention and management of sexually transmitted and reproductive infections (STI/RTI)

1. Community based doorstep distribution of contraceptives

The community based distribution of contraceptives through ASHAs and focused IEC and BCC efforts are being undertaken for enhancing demand and creating awareness about family planning. To improve access to contraceptives by eligible couples, the services of ASHAs are utilised to deliver contraceptives at the doorstep of households. ASHA charges a nominal amount from beneficiaries

for her effort to deliver contraceptives at the doorstep, that is, INR 1 for a pack of 3 condoms, INR 1 for a cycle of OCPs and INR 2 for a pack of emergency contraceptive pills (ECP). Initially, the scheme was implemented in 233 districts across 17 states; now the scheme has been extended to all the districts in the country.

As a matter of service guarantee, the states are required to ensure that family planning information, commodities and services are provided absolutely free to every client. The core area of focus in this phase should be the provision of contraceptives up to the village level, improved logistic management system and development of appropriate IEC and BCC tools.

2. Promotion of spacing methods (interval IUCD)

Introduction of a new IUCD of five years duration; post-delivery IUCD insertion; counsellors in District Hospitals and high case load facilities and training of health personnel in IUCD insertion at all levels of health facilities are the key measures taken for promotion of spacing methods. Availability of IUCD 380 A (that provides protection for over 10 years) and 'fixed day services' at all facilities are to be ensured. A new scheme has been launched to incentivise ASHAs to encourage the delay of the first birth in newly married couples and ensure spacing of three years between the first and second childbirths.

Ensuring IUCD services on fixed days at all sub centres and PHCs should receive focus in this phase. This would enable the clients to avail services in close vicinity of their community. It is expected that facilities above the PHC (i.e. CHC, SDH and DH) will provide regular IUCD insertion services. The states need to strengthen the counselling system at the facilities with high case load and in order to do so, placement of RMNCH counsellors would be a key strategy.

3. Sterilization services

This service component is limited to those couples who have achieved the desired family size and does not apply to the adolescent age group.

Important steps include promotion of non-scalpel vasectomy for increasing male participation. Other steps include the emphasis on Minilap tubectomy services, accreditation of private providers and NGOs for service delivery, and increasing the pool of trained service providers (Minilap, Laparoscopic sterilization and non-scalpel vasectomy).

Operationalising fixed day centers for sterilization is an essential step in this direction. Improving male participation remains critical to increasing the coverage as does the monitoring of complications, failures and deaths following sterilization operation.

Several schemes have been launched to strengthen sterilisation services in the country. Under the Compensation Scheme for sterilisation acceptors, compensation is provided for loss of wages to the beneficiary and payments made to the service provider (and team) for conducting the sterilisation procedure. The compensation in cases of failure of sterilisation, medical complications or death resulting from sterilisation, and indemnity cover to the doctor/health facility performing sterilisation procedures is provided through the Family Planning Insurance Scheme.

4. Comprehensive abortion care

Eight percent of maternal deaths in India are attributed to unsafe abortions. Besides this, women who survive unsafe abortion are likely to suffer long-term health complications. Unsafe abortions place a financial and logistic burden on the public health system, especially the need for emergency care and also contribute in a significant way to maternal deaths. Therefore, safe and comprehensive abortion care is an essential component of overall pregnancy care.

The pregnancy test to detect pregnancy at an early stage addresses several issues relating to maternal health, including early detection of unwanted pregnancy and provision of safe abortion facilities. These Pregnancy Testing Kits are already part of the RCH programme and are supplied under the brand name Nishchay to all the SHCs in the country. The supply and promotion of these kits would be strengthened in future. The provision of testing for early pregnancy should be as accessible to all adolescents as they are to women in older age groups.

Consistent efforts are required to expand and sustain safe abortion services in peripheral health care facilities in rural areas. The strategies for providing safe abortion services are the provision of Manual Vacuum Aspiration (MVA) facilities and medical methods of abortion in 24 X 7 Primary Health Centres. The comprehensive Medical Termination of Pregnancy (MTP) services are to be made available at all District Hospitals and Sub-district level hospitals with priority given to 'delivery points', and also by encouraging private and NGO sector to provide quality MTP services. The certification and regulation of private and NGO sector providers to provide quality MTP services should be done through the district level committees within the framework of the MTP Act. It is equally important to spread awareness in the community about abortion and the availability of these services through appropriate IEC and BCC messages. Capacity building of Medical Officers, to equip them with skills necessary to provide safe abortion services at PHC level and above; of ANMs, ASHAs, field functionaries and RMNCH Counsellors to provide confidential counselling for MTP and post-abortion care, including family planning and orientation of obstetrician-gynaecologist faculty of Medical Colleges in the latest technology and non-clinical aspects of comprehensive abortion care are important elements in the provision of abortion care. Public-private partnership and the involvement of professional associations in capacity building activities would yield better outcomes.

Appropriate and approved medical abortion drugs (Mifepristone + Misoprostol for upto 7 weeks and Ethacridine lactate for 12 to 20 weeks)are to be included in the essential drug list and availability of these drugs along with the necessary equipment has to be ensured in the public sector facilities wherever there is a trained service provider.

5. 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 RTIs/STIs. All individuals with RTIs/STIs have a significantly higher chance of acquiring and transmitting HIV. Moreover, STIs and RTIs are associated with a number of adverse pregnancy outcomes including abortion, stillbirth, preterm delivery, low birth weight, postpartum sepsis and congenital infection. The control of STIs/RTIs, especially in pregnancy, is thus a priority, and STI/RTI management must be linked to pregnancy care.

Again, controlling STI/RTI helps decrease HIV infection rates and also provides a window of opportunity for counselling about HIV prevention and reproductive health. These services are to be provided at all CHCs and FRUs, and at 24 X 7 PHCs. The provision of these services should first be made at all identified '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. 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 should be ensured first at the delivery points and then at all levels of facilities and with service providers trained in syndromic management of STI and RTI.

Importantly services should be made available across the entire reproductive age group including adolescents, youth and adults.

CHAPTER 6

Health Systems Strengthening for RMNCH+A Services

A. Infrastructure

The key steps proposed for strengthening health facilities for delivery of RMNCH+A interventions are as follows:

a) Prepare and implement facility specific plans for ensuring quality and meeting service guarantees as specified under IPHS.

b) Assess the need for new infrastructure, extension of existing infrastructure on the basis of patient load and location of facility.

c) Equip health facilities to support forty-eight-hour stay of mother and newborn.

d) Engage private facilities for family planning services, management of sick newborns and children, and pregnancy complications.

e) Strengthen referral mechanisms between facilities at various levels and communities.

f) Provision for adequate infrastructure for waste management.

New construction and renovation of existing facilities

It is important that construction and renovation work is completed within a defined time frame and not allowed to spill over beyond the stipulated time. The approved locations for constructions/ renovations are not to be altered. For new constructions upto CHC level, a maximum of two years, and for a District Hospital, a maximum period of three years is envisaged. Renovation/repair initiated for any health facility should be completed within a year. The requirement of funds should be projected accordingly in the state annual plans and budgets.

Standardised drawing, detailed specifications and standard costs must be evolved keeping the Indian Public Health Standards (IPHS) in view. Third party monitoring of work through reputed institutions should to be introduced to ensure quality.

Information on all ongoing work must to be displayed on the NRHM website as part of mandatory disclosure.

All government health institutions in rural areas should carry a logo of NRHM in English/Hindi and regional languages as recognition of support provided by the Mission.

Delivery points

The provision of services for delivery care in a health facility generally serves as an important indicator to assess whether the facility is optimally functional or not. The concept of 'delivery point'

emerges from this presumption. Among the health facilities designated as L1, L2 and L3, there are some facilities which are conducting deliveries above a minimum benchmark (minimum three normal deliveries per month at L1; minimum ten deliveries per month, including management of complications, at L2; minimum twenty to fifty deliveries per month including C-section at L3). These are designated as 'delivery points'. According to the government mandate, these facilities should be the first to be strengthened for providing comprehensive RMNCH services. The shortfall in trained human resource at delivery points, particularly sub centres and those in high focus districts (HFDs)/ tribal/remote areas should be addressed on priority basis. The short-term planning should focus on making delivery points functional to provide comprehensive RMNCHA services as defined for each level and to ensure adequate geographical coverage. This should be supported by a referral transport system that reaches the patient within 30 minutes of receiving a call and the health facility within the next 30 minutes. The long-term goal should be to establish and operationalise BEmOC (Basic Emergency Obstetric Care) and CEmOC (Comprehensive Emergency Obstetric Care) centres, as per the expected delivery load in the state and district.

Maternal and Child Health (MCH) Wing:

Most health facilities, especially those at secondary and tertiary level are overwhelmed by a very high case load of pregnant women and newborns due to the increase in institutional deliveries following launch of JSY and JSSK. Therefore, it has been decided that dedicated Maternal and Child Health wings will be established in high case load facilities with adequate provision of beds. The new MCH wings will be comprehensive units (30/50/100 bedded) with antenatal waiting rooms, labour wing, Essential Newborn Care room, SNCU, operation theatres, blood storage units and a postnatal ward as well as an academic wing.

This will ensure provision of emergency maternal and newborn care services as well as forty-eight hours stay, and thus quality postnatal care to mothers and newborns.

Human resources

The most important aspect of the RMNCH+A approach is the augmentation of human resources over the next years. For sustainable Human Resource Development, policy reforms for deployment of health personnel and the move from 'contractual' to 'regular' employees should be expedited. Ad hoc recruitments done under NRHM can at best be an interim measure. The creation of new posts and filling up of regular posts under the state government will be undertaken so that the contractual appointments can be slowly reduced and a sustainable HR structure is developed. Forecasting the future requirement of doctors, nurses and paramedical staff for RMNCH+A services should be an important first step.

The following actions will be undertaken to ensure adequate skilled human resources:

Recruitment

A comprehensive HR policy is to be formulated and implemented, and uploaded on the State NRHM website. Decentralised recruitment of all the HR engaged under NRHM by delegating the recruitment process to the District Health Society under the chairpersonship of the District Collector/Rogi Kalyan Samitis should be done. Also, preference should be given to local candidates to ensure availability and presence of service providers in the community. Residential facilities should essentially be

considered when new construction is undertaken so as to ensure that the health personnel reside at the place of posting. Quality of HR needs to be ensured through appropriate qualifications and a merit- based transparent recruitment process.

Strengthening sub centres through additional human resources

For the rural population, sub centres are the 'first port of call' for accessing health care. The sub centres will be accorded highest priority in terms of infrastructure strengthening and human resources allocation in this implementation phase. These sub-centres need to be equipped for providing basic treatment and care for most common health conditions. It is envisaged that the sub-centres in remote and hilly areas will be manned by at least two ANMs, one male multipurpose worker, one pharmacist and one AYUSH doctor or Community Health Officer. Duty rosters for these functionaries will ensure round the clock provision of services to beneficiaries. The allocation of specific work areas and job responsibilities to both ANMs will be done.

Rational deployment of available human resources

It has been observed in several states that even the available human resources are not properly placed at the right facility, resulting in under utilization of skills. The states need to develop a mechanism for rational deployment of service providers so that maximum possible number of facilities can be operationalised.

The rational deployment policy will include posting of staff on the basis of case load (OPD/IPD/Normal deliveries/C-sections), rational deployment of specialists, especially gynaecologists, anaesthetists, EmOC and LSAS trained doctors in teams, posting of trained HR as per the level of the facility, for instance LSAS, and EmOC to be posted in the FRUs, and filling up of vacancies in high focus/remote areas on priority basis.

The details of facility wise deployment of all human resources engaged under NRHM are to be displayed on the state NRHM website.

Placing adequate staff as per IPHS norms and case loads

This is particularly important for facilities managing obstetric emergencies, sick newborn, and post abortion complications. The IPHS has now been modified to reflect the human resource needs of facility-based reproductive, maternal and child care at different levels of health care facilities.

Multi-skilling of Medical Officers for reproductive, adolescent, maternal, newborn and child health

Since most states are unlikely to be able to recruit specialist doctors as per the norms in the near future, these skills will be made available in immediate and medium term, by building the capacity of general duty Medical Officers in critical gynaecological, obstetric, newborn and child health (paediatrics) competencies so that they can deliver these services.

A comprehensive reproductive, maternal, newborn and child health skill lab for quick acquisition of knowledge and skills will be developed in the states. The process is being led by Maternal Health Division with support from an expert group.

AYUSH doctors will be more effectively utilised for supportive supervision, School Health Programme, Child Health Screening and WIFS.

Empowering nurses for maternal, child health and family planning at facilities

Optimal numbers of nurses that are skilled in delivery and postpartum care, sick newborn and child care, will be made available at the health facilities as per the IPHS in order to provide ambulatory and emergency care for women and children. Nurses and ANMs would also be entrusted with the task of counselling and providing family planning services.

Creation of a public health cadre

The rationale for promoting the establishment of such a cadre emerges from the need to have specialists with expertise in public health planning, priority setting, management and monitoring of public health programmes. The notification for creation of a public health care is to be undertaken by state governments. The Government of India has constituted an expert group to provide necessary assistance to state governments in establishing, training and mentoring the public health cadre. This setting up of a separate and organised public health cadre in a time bound manner will be linked to incentivisation and release of funds under annual Programme Implementation Plans.

Task shifting

The success of the RMNCH +A strategic approach depends on the accessibility and reach of these services provided by qualified and trained personnel to the rural masses.

In resource constrained situations such as lack of infrastructure or unwillingness of specialists to be posted in rural remote facilities, sub centres need to be strengthened as these are the nearest link between the rural population and health system. With a view to make ANMs and nurses proficient, the Government of India has taken several steps to strengthen these cadres by imparting several trainings that include Skilled Birth Attendance, Integrated Management of Newborn and Childhood Illnesses, Navjaat Shishu Suraksha Karyakram and IUCD insertion.

One of the objectives for undertaking the capacity building of this cadre is task shifting and delegating some of the technical responsibilities for such activities. Services like presumptive treatment for common illnesses, basic obstetric and newborn care, contraceptive counselling and services can be provided by ANMs/SNs and therefore doctors are not mandatorily required.

For any additional job or responsibility to be undertaken, it is pertinent that besides technical strengthening a better career path for the cadre is designed so that there is enough motivation and willingness to carry out the designated work.

A comprehensive roadmap has been developed for strengthening of the nursing cadre so that the task shifting becomes easy and is accomplished with willingness. Some of the steps being undertaken are as follows:-

Strengthening of pre-service training

It has been done by adding six months Internship for ANMs as a part of the curriculum while increasing the entry level qualification. In addition, one year basic diploma curriculum has been developed by the Indian Nursing Council. Skill building trainings like IMNCI, NSSK, IYCF, SBA and EMONC are being introduced into medical and nursing education.

- Competency based internship and certification

A six months skill-based internship is on the cards for ANM and GNM and it is proposed that certification be provided only after the skill-based internships, both by public and private institutions. The competency-based curriculum is being developed by the Indian Nursing Council which will be mandatory for both public and private institutions to follow.

The major areas of task shifting to AYUSH providers under consideration are routine ANC, detection of high risk pregnancies and complications during pregnancy, management of common ailments, diarrhoea management, primary care for wounds and injuries, as well as empowerment of the AYUSH providers to prescribe allopathic drugs for basic emergency management before referral of cases to referral/higher centres.

Capacity building of health providers

The capacity of all staff caring for newborns and children at the District Hospital, FRUs and 24X7 facilities will be enhanced, building on existing training programmes. The quality assurance of all training programmes, innovative training methodology, post training supportive supervision and handholding will be encouraged.

The training programmes on RMNCH+A will also be reflected adequately in the pre-service education programmes of all health workers and professionals. These training programmes require increased institutional capacity in terms of training infrastructure and human resources dedicated to training and post training supervision. Innovative approaches in training and education for RMNCH+A (such as tele-education, computer-based instruction, self-learning programmes) for rapid, high quality roll out of trainings will be encouraged.

Strengthening training institutions

In all, seven National Nodal Centres and one State Nodal Centre (in each of the ten high focus states) will be created. The first step in this direction is the creation of National and State Nodal Centres for hand holding and supportive supervision of ANM and nursing schools. The proposed National Nodal Centres are NRS Medical College Kolkata; St Stephen's Delhi; Government College of Nursing, Vadodara; CMC Vellore; LHMC, Delhi; CMC, Ludhiana; Rajkumari Amrit Kaur College of Nursing, Delhi.

In consultation with states, one State Nodal Centre will be identified in ten high focus states. If time bound activities are undertaken, it is expected that in the next three years, all Government and GNM Training Schools will be strengthened in terms of faculty upgradation, skills lab, computer lab, library and other facilities in these ten states. These centres will also be linked with health facilities in the vicinity so that collaboration of the teaching and clinical staff is ensured and supportive supervision system improved.

Career development for 'in service' cadre

A systemic career development path for the 'in service' cadre has been defined. It is proposed that after a specified period of service and followed by additional training, the ANM will be eligible for selection as Lady Health Visitor (LHV) or General Nurse Midwife (GNM), and LHV will be eligible for the position of Block Public Health Nurse (PHN). The GNM will be eligible to progress to the level of Block Nurse Midwife Practitioner. The Block PHN and Block Nurse Midwife will be at the same level and can be selected as District PHN based on competency and assessment by a committee of professionals.

Performance appraisal

All contractual staff will have job descriptions with reporting relationships and quantifiable indicators of performance. Performance appraisal and hence increments of contractual staff will be linked to progress against indicators.

Staff productivity will be monitored. Continuation of additional staff recruited under NRHM for 24/7 PHCs/FRUs/SDH, who do not meet performance benchmarks, will be reviewed by the state.

All performance based payments/difficult area incentives should be under the supervision of RKS/ Community Organizations (PRI).

B. Policies on drugs, diagnostics, equipment, procurement system and logistics management

Clear articulation of policy on entitlements to free generic drugs for out/in patients in public health facilities is to be made by the states for minimising the out of pocket expenses. Rational prescriptions and use of drugs; timely procurement of drugs and consumables; smooth distribution to facilities from the District Hospital to the sub centre; and uninterrupted availability to patients is to be ensured. For this purpose, there are some steps that are to be taken on a priority such as quality assurance; prescription audits; finalisation of EDLs and a drug formulary which will be made available in all public health facilities; placing essential drug lists (EDL) in the public domain; computerised drugs and logistics MIS system; and setting up of a dedicated corporation (for example on the lines of Tamil Nadu Medical Services Corporation). An overall procurement and logistics strategy, detailed design and plan for rate contracting, regular stock updates, indent management, warehousing, and contingency funds with devolution of financial powers will be put in place.

A Central Procurement Agency for the efficient purchase of quality medicines for distribution to states and union territory governments is being set up. The Central Procurement Agency will be an autonomous procurement agency for purchase of medicines, vaccines, contraceptives and medical equipment for national health programmes.

A rational prescription of diagnostic tests; reliable and affordable availability to patients; partnerships with private service providers; prescription audits; free diagnostics for pregnant women and sick neonates will also be emphasised.

A regular needs assessment for equipment; timely procurement; availability of essential functional equipment in all facilities; identification of unused/ faulty equipment; regular maintenance and MIS/competitive and transparent bidding processes are important aspects that will be addressed by states in order to ensure delivery of quality services.

C. Quality of care

The provision of quality services requires an efficient organization of work and a high level of motivation and consciousness about quality besides the addition of infrastructure and human resources, equipment, drugs and supplies. It is equally important that services (other than those that certain groups are entitled to access free of cost) in the public sector are kept in an affordable range. The health facilities also need to be women, mothers, newborn, child and adolescent friendly, with affirmative action to ensure that there are no social barriers or processes of exclusion that are

keeping out the poor and marginalized. While the states will be allowed flexibility, quality assurance system will be standardized across all the States. Mandatory Quality Assurance mechanism for sterilisation services was put in place by the MoHFW following directions from the Hon'ble Supreme Court in 2005 and the structure is already in place up to the district level. The scope of the Quality Assurance (QA) system is now enhanced to include the full range of RMNCH+A services.

For rolling out QA system, organisational arrangements will be set up at various levels with clearly defined roles and responsibilities for each level. These will include (1) Central Quality Supervisory Committee; (2a) State Quality Assurance Committees, (2b) Quality Assurance Cell and (2c) Full time quality assessors; (3) District Quality Assurance Committees; and (4) Quality Circles at the District Hospital level.

The central QA team will comprise technical officers from the programme divisions of the Ministry of Health and Family Welfare and counterparts working with technical support partners. The QA standards will be defined for each technical theme, categorised by the level of health facilities. The Indian Public Health Standards for various health facilities, along with the internationally accepted best practices and experience from the states, will be used as reference points. Technical protocols for management of various clinical conditions will also be included.

Quality certification

Quality certification of public hospitals will be encouraged. One type of certification involves certification of quality of care in terms of the input standards – infrastructure, human resources, drugs and equipment – and the output standards in terms of package of services available. This is the certification for achievement of Indian Public Health Standards. Another form of certification relates to the organization of work and processes central to providing ethical, efficient and effective quality care. It only certifies that there is a quality management system in place which ensures the best quality of outputs for the level of inputs currently available. Quality certification should not remain limited to standards of infrastructure but should also have thrust on comprehensive in-house quality assurance for both infrastructure and service delivery. It is recommended that health facilities should be first certified by District and State Quality Assurance Cells/Committees before any third party certification is sought.

CHAPTER 7

Programme Management

While the number of staff and their placement in the organisation structure will primarily be determined by the organisational set-up in each state, certain guiding principles have been set out with the aim of ensuring that RMCNH+ approach receives the necessary organisational emphasis. States can assess the extent to which these guiding principles have already been adopted and make corrections wherever necessary.

In order to obtain a clear understanding of the programme management arrangements, detailed organisation charts for the Department of Health And Family Welfare at state, district and sub district levels have been specified. The proposed organization structure is consistent with NRHM goals and strategies, and reflects expertise in various areas.

Structure and staffing of Programme Management Units

National Level: At the national level, the RCH Division currently has the provision for Deputy Commissioners, Assistant Commissioners, and a team of technical consultants. The existing structure will be substantially strengthened with additional officers and consultants to provide management support and technical assistance in areas such as nutrition, capacity building, quality assurance and logistics management. A detailed structure will be put in place, in line with the proposed Technical Support Unit under Universal Immunization Programme, Ministry of Health and Family Welfare.

State level: A dedicated full-time Director for RCH (including Maternal Health, Child Health, Family Planning and Adolescent Health) will take charge at the state level. Director RCH will be supported by separate dedicated full-time directorate officials for Maternal Health, Child Health, Family Planning and Adolescent health as well as for key cross cutting functions such as facility operationalisation, training and quality assurance systems. The key technical areas of RCH will also have a dedicated/ nodal person at district level. They can be a mix of directorate staff and consultants. As a minimum, there should be a designated person for each function with supervision being provided by a directorate official.

The State Directorate will be strengthened for the management of all technical components of RMNCH+A services including training, communication and planning. Additional expertise in community-based programmes and on quality assurance of health facilities will be provided. For each of these areas, a dedicated senior officer will lead the team, supported by a group of officers and consultants.

District and block level: At each district, the staffing level will be as follows:

- A dedicated directorate official (possibly Additional Chief Medical and Health Officer (CMHO) /RCH Officer) for RMCNH+A (including maternal health, child health, family planning and adolescent health)

- Additional CMHO, RCH Officer to be supported by separate dedicated full-time staff for maternal health, child health, family planning and adolescent health components
- A nurse-midwife/master trainer/staff nurse who would mentor or provide supportive supervision to LHVs/ ANMs in improving quality of service delivery across maternal health, child health and family planning.
- Key cross cutting functions – facility operationalisation, training and quality assurance systems – should be under the purview of the District Programme Management Unit which could be strengthened accordingly.

The above staffing pattern is based on the assumption that LHVs are in place to provide first level supervision. Further, the number of additional staff would need to be determined by each state on the basis of estimated workload and the extent of supervision required. A supportive supervision system will be established with identification of nodal persons for districts; frequency of visits; checklists and action taken reports. At the block level, Block Programme Management Unit will be strengthened with technical expertise in RCH, especially in the 264 high focus districts.

Urban Areas: Correspondingly, technical and management capacity for child health will be strengthened in urban areas, within the National Urban Health Mission framework.

Supportive Supervision to strengthen the capacity of frontline workers and service providers to deliver quality RMNCH services

It is being increasingly recognized that while increased investment in healthcare is leading to improved coverage (such as of institutional births, immunisation etc), improvement in quality of care has not been commensurate. In many Joint Review Missions and Common Review Missions, the absence of supportive supervision has been identified as a critical bottleneck in improving the performance of health staff and in delivering quality services.

Supportive Supervision within the healthcare context implies regular and dependable interaction between a health provider and a more experienced professional; it helps to identify and solve problems, improve services and advance skills and knowledge.

The RMNCH+A strategic approach recognizes the need to strengthen supportive supervision of frontline workers (ASHAs, ANMs) and service providers (Staff Nurses and Medical Officers) in order to bring about integration of primary care services, improve quality, enhance skills and skill application. The key challenges in providing supportive supervision are:

- Inadequate numbers of supervisors within the system.
- Restricted mobility of supervisors constraining the field supervision
- Lack of 'supportive' skills due to lack of training
- Absence of authority to ensure compliance
- Vertical programs with vertical supervision leading to fragmentation
- No clear guidelines for supportive supervision; and
- Absence of a supportive supervision policy.

There is clearly a need to develop Supportive Supervision Policy with clear line accountabilities, authority and support structures to institutionalise this mechanism in the long term.

The suggested roadmap for short-medium term is briefly outlined below:

i. Supportive supervision of health facilities (focusing on 'delivery points': select subcenters, 24X7 PHCs and CHCs):

Engaging generalist RCH nurse supervisors at block and district level

Some states have Block and District Public Health Nurses, who supervise the staff nurses of the PHCs in the catchment area. The expansion of such nurses' cadre in all high focus districts will strengthen supportive supervision. Different modalities such as regular recruitments, contracting out by the District Health Society, partnering with nursing institutions can be followed to engage these nurses. The District Public Health Nurses who are part-time faculty of the District Nursing or ANM Training School should also be considered for providing supportive supervision.

A clear 'terms of reference' should be prepared for these nurse-supervisors, providing them with required authority as well as training in technical and supervisory skills.

Preparing a clear plan of supervision

In addition to the nurse supervisors, specialists (for instance, in Paediatrics and Obstetrics) posted in districts can be engaged in supportive supervision of doctors and nurses in the identified facilities. It would also be useful to engage District and Block Programme Managers and officials in the supervisory team.

While the generalist nurse supervisors will make more frequent field visits for supervision, the officials and specialists can join in periodically (for example, every quarter).

Adequate mobility support should be built into the State's Annual Plan to ensure that the 'supervisor' carries out the required field visits.

Engaging Medical College faculty for supportive supervision of District Hospitals

The supportive supervision by Institute of Child Health in Tamil Nadu has led to significant improvement in quality of maternal-newborn care in eight districts. A similar engagement of Medical College faculty in other districts and states would be a useful strategy.

Preparing integrated guidelines and checklists for supportive supervision, eg; linking UIP-MNCH(Universal Immunisation Programme and Maternal, Newborn And Child Health) supervisory mechanism

ii. Supportive supervision of frontline workers

Potential supervisors of frontline workers include LHVs, ASHA supervisors, ICDS supervisors and AYUSH doctors. Many states have engaged these human resources creatively for supportive supervision of frontline workers (for example, Odisha engages AYUSH doctors and ICDS supervisors in supportive supervision of the frontline workers).

In order to provide a system for supportive supervision of frontline workers, following steps are proposed:

Skill building of ANMs should be considered for ensuring supportive supervision of ASHAs (and AWWs) is required. While ANMs do perform supervisory functions informally, their skills in supportive supervision are limited and need to be enhanced on this specific issue.

- ASHA support structure should be strengthened by ensuring presence of skilled ASHA facilitators at sector, block and district level, backed by institutions for training and support.
- Innovative ways of supervision using information-communication technology should be explored.
- Non-financial incentives and recognition systems should be institutionalised.
- Supervisory plans, checklist and guidelines, and addressing the above requirements should be developed as tools to guide the supervisors.

Improving Governance

Responsiveness, transparency and accountability are critical to demonstrating results at a time when increasing investments are being made into the health sector.

- The health system as an institution should ensure that the policies and programmes are responsive to the health and non-health needs of the clients. The demonstrated initiatives including innovations for responsiveness, in particular, the local health needs such as the use of epidemiological data for planning, active participation of public representatives in District Health Society and Rogi Kalyan Samiti meetings, using innovative approaches to reach the unserved population and so on should be encouraged and incentivised.
- The transparency initiatives in service delivery can be defined as any attempt to place information in the public domain, directly accessible to those concerned with the same, and where enough information is provided for citizen groups, providers or policy makers to understand and monitor health matters. The demonstrated initiatives/innovations for transparency by the states, such as mandatory disclosures and other important information including HR posting, need to be displayed on the state NRHM website. The schedules of MMUs and RCH camps etc. should be disseminated among user groups.
- Examples of demonstrated initiatives/innovation for accountability include call centre for integrated grievance handling system where aggrieved party would receive an SMS with a grievance registered number; action would be taken within a stipulated time. Another initiative is the community monitoring where *'jan sanvaad and sunwai'* could be held and system put in place for taking remedial action. Examples of demonstrated initiatives to improve accountability in HR related aspects could include ensuring that the staff has job descriptions with clearly defined indicators of performance, and performance monitoring against targets forms an integral part of the performance appraisal system. Another action could be to publicise innovations, good programme management and functionaries that have brought about demonstrable improvements or shown exceptional commitment to achieving goals, on the state NRHM website.

CHAPTER 8

Monitoring, Information & Evaluation Systems

It is envisioned that there will be a huge expansion in the integrated use of health informatics for human resource planning and management, GIS applications, mobile transmission, hospital information systems, disease surveillance systems and nutrition as well as social determinants monitoring, death reporting, case-based follow-up systems including what is referred to as pregnancy and child tracking.

The approach towards health management information systems would be to permit multiple systems which meet well defined and regulated data standards and standards of inter-operability, with each user level or institution being able to access the information most useful at that level, rather than one single system to which all data entry and interpretation must conform.

Various systems for monitoring and evaluation include:

- **Civil registration system:** All efforts will be made to ensure 100% registration of births and deaths under Civil Registration System. The data/information would be captured from both public and private health facilities.
- **Web enabled Mother and Child Tracking System (MCTS):** The name-based tracking of pregnant women and children has been initiated under NRHM with an intention to track every pregnant woman, infant and child up to the age of three years by name, for ensuring delivery of services like timely antenatal care, institutional delivery and postnatal care for the mother, and immunization and other related services for the child. The MCTS is to be fully updated for regular and effective monitoring of service delivery, including tracking and monitoring of severely anaemic women, low birth weight babies and sick neonates. In the long run, it could be used for tracking the health status of the girl child and school health services. A more recent initiative is to link MCTS with AADHAR in order to track subsidies to eligible women.
- **Maternal Death Review (MDR):** The purpose of the maternal death review, both facility and community based, is to identify causes of maternal deaths and the gaps in service delivery in order to take corrective action. The guidelines on MDR have been provided to all states and the MDR process has been institutionalised. The analysis of these deaths can identify the delays that contribute to maternal deaths at various levels and the information can then be used to adopt measures to prioritise and plan for intervention strategies and to reconfigure health services.
- **Perinatal and Child Death Review:** The Perinatal and Child Death Review is an important strategy to understand the geographical variation in causes leading to newborn and child deaths, and thereby initiating state-specific child health interventions. An analysis of newborn and child deaths provides information about the medical causes of death and helps to identify the gaps in health service delivery, or the social factors that contribute to these deaths. This information can be used to adopt corrective measures and fill the gaps in community and facility level service delivery. A uniform Child Death Review process and formats will be adopted across the states, so that the information can be compared over a period of time and common factors be identified

and addressed through national programmes. The Infant and Under-five Death Review must be initiated for deaths occurring both at community and facility level. The death reports with cause of death for any child under five should be shared with district health teams on a quarterly basis.

- **Health Management Information System (HMIS) based monitoring and review:** The need for relevant, accurate and timely data to facilitate improvement in operational planning, monitoring and evidence-based policy formulation is well recognised. To reach this end, in 2008, a web-based Health Management Information System (HMIS) was initiated. At present, all 35 states and union territories as well as 642 districts upload health related data on a range of outputs and service delivery indicators; by March 2013, facility level data will also be available.

  Indicators that reflect key outcomes such as full antenatal care, institutional deliveries, sterilisation procedures, IUCD insertion, full immunisation, child deaths due to diarrhoea and acute respiratory infections, and maternal deaths should be regularly monitored and interpreted at national, state and district level. The process indicators such as postnatal home visits for mothers and newborns, newborns admitted to SNCUs, number of caesarean sections should be reviewed at regular intervals. The review of states and districts based on HMIS data should be promoted so as to strengthen this system and improve the quality of data.

  A regular, focused review at different levels including those by the Health Secretary/Mission Director/District Health Society headed by District Collector/Officers at Block/PHC level should be the based on HMIS and MCTS data analysis.

  A new initiative for monitoring and reviewing the progress is the introduction of the 'score card'. The score card refers to two distinct but related management tools: (1) HMIS based dashboard monitoring system and (2) Survey based child survival score card. The dashboard seeks to improve accountability in the public health system and catalyse states into using the HMIS data for improved decision-making; a comparative assessment of state and district performance in terms of service delivery is proposed on a quarterly/year to quarter basis. A list of dashboard indicators that can be used for monitoring the major components of the RCH programme are provided in the Annexure.

  Unlike the HMIS-based dashboard, the survey-based score card captures both public and private sector data and provides a basis for assessment of performance at national and state levels in terms of both outcomes and service delivery; this would be updated as and when new survey results are available. Further details about the methodology are provided in the Annexure.

- **Review missions:** Annual Joint Review Missions by the RCH Division and Common Review Missions under NRHM, the concurrent evaluation process led by the IIPS, research studies and evaluations done by the international advisory panel and various national institutions are some of the mechanisms already in place for reviewing the progress against key targets and indicators.

  Some of the members of the review mission are independent of the government and devoid of conflicts of interest. These members are given access to all the data and facilities to draw unambiguous conclusions about the performance of the delivery system and offer credible recommendations on strengthening the system, wherever progress is unsatisfactory.

- **National surveys:** The Sample Registration System, the National Family Health Survey and District Level Household Survey and the Annual Health Surveys provide important health data which must be used to undertake context specific planning for particular geographical areas (blocks, districts) and population.

- **Rapid programme assessments:** Rapid Programme Assessment can be conducted to identify the operational bottlenecks and make course corrections for community and facility-based RMNCH+A interventions.
- **Leveraging technology:** Use of GIS maps and databases for planning and monitoring; GPS for tracking ambulances and mobile health units; mobile phones for real time data entry; video conferencing for regular reviews; closed user group mobile phone facility for health staff – these are some of the possibilities for increasing connectivity, communication and monitoring. The potential for using technology is much more and sky is the limit!

CHAPTER 9

Community Participation

The community-based monitoring of health services is a key strategy under National Rural Health Mission (NRHM) to ensure that services reach those for whom they were meant, especially the poor, women and children residing in rural areas. Community monitoring is also seen as an important aspect of promoting community led action in the field of health. It empowers the community members, community-based organisations, local committees, and Panchayat representatives to systematically provide feedback on how the health system is performing.

A number of initiatives are being implemented throughout the country to improve community participation, increase accountability and thus improve service delivery. The government is increasingly seeking direct citizen engagement and participation in planning, monitoring and implementation of healthcare services under the community monitoring initiative. In this phase of implementation, community participation and communitisation processes must receive special attention and community structures should be mobilised through advocacy and capacity building in order to create a conducive environment for utilisation of available health services and enhancing the quality of services locally.

The following are some of the recommended processes for increasing community involvement and communitisation.

i. **Engage women systematically at the community level:** More efforts to directly engage and mobilize women at the community-level are needed. The community leaders, existing Village Health Nutrition and Sanitation Committees, self-help groups (SHGs) and ASHAs should be leveraged to engage women in taking responsibility of their own health in a more systematic way. The behaviour change communications programmes, capacity building and technical assistance from the government and civil society is needed to provide impetus to these efforts.

ii. **Formalise and make accountability mechanisms system-led:** At the service-delivery level, more formal, institutionalised systems for complaint and redressal should be put in place. They must be supported by timely emergency response systems, such as telephone helplines and proper managerial authority should be granted so that structures are in place to rectify acute challenges related to referral and transportation or the mistreatment/exploitation of patients at the facilities. A formal system to lodge complaints and seek redress should also provide oversight to help protect women who register complaints, from future reprisals. The demonstrated initiatives/ innovation for accountability, for instance call centre for integrated grievance handling system, can be considered.

iii. **Engage Village Health Sanitation and Nutrition Committees (VHSNC) and Rogi Kalyan Samiti (RKS):** The decentralized planning and communitisation encompasses capacity building in terms of training and sensitisation of ASHAs, Village Health Sanitation and Nutrition Committees (VHSNC) and Rogi Kalyan Samiti (RKS) members about their roles and responsibilities towards

optimal utilisation of grants and funds in the best interest of the users. The sensitisation on maternal and child health issues should be included as a component in these trainings. Active community participation and encouraging contributions from public/community can be brought about by the involvement of the VHSNCs and empowered PRIs. At the community level, VHSNCs members, PRI members, AWW, ANM, ASHA, local leaders, NGO representatives, teachers etc. should be involved in planning as well as monitoring Village Health and Nutrition Days (VHNDs). And their convergence with other programmes (such as SABLA, ICDS, Nirmal Bharat Abhiyaan) should take place on a regular basis in such a way that they are effective in delivering the package of RMNCH+A services through community/outreach programmes.

iv. **Utilize the Village Health and Nutrition Days (VHNDs)as a platform for assured and predictable package of outreach services:** The VHNDs can be utilized to reach women and communities in the most remote hamlets. So far, VHNDs have contributed to increased coverage of immunization and antenatal care witnessed over the last few years. However, their potential for newborn and child health and nutrition services has not been adequately tapped. To increase the coverage and effectiveness of VHNDs, it is proposed that detailed mapping of remote hamlets and small villages be carried out so as to ensure that every hamlet has access to VHND within 20 minutes of travel time. The selected sites should have provision of basic amenities including privacy for examining pregnant women. The monitoring of VHND by PRI/VHSNC would ensure occurrence, quality and comprehensiveness of services. The package of services in VHND should be expanded as shown in the box below:

Expanded package of services in VHND:

- Immunization as per schedule
- Antenatal care including birth preparedness and complication readiness
- Post-natal care to mothers including counselling for contraception
- Facilitating access to contraceptive services
- Growth monitoring
- Counselling on key practices for improved newborn and child health and nutrition
- Demonstration on preparing and use of ORS and Zinc, and provision of ORS and Zinc for treatment of childhood diarrhoea
- Follow-up care of severely malnourished children
- Testing and treatment for anaemia in pregnant women
- Referral support to ASHAs, AWWs in community level care, for children with illness
- Sessions and services for adolescent girls and boys

v. **Social audit and communitisation efforts at the Panchayati Raj level:** Capacity building and technical assistance will be required to prepare Panchayati Raj institutions to assume this new responsibility of social audit and leading the communitisation process. These social audits can be centred around activities like

1) conduct of maternal death audits via verbal autopsies,
2) utilization of health facility checklists, and

3) providing shared platforms for beneficiaries, government officials and service providers to address grievances related to RMNCH+A health service delivery.

At the block and district level, convergence meetings can be organized particularly between health and other departments like WCD/ICDS in the presence of local leaders/elected representatives on a regular basis to review findings of the social audits and to identify actions for further actions/support. The PRI members should be empowered by orientation and effectively involved in monitoring VHND, implementation of schemes under various departments and sharing the findings/observations at the Gram Sabha as well as the Panchayat Samiti meetings.

With increasing representation of women in the Panchayats, there is now a distinct opportunity to engage with them, sensitise them and empower them to voice their concerns and push for decisions that will improve the condition of these women and children, and by extension, the men in their villages.

CHAPTER 10

Behaviour Change Communication

A significant proportion of maternal, neonatal and child deaths can be prevented by adopting key health care practices such as prompt seeking of care for pregnancy complications, early initiation of and exclusive breast feeding, hand-washing, home management of diarrhoea, and so on. A well-implemented behaviour change communication strategy has the potential to significantly improve these practices and consequently accelerate reproductive, maternal and newborn health and child survival. The challenge with behaviour change efforts has largely been that it has been implemented in silos and in segmented approaches such as family planning, adolescent health, child health, maternal health and HIV. As a result, behaviour change intervention within the national programme has failed to reach a critical mass.

An integrated, evidence-based behaviour change strategy, using the life stages and continuum of care approach is critical to addressing the socio-cultural barriers and to help in acceptance and adoption of preventive practices and appropriate care seeking. An appropriate BCC strategy would also address issues that underlie the low uptake of health care services, for example entitlement to health services, women's autonomy and availability of health care services in the vicinity.

The first step in this direction is the development of an evidence-based effective communication strategy plan. This plan would:

1. Identify determinants of practices or behaviours that are prevalent locally.
2. Prioritise practices that have the greatest impact on maternal and child health and survival, and that are most amenable to change.
3. Promote a core set of messages in practices related to key RMNCH+A areas as listed under priority interventions.
4. Identify the key stakeholders whose behaviours/social norms can impact RMNCH+A indicators.
5. Ensure participation of stakeholders at different levels including the community, service providers and front line functionaries across the continuum of care cycle.
6. Guide the use of a mix of mass-media, mid-media and interpersonal communication (IPC) to influence individual practices and social norms to promote positive change.
7. Build state/district capacity on designing effective communication interventions.
8. Actively monitor the strategy's impact on changes in behaviour and in reproductive, maternal, newborn, child and adolescent health.

To operationalise the RMNCH+A communication strategy, the following elements should be put in place:

- Strengthen communications divisions/bureau in states and their linkages with the technical bureau.

- Support the development of human resource capacity, in strategic communication (planning, implementation, monitoring and evaluation) as well as community mobilisation and interpersonal communication skills.
- Build partnerships with key stakeholders and influencers (for example media, development partners) to maximize reach and impact.
- Capitalise upon existing communication initiatives and interventions for scale up, and maximise the utilisation of available resources for implementation and scale up.

CHAPTER 11

Priority Actions in High Focus Districts and Vulnerable Population (Urban Disadvantaged and Tribals)

'Reaching the Unreached' in underserved areas in urban slums, tribal areas and vulnerable population including SC, ST, migrants, urban poor and adolescents will be the topmost priority under the RMNCH+A strategic approach. As reproductive, maternal and child morbidity is more likely to be concentrated in these areas, focused planning and investments in these geographical regions is likely to bring greater returns and make larger impact on health indicators. An equity approach in selecting, implementing and monitoring of high impact RMNCH+A interventions will be considered to ensure that these groups are reached.

Through this strategy, it will be ensured that disparities between the sub populations are progressively minimised through affirmative action, and interventions are designed to reach all marginalised and vulnerable population with special needs. Again, special focus on women and the girl child will be ensured in all interventions. Increased access to underserved and marginalised population (including tribals and other vulnerable groups) by removing physical, social and financial barriers and fostering community mobilisation will receive maximum attention.

An explicit pro-poor focus will be maintained in planning and implementation through identification of vulnerable groups in high focus districts with relatively weak performance against RMNCH indicators, so as to ensure that their needs are met. Also, focused interventions and priority investment of resources in these districts will be made as this is vital to reducing intra-state disparities in the health status of women and children.

Some of the steps that have already been instituted or proposed recently to achieve this goal are as follows:

Differential planning and need-based financing

Annual Health Survey conducted in nine states and 284 districts shows that 59% of total births take place in these districts but they contribute to 70% of infant deaths and 62% of maternal deaths. The District Health Profiles for 284 districts have been prepared to enable preparation of District Specific Action Plans.

In order to fast track improvements and reduce regional disparities, 264 high focus districts have already been identified for action. Additional districts may be identified by states for priority action, based on performance indicators. Extensive district planning support and supportive supervision is provided through dedicated teams comprising officials of the Ministry of Health, development partners and professionals.

The dedicated multi-functional teams (drawn from the State Programme Management Unit) will be made responsible for providing mentoring support to high focus districts. These teams would be

required to travel a minimum number of days per month, and would be responsible for ensuring that each high focus district has a realistic plan and that effective implementation takes place. The district teams would need to be adequately trained and supported by checklists and supervision guidance notes.

The high focus districts will be allocated at least 30% more resources than a non-high focus state, that is, high focus districts get a weightage of 1.3 against 1 for non-high focus.

Strengthening health infrastructure

Construction of sub centres will be prioritised in high focus districts. At least 25% of all sub centres under each PHC will be made functional as delivery points in the HFDs.

Deployment of human resources and training: Underserved facilities, particularly in high focus districts, will be strengthened through contractual staff engaged under NRHM. It will be ensured that the remotest sub centres and PHCs are staffed first. The contractual HR engaged under the NRHM, that is, specialists, doctors (both MBBS and AYUSH), staff nurses and ANM will be posted to the desired extent in inaccessible/hard-to-reach areas before deploying them in better served areas. Further, CHCs in remote areas will be allocated contractual HR ahead of District Hospitals.

A shortfall in trained human resource at delivery points, particularly sub centres and those in HFDs/ tribal/remote areas will be addressed on priority.

In twelve high focus states, pre service nursing training will be planned with the State Nursing Cell, which, if not present, should be made functional at the earliest. At least one State Nodal Centre for nursing training will be planned and made functional.

The orientation on traditional life style of respective communities and trust building skill trainings will be essential for the staff that gets deployed in these areas. The recruitment of front line workers and ANMs from the same community to serve these communities would also add value in ensuring improved utilisation of RMNCH+A interventions.

Incentives for personnel in hard-to-reach areas

Provision of human resource is to be based on a gap analysis of difficult and hard-to-reach areas. A clear action plan for identified backward districts (such as difficult access, insurgency affected, minority, tribal, Scheduled Castes /Scheduled Tribes dominant etc.) and provision of special incentives to medical and para-medical staff for performing duties in such difficult areas is strongly recommended. An appropriate financial and non-financial incentive scheme for attracting qualified human resource should be worked out by states and proposed in the PIP with time-bound targets for addressing the key issues and ensuring effective adoption of RMNCH+A approach in the high need areas.

Public private partnerships

In order to reach underserved/un-served areas in order to supplement public health care delivery, RMNCH+A services can be brought in and contracted out to accredited private providers, organisations and NGOs. Also, in future there will be focus on social franchising and accreditation of private providers to provide RMNCH+A services.

Mobile Medical Units (MMU)

Till the time the health infrastructure is strengthened in underserved/un-served areas, services will be provided through Medical Mobile Units. The services through MMUs will be revamped and instead of MMUs functioning in isolation, their services will be integrated with Primary Health Care facilities and VHNDs while engaging village panchayats/communities for monitoring of services. It is proposed that the package of services to be delivered through MMUs be defined based on the local context and epidemiology and the delivery of services closely monitored. The health teams on MMUs should visit AWCs for providing services to children below 6 years of age, and the records for services thus rendered maintained at the AWC. The route chart of MMUs is to be widely publicised, GPS installed for tracking movement of vehicles and performance monitored on a monthly basis in terms of numbers of patients served and services rendered.

Maternity waiting homes

To improve access to the maternal and newborn care, including timely treatment of complications, establishment of Maternity Waiting Homes are a feasible option in some of the hard-to-reach and tribal areas. These waiting homes could be either built in the compound of an existing health facility or in close proximity of the facility. Pregnant women, specifically those diagnosed with complications, can stay in these homes before delivery and then be transferred to the facility for delivery and complication management.

Tribal Health

The states will clearly map out tribal areas and pockets which are hard to reach before planning activities for the next phase and closely monitor progress (physical, expenditure) on all health activities in notified tribal areas.

Under the NRHM, there is a provision to include specific plan and allocate budgets on a priority basis to tribal areas of the country. There are also provisions for the norms to be relaxed for ASHA recruitment, development of health infrastructure, medical mobile unit services (two units per district as compared to one for others) and performance-based incentives to doctors and staff posted in a few selected and notified tribal areas.

The communication strategies for tribal areas, considering the local context, need to be planned and scaled up. Also, convergence with other departments concerned with tribal health and development will be encouraged to improve the health and well-being of tribal and hard-to-reach communities.

Strategies for inaccessible/remote hilly areas

In hard to reach and inaccessible areas, where there is no motorable road, special transportation schemes and incentives are to be put in place for bringing pregnant women and sick neonates upto the pickup point for referral transport, situated on the nearest road head. The mode of transport could be palkis, carts etc. Through better antenatal care, that would include a more systematic planning of the delivery; it is envisaged that the transport needs will be explored and better managed as appropriate to the circumstances.

To improve access to health facilities for the pregnant women, 'birth waiting homes' are to be constructed in such areas that are within the compound of the health facility or in close proximity. The pregnant women can stay in these homes well before their 'expected date of delivery' and can be transferred to the facility once they go into labour. All pregnant women may be incentivised for staying at these facilities at least for a week before the expected date of delivery.

All suitable incentives are to be given to ANMs (SBAs) for attending home deliveries in remote and inaccessible areas.

Health of the urban poor

Urban poor, particularly the slum dwellers and other vulnerable population (such as the homeless, street children, rag pickers, temporary migrants, construction workers etc.), will receive focus through the Urban Health Mission.

Access to RMNCH+A services will be enhanced with the creation of service delivery infrastructure addressing urban health needs. These will be planned on the basis of the need assessment including spatial mapping of slums and health facilities. Efforts will be made to standardise and strengthen the existing public health institutions like the Urban Family Welfare Centres and Maternity Homes.

Urban Primary Health Centres, serving approximately 40,000–55,000 population, would be located close to slum areas and will have working hours that are suitable for a population that is busy earning livelihood during the day. In addition, 30–50 bedded Urban Community Health Centres, providing 'in patient' care in cities with population above 5 lakhs will be established as referral facilities. Public health laboratories will be strengthened for early detection of disease outbreaks in urban concentrations.

A framework for pro-poor partnerships with NGOs, charitable hospitals, private providers and public sector facilities will be provided in order to leverage their large presence in urban areas and to fill gaps in health service provisioning.

In terms of human resources, link worker/Urban Social Health Activist (USHA) will be the frontline community worker, similar to ASHA, and will serve as an effective and demand generating link between the health facilities and urban slum population. Mahila Arogya Samiti will act as community-based peer education group involved in community monitoring and referral after their capacities have been adequately built. Preventive and promotive actions will be strengthened through coordination with local urban bodies by Mahila Arogya Samitis and USHAs.

CHAPTER 12

Convergence and Partnerships

A. Convergence with on-going programmes

i. **National Vector Borne Disease Control Programme (NVBDCP):** In about 200 endemic districts, malaria is an important cause of maternal and child mortality. Linkages will be made with NVBDCP to prepare guidelines for management and control of malaria among pregnant women and children, and to ensure prevention and management of malaria among pregnant women in these districts.

ii. **National AIDS Control Programme:** Recent joint communication between NRHM and National AIDS Control Organisation (NACO) provides a platform for convergent action. The framework will be used for expanding and integrating the PMTCT services, managing sexually transmitted infections and establishing blood banks. The treatment of the woman and child with HIV will also be accorded due priority.

iii. **AYUSH:** A large number of AYUSH practitioners are untapped providers for newborn and child health care and can be suitably engaged in consultation with the Department of AYUSH. Also, AYUSH would be used to promote a healthy lifestyle in rural population. There is a ready acceptance for many of these remedies and these will be appropriately positioned in the health facilities.

iv. **National Urban Health Mission (NUHM):** Linkages with NUHM will be established to ensure that the proposed strategic directions in this document are adequately reflected in plans and actions under NUHM.

v. **PC&PNDT Act implementation:** The states may set-up an inter-departmental task force with Women and Child Development, Law and Justice, Information Technology, Panchayati Raj, Youth Affairs for an integrated approach to reverse the decline in child sex ratio.

vi. **Adolescent health:** An active participation from key stakeholders beyond the health sector such as education, social welfare and use of existing common platforms are crucial for implementing this preventive and progressive adolescent health strategy. Much of the convergence framework is already part of the NRHM framework. A convergence among various programmes within MoHFW, including the existing adolescent health strategy, school health, adolescent education programme(AEP) of NACO, mental health and anaemia control initiatives, schemes of Ministry of Women and Child Development, Ministry of Youth and Sports Affairs as well as Ministry of Human Resource Development can prove helpful in providing comprehensive services to this age group. In terms of specific schemes, SABLA or Rajiv Gandhi Scheme for Empowerment of Adolescent Girls offers an excellent opportunity to converge and address the multi-dimensional concerns of adolescent girls. The SABLA scheme is implemented across the country, using the platform of ICDS. The objectives of the enabling self-development and empowerment of

adolescent girls, improving their nutrition and health status, spreading awareness about health, hygiene, nutrition and Adolescent Reproductive and Sexual Health (ARSH) are issues common to Ministry of Health & Family Welfare.

The Ministry of Women and Child Development has also decided to launch a scheme called Saksham to empower adolescent boys by educating them on gender sensitivity and moral behaviour. Saksham aims to target young boys, in the age group 10–18 years, for their holistic development by giving lessons in gender sensitivity and inculcating in them respect for women. Both these schemes should be leveraged to reach out to adolescent boys and girls with appropriate information and messages on RMNCH+A and to mobilise them to adolescent health services, where utilisation of existing facilities remains a major bottleneck.

vii. **Maternal and child nutrition:** Linkages with ICDS are integral to RMNCH+A approach, where nutrition and early child development are integral to child survival and maternal health. The IMNCI and VHNDs already provide platforms for convergence of programmes for adolescents, women and child nutrition, micronutrient supplementation and promotive health services. The states will be encouraged to take measures to have the ICDS and health areas co-terminous.

One major area of synergy is to establish the programme for community-based management of children with severe acute malnutrition. Another area is the active prevention of malnutrition in children through home visits and AWCs, where both ASHA and AWW must act in synergy.

In addition, counselling and treatment for pregnancy anaemia, promotion of early initiation and exclusive breast feeding, and complementary feeding practices will be the areas that will need common approaches and integration among the departments at all levels of the health system. These integrations will be reflected in programme tools, guidelines, implementation plans and monitoring and evaluation frameworks.

viii. **Inter-sectoral coordination:** Appropriate linkages will be established with other sectors and programmes such as the Total Sanitation Campaign (Nirmal Bharat Abhiyan) for the prevention of anaemia and diarrhoeal diseases; National Rural Employment Guarantee Scheme (for enabling environment to promote breastfeeding and secure food security entitlements); maternity entitlements like IGMSY (Indira Gandhi Matritva Suraksha Yojana) under the Ministry of Women and Child Development, School Health Programme with Departments of Education and Departments of Rural Development. A linkage with the Ministry of Tribal Affairs is important for reaching out to tribal dominant blocks and districts and developing Tribal Health Plan for these areas. The detailed plans will be worked out in consultation with these key ministries.

ix. Linkages with disaster management authorities to extend support to women and children who become especially vulnerable in the event of a man made or natural disaster should be considered. The states and union territories should take stock of key measures to be undertaken in such a situation and preparedness should be tested periodically.

B. Partnerships

Partnerships with a wide range of stakeholders will be strengthened in order to achieve public health goals and to make services available to all, particularly to the under-served segments of the population. The corporate sector with their techno-managerial expertise as well as expertise on innovation and research can partner to bring further improvement in service delivery and also support in augmenting the health system. The professional bodies like the Indian Academy of Paediatrics (IAP), Federation of Obstetric and Gynaecological Societies of India (FOGSI), Indian Association of Preventive and Social Medicine (IAPSM), Indian Medical Association (IMA) to name a few can play a key role in advancing knowledge, and the study and practice of evidence-based interventions, and also in assisting the government in training human resource for health in the public health system. The accredited private providers can play a critical role in gap filling of essential RMNCH+A services, including comprehensive abortion care, family planning procedures and emergency obstetric care.

The development partners will continue to play an important role in the generation and dissemination of evidence-based best practices, providing technical assistance at national and sub national level, harmonisation of standards and guidelines, bringing greater programme accountability and enhancing learning opportunities through assistance for data collection, analysis, reporting and use of programme data, joint programme monitoring and tracking of progress, and providing access to expert resources and facilitating convergence across sectors. However, the critical aspect is bringing harmony and synergy between the efforts of partner agencies and the government, both at central and state level by clearly defining the key thematic and geographical areas in which individual agencies would specifically contribute. The technical partners can further support integrated programme implementation and monitoring in selected districts. The development partners could also establish partnership with public health institutions and newly established AIIMS, which the Government of India is setting up as technical hub institutions, by bringing in high order technical expertise and strengthening them in an area where the partners have expertise.

The NGOs have a significant role in addressing gaps in information and spreading awareness about RMNCH+A services, especially in the underserved and un-served areas, to facilitate communitisation processes, address social determinants of health, undertake local advocacy and facilitate interface between community and the local government.

With its innovation capabilities, resources and potential for commercial success, the private sector is an important partner in contributing to achievement of the health goals. The private sector has a crucial role to play in ensuring that affordable products and services of quality can reach the hardest to reach for achieving results with equity.

Public and corporate sectors can play innovative roles in financing and providing healthcare services. Active engagement by corporates, both philanthropically and through the core business and Corporate Social Responsibility (CSR) initiatives, is to be explored for bringing collective impact to reduce maternal and child mortality rates further in India.

CHAPTER 13

Technical Support for RMNCH+A Service Delivery

To provide technical support for the generation of new evidence, synthesis of available evidence, capacity building, programme monitoring, effective use of technology, following institutional mechanisms will be set up at the national level:

Technical Support Unit (TSU) within Ministry of Health and Family Welfare (MOHFW): The TSU, like the one for immunisation, will be set up within MOHFW to support monitoring, management and coordination functions.

National Child Health Resource Centre: The centre will act as a repository of all technical and programmatic guidelines, documents and reports on child health and development. The centre will also support the RCH Division on preparation and dissemination of programmatic guidelines.

Regional Collaborative Centres for reproductive, maternal, newborn child and adolescent health: These centres will be created, starting first in the high priority states, to provide support to the states in areas of capacity building, research, programme monitoring and mentoring for RMNCH+A.

In addition to the above, technical support will be drawn from National Health System Resource Centre, National Institute of Health and Family Welfare, National and Regional Collaborative Centres for facility-based newborn care, existing centres of excellence such as All India Institute of Medical Sciences, regional AIIMS like institutions, development partners and professional organizations.

The expertise available within centres of excellence and medical colleges will also be drawn upon for extending technical and mentoring support to the state RCH programme.

RMNCHA Coalition: The RMNCHA Coalition will proactively engage with the RMNCH efforts of the Global Strategy for Women and Children's Health and the Independent Review Group. In addition, it will also undertake capacity building in resource tracking and policy analysis, development of online communication platforms, workshops and meetings to promote cross sectored engagement, training in media and communication skills and message development, development and translation of policy briefs and support to the government for preparing various reports and documents on this matter.

'India Call to Action' on child survival and development: The partners supporting the India Call to Action in 2013 will continue to follow on commitments made by stakeholders and provide technical support both at national level and in priority states and districts. They will also facilitate in supporting communication progress on maternal and child health and survival.

Consortium for operations research on maternal and child health: The consortium will provide a single window for operations research and evidence synthesis on issues related to maternal and child health. In response to specific needs, the consortium will also conduct evidence review, coordinate operations research (including cost-effectiveness analysis), and provide synthesised evidence on 'what works' to enhance policies and programmes. The consortium will have a transparent mechanism to generate and synthesise evidence.

Technical Resource Groups (TRGs): These groups will be constituted for bringing in necessary expertise and support on thematic areas. A number of TRGs are already in place by order of MOHFW and they will be adequately represented in other advisory bodies like the RMNCH+A coalition.

Annexure

ANNEXURE 1: Evidence based interventions across the continuum of care

Continuum of care	Adolescence and pre-pregnancy	Pregnancy (antenatal)	Childbirth
Community Strategies	• Preventive health check-ups in school • Weekly iron and folic acid supplementation for adolescent boys and girls • Promotion of menstrual hygiene amongst adolescent girls (Information and supplies) • Information and BCC on key adolescent health issues	• Iron and folic acid supplementation • Tetanus vaccination • Tracking of pregnant women with severe anaemia and case management • Birth preparedness and complication readiness	• Skilled birth attendance for home deliveries in difficult, hard-to-reach areas • Promotion of immediate and routine newborn care comprising immediate drying, warming, skin to skin contact and initiation of breast feeding within one hour after delivery.
Primary	• Provision of adolescent friendly reproductive and sexual health information, counselling , services and supplies. • Provision of iron and folic acid tablets	• All the above, plus • Testing for HIV • Treat maternal anaemia • Management of STI/RTI	• All the above, plus • Care during labour and delivery • including identification of maternal and newborn complications and timely referral • Newborn resuscitation
First Referral	• All the above, plus: • Access to Safe abortion and post abortion care	• All the above, plus: • Management of high blood pressure and preeclampsia • Access to safe abortion services • Treatment of complications of spontaneous/unsafe abortions	• All the above, plus: • Caesarean section • Emergency obstetric and neonatal care including Caesarean section
Higher Referral and Tertiary		• All the above, plus • PPTCT	• All the above
All Levels: **Community** **Primary** **Referral**	• Information and counselling on sexual reproductive health concerns • Family planning advice, services and supplies • STI/HIV prevention information, counselling & services • Peri-conceptional Folate supplementation	• Essential preventive and promotive care during pregnancy (antenatal care, nutrition counselling,birth preparedness)	

Postnatal (mother)	Postnatal (newborn)	Infancy & childhood
• Home-based postnatal care and support for breast feeding • Detection and management of postpartum sepsis and other complications	• Home-based newborn care till six weeks • Identification and prompt referral of 'at risk' and 'sick' newborn • Presumptive antibiotic therapy for newborns at risk of bacterial infection	• Screening for disease, deficiency and disability, and referral through preventive health check-ups in school • Vitamin A supplementation from 6 months to 5 years of age • Iron and folic acid supplementation from 6 months to 5 years of age • Deworming twice a year for children 1–5 years • Pulse polio rounds for children up to five years • Second dose of measles vaccine (SIA: Supplementary Immunisation Activity) • Community based management of common neonatal and childhood illnesses • Follow up of children with low birth weight • Identification of children with severe acute malnutrition
• Postpartum care (at a health facility for 48 hours)	• Neonatal resuscitation with bag and mask • Essential newborn care	• Outpatient clinical services for common childhood illnesses
• Management of postpartum sepsis and other complications, including postpartum haemorrhage and pregnancy induced hypertension	• Management of low birth weight babies (with no other complications) • Phototherapy • Management of newborn sepsis • Stabilisation and referral of sick newborns and those with very low birth weight	• Facility based management of childhood illnesses (including case management of childhood pneumonia and diarrhoea) • Management of children with severe acute malnutrition (depending on the availability of Nutrition Rehabilitation Centres)
• Screen for and initiate or continue anti-retroviral therapy for HIV	• Managing low birth weight babies (< 1800 gms) • Managing all sick newborns • Follow up of babies discharged from the special newborn unit and high risk newborns	• Management of children with severe acute malnutrition • Paediatric anti-retroviral therapy
• Post-partum family planning advice and provision of contraceptives • Nutrition counselling	• Immediate thermal care (to keep the baby warm) • Initiation of early breast feeding (within the first hour) • Hygienic cord and skin care • Early initiation of breast feeding • Weighing of the newborn • Breast feeding support • Immunisation services • Birth registration • Early Childhood Development	• Promotion of Infant and young child feeding practices • Routine Immunisation against seven childhood preventable diseases (Diphtheria, Pertussis, Tetanus, Tuberculosis, Polio, Hepatitis B, H influenza) • Use of ORS and Zinc for diarrhoea • Early Childhood Development

ANNEXURE 2: Score Card

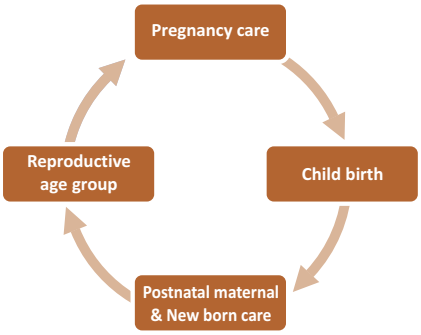
Methodology

HMIS-based dashboard monitoring system:

- Choice of Indicators for dashboard monitoring system are based on life cycle approach:

Proportion of:
- 1st Trimester registration to total ANC registration
- Pregnant women received 3 ANC to total ANC registration
- Pregnant women given 100 IFA to total ANC registration
- Cases of pregnant women with Obstetric Complications and attended to reported deliveries
- Pregnant women receiving TT2 or Booster to total ANC registration

Proportion of:
- Post-partum sterilization to total female sterilization
- Male sterilization to total sterilization
- IUD insertions in public plus private accredited institutions to all family planning methods (IUD plus permanent)

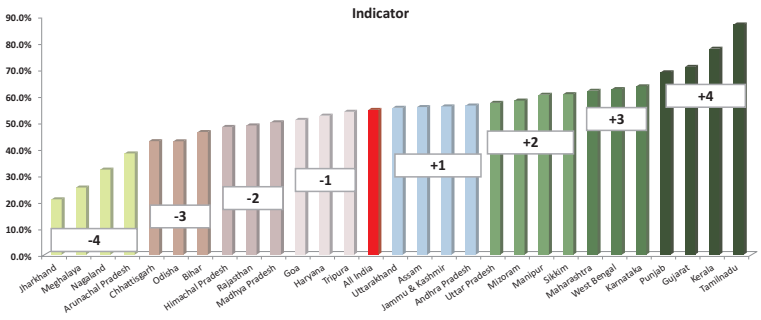


Proportion of:
- SBA attended home deliveries to total reported home deliveries
- Institutional deliveries to total ANC registration
- C-Section to reported deliveries

Proportion of:
- Newborns breast fed within 1 hour to total live births
- Women discharged in less than 48 hours of delivery in public institutions to total number of deliveries in public institutions
- Newborns weighing less than 2.5 kg to newborns weighed at birth
- Newborns visited within 24hrs of home delivery to total reported home deliveries
- Infants 0 to 11 months old who received Measles vaccine to reported live births

- Steps underway to include proportion
  - Pregnant women <19 yrs old to total women registered for ANC
  - Home Based New born Care (HBNC) visit by ASHA to planned visits
  - Children 9–11 months fully immunised to children 9–11 months due for immunisation
  - Children with diarrhoea who were treated with ORS to children reported with diarrhoea
  - Children with diarrhoea who were treated with ORS and Zinc to children reported with diarrhoea
  - Children discharged live from SNCUs to number of admissions in SNCUs
  - Children with ARI who received treatment to children reported with ARI
- All India average for each indicator will be taken as the reference point
- States scores will be determined on the basis of the national average:
  - Positive scores from 1 to 4 for those above the national average (for positive indicators) and for those below the national average (for negative indicators).
  - Negative scores -1 to -4 for those below national average (for positive indicators) and for those above national average (for negative indicators).
- All the indicator scores for each state will be consolidated as state score (all indicators have the same weightage)

- States have been classified into four categories based on the state scores (based on four quartiles)
- Inconsistent data have been deleted from the score sheet and states have been given negative score for the indicator
- The quarterly dashboard monitoring system at national level will be compiled in the month following the quarter. States commit their HMIS data within three weeks following a quarter.



- Each state undertakes a similar exercise for all their districts.

Survey based score card

- 19 survey based outcome and coverage indicators related to health, nutrition and sanitation will be used for the score card.
- Latest available data from national surveys will be taken into consideration including Sample Registration System, Coverage Evaluation Survey, District Level Household and Facility Survey, National Family Health Survey, Census, Annual Health Survey.
- All India average for each indicator will be taken as a reference point. States will be colour coded based on:
  - Mortality Indicators, Nutrition, Fertility: Green – Less than 20% of the national average, Yellow– 20% below and above national average, Red– More than 20% of the national average
  - Remaining Indicators: Green – More than 20% of the national average, Yellow – 20% below and above the national average, Red – Less than 20% of the national average
- The scorecard will be updated as and when (every 1–2 years) new survey data is available.

Indicators for survey based score card	
Mortality	• Under-five mortality rate • Infant mortality rate • Neonatal mortality rate • Maternal mortality ratio (per 100,000 live births)
Fertility	• Total Fertility Rate • Births to women during age 15–19 out of total births
Nutrition	• Children with birth weight less than 2.5 Kg • Children under 3 years who are underweight
Gender	• Child sex ratio 0–6
Cross-cutting	• Full Immunization • Children (12-23 months) receiving • 1 dose BCG, 3 doses of DPT/OPV • Each and 1 measles vaccine • Household having access to toilet facility • Couple using spacing method for more than 6 months
Diarrhoea	• ORT or Increased Fluids for Diarrhoea • (Among children <2 year of age • who had diarrhoea in preceeding • 2 weeks)
Pneu-monia	• Care Seeking for ARI in any health facility • (Among children <2 year of age who • had ARI in preceding 2 weeks)
Service Delivery	• Woman who received 4+ ANC • Skilled Birth Attendance (Delivery by Doctor, ANM/Nurse/LHV) • Mothers who received postnatal care from a doctor/nurse/LHV/ANM/other health • personnel within 2 days of delivery for their last birth (%) • Early Initiation of Breast Feeding (<1hr) • Exclusive Breast feeding for 6 months (among 6–9 months children)

ANNEXURE 3: List of published documents (guidelines/training manuals) on RMHCH+A

S. No.	Manual/Guideline	Date/Year of Publication	Language
	Family planning		
1	Contraceptive Update Manual for Doctors	October 2005	English
2	Contraceptive Updates Facilitator's Guide	October 2005	English
3	Manual on Standards in Female and Male Sterilization	October 2006	English
4	Manual on Quality Assurance in Sterilization	October 2006	English
5	Reference Manual on IUCD for MOs	July 2007	English
6	Reference Manual on IUCD for Nursing Personnel	December 2007	English and Hindi
7	Standard Operating Procedures (SOP) for Sterilization in Camps	March 2008	English
8	Operational Guidelines on FDS (Fixed Day Static) Approach for Sterilization Services	November 2008	English
9	Guidelines on Emergency Contraceptive Pill	November 2008	English
10	Repositioning IUCD in the Family Welfare Programme	2008	English
11	Reference Manual on Minilap	November 2009	English
12	Clinical Skill Building Guidelines on Male & Female Sterilization	July 2009	English
13	Guidelines for Training in Sterilization	March 2010	English
14	PPIUCD Reference Manual	November 2010	English and Hindi
15	PPIUCD & PPFP Counseling Manual & Note-book	January 2012	English and Hindi
16	Booklet on FP – "Loving Couples – Healthy Couples"	October 2012	English and Hindi
17	Hand-book for RMNCH/ FP Counselors	October 2012	English and Hindi
	Maternal Health		
18	Setting up Blood Storage Units	2003	English
19	Operationalization of FRUs	2004	English
20	Operational Guideline for Conducting Anaesthesia Training(LSAS) for Medical Officers	2004	English
21	Operationalization of 24 X 7 PHCs	2005	English
22	VHND Guidelines.	2007	English
23	Operational Guidelines for Conducting SBA Training.	2008	English
24	National Guidelines on Management of RTIs/STIs	2008	English
25	Trainee's Handbook for Training of Medical Officers in Pregnancy Care and Management of Common Obstetric Complications	August 2009	English
26	Workbook for Training of Medical Officers in Pregnancy Care and Management of Common Obstetric Complications	August 2009	English
27	Trainer's Guide for Training of Medical Officers in Pregnancy Care and Management of Common Obstetric Complications	August 2009	English
28	Guidelines for Accreditation of Private Health Facilities in Providing SBA Training	August 2009	English
29	Guidelines for Antenatal Care and Skilled Attendance at Birth by ANMs/SNs/LHVs (SBA)	April 2010	English
30	Handbook for ANMs/SNs/LHVs as SBA	April 2010	English
31	Trainer's Guide for Conducting Training of ANMs/SNs/LHVs as SBA	April 2010	English

S. No.	Manual/Guideline	Date/Year of Publication	Language
32	Comprehensive Abortion Care Training and Service Delivery Guidelines	2010	English
33	Guidelines for Accreditation of Private Health Facilities for Providing RCH Services	April 2010	English
34	Joint MCP Card	April 2010	English
35	Maternal Death Review Guide Book	2010	English
36	SBA Training Videos	2010	Hindi
37	My Safe Motherhood Booklet for Expecting Mothers	2010	English and Hindi
38	SBA quality protocols posters (set of 16 posters)	2011	English
39	EmOC Protocol Posters	2011	English
40	Training of Medical Officers to Deliver STI/RTI Services – Participants' Handout	May 2011	English
41	Training of Doctors to Deliver STI/RTI Services – Resource Material for Trainers	May 2011	English
42	Operational Guidelines for Programme Managers and Service Providers for Strengthening STI/RTI Services	May 2011	English
43	Training of Nursing Personnel to Deliver STI/RTI Services – Facilitators' Guide	May 2011	English
44	Training of Nursing Personnel to Deliver STI/RTI services – Participants' Handout	May 2011	English
45	Training of Laboratory Technicians to Deliver STI/RTI Services – Facilitators' Guide	May 2011	English
46	Training of Laboratory Technicians to Deliver STI/RTI Services – Participants' Handout	May 2011	English
47	Guidelines for Janani Shishu Suraksha Karyakaram (JSSK)	June 2011	English
48	Strengthening Pre-Service Education for the Nursing and Midwifery Cadre in India	December 2012	English
49	16 Weeks EmOC Training Guide for Coordinators	January 2013	English
50	16 Weeks EmOC Training Course Curriculum (for Trainers and Trainees)	January 2013	English
51	16 Weeks EMOC Trainer's Resource Package	January 2013	English
52	16 Weeks EmOC Trainee's Resource Package	January 2013	English
53	16 weeks EmOC Trainee's Log Book/Work Book	January 2013	English
54	16 Weeks EmOC Training Guide for Coordinators	January 2013	English
55	16 Weeks EmOC Training Course Curriculum (for Trainers and Trainees)	January 2013	English
56	Guidelines for Pregnancy Care and Management of Common Obstetric Complications by MOs	January 2013	English
57	Skills Lab for RMNCH Services: Operational Guidelines	February 2013	English
58	Maternal & Newborn Health Toolkit	February 2013	English
	Adolescent health		
59	Implementation Guide on RCH-II : Adolescent Reproductive & Sexual Health Strategy	April 2006	English
60	Orientation Programme for Medical Officers to Provide Adolescent Friendly Reproductive & Sexual Health Services: Facilitators' Guide	2006	English and Hindi

S. No.	Manual/Guideline	Date/Year of Publication	Language
61	Orientation Programme for Medical Officers to Provide Adolescent Friendly Reproductive & Sexual Health Services: Hand-outs	2006	English and Hindi
62	Orientation Programme for ANMs/LHVs to Provide Adolescent Friendly Reproductive & Sexual Health Services: Facilitators' Guide	2006	English and Hindi
63	Orientation Programme for ANMs/LHVs to Provide Adolescent Friendly Reproductive & Sexual Health Services: Hand-outs	2006	English and Hindi
64	Operational Guidelines for Menstrual Hygiene	2011	English and Hindi
65	Training Module for ASHA on Menstrual Hygiene	2011	English and Hindi
66	Flip Book for Menstrual Hygiene	2011	English and Hindi
67	Menstrual Hygiene – Reading material for ASHAs	2011	English and Hindi
68	Operational Framework for Weekly Iron and Folic Supplementation Programme	June 2012	English
69	Guide for Training Master Trainers on Weekly Iron and Folic Acid Supplementation Programme	July 2012	English
70	Operational Guidelines for School Based WIFS Programme	July 2012	English
71	Operational Guidelines for ICDS Based WIFS Programme	July 2012	English
72	Technical Handbook on Anaemia	July 2012	English
73	Hand-out for Children (WIFS)	August 2012	English
74	Nutrition and Health Education Session Guide	August 2012	English
75	National iron +Initiative: Guidelines for Control of Iron Deficiency Anaemia	2013	English
	Immunisation		
76	Investigation of outbreaks of Vaccine Preventable Diseases	1988	English
77	Operational Guidelines for Mopping up Immunization	2004	English
78	Field Guide – Measles Surveillance & Outbreak Investigation	2005	English
79	Field Guide – Surveillance of Acute Flaccid Paralysis	2005	English
80	Guidelines for Reporting and Management of AEFIs	2005	English
81	Standard Operating Procedures for Investigation of AEFI		English
82	Measles Mortality Reduction India Strategic Plan 2005–2010	2005	English
83	Immunization Handbook for Health Workers	2006	English
84	Facilitators' Guide – Immunization Handbook	2006	English
85	Pulse Polio Immunization Programme – Operational Guidelines	2006	English
86	Operational Guidelines for Hepatitis B	2009	English
87	JE Vaccination in India – Operational Guidelines	2010	English
88	AEFI Surveillance and Response – Operational Guidelines	2010	English
89	Training Module for Vaccinators – Japanese Encephalitis – 2005-2010	2010	English
90	Measles Catch-up Immunization Campaign – Guidelines	2010	English
91	Immunization Handbook for Medical Officers	2010	English
92	Handbook for Vaccine and Cold Chain handlers	2011	English and Hindi
93	Operational Guidelines – Introduction of Hib as Pentavalent Vaccine in UIP in India	2011	English
94	National Vaccine Policy	2011	English

S. No.	Manual/Guideline	Date/Year of Publication	Language
95	Intensification of Routine Immunization – Communication, Operational and Technical Guidelines	2012	English
96	Training Guide for National Cold Chain management Information System	2012	English
97	Immunization Infokits for Health Workers	2012	Hindi
98	Immunization Infokits for ASHAs and Anganwadi Workers	2012	Hindi
99	Facilitators' Guide – Intensified Training of Frontline Workers	2012	English
100	Intensification of RI Communication , Operational and Technical Guidelines	2012	English
101	Immunization Guide for Block Programme Managers	2012	English
102	Year of Intensification of RI (2012–13) Ready Reference Guide	2012	English
103	Year of Intensification of RI (2012–13) Ready Reference Guide	2012	Hindi
104	Routine Immunization Monitoring Formats	2012	English
	Newborn and Child health		
105	Navjaat Shishu Suraksha Karyakram – Basic Newborn Care and Resuscitation Program: Training Manual	2009	English and Hindi
106	Navjaat Shishu Suraksha Karyakram – Basic Newborn Care and Resuscitation Program: Facilitator's Guide	2009	English
107	Facility Based IMNCI (F-IMNCI): Facilitators' Guide	2009	English
108	Facility Based IMNCI (F-IMNCI): Participants' Manual	2009	English
109	Operational Guidelines for Facility Based Integrated Management of Neonatal and Childhood illnesses		English
110	Operational Guidelines for Integrated Management of Neonatal and Childhood illnesses		English
111	Home Based Newborn Care Operational Guidelines	2011	Hindi and English
112	Operational Guidelines for Management of Children with Severe Acute Malnutrition	2011	English
113	Facility Based Newborn Care Operational Guide	2011	English
114	Operational Guidelines on Facility Based Management Of Children With Severe Acute Malnutrition	2011	English
115	Guidelines for Enhancing Optimal Infant And Young Child Feeding Practices Through the Health System	2013	English
	PC&PNDT Act		
116	Handbook on Preconception & Prenatal Diagnostic Techniques Act, 1994 and Rules with Amendment	2006	English

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