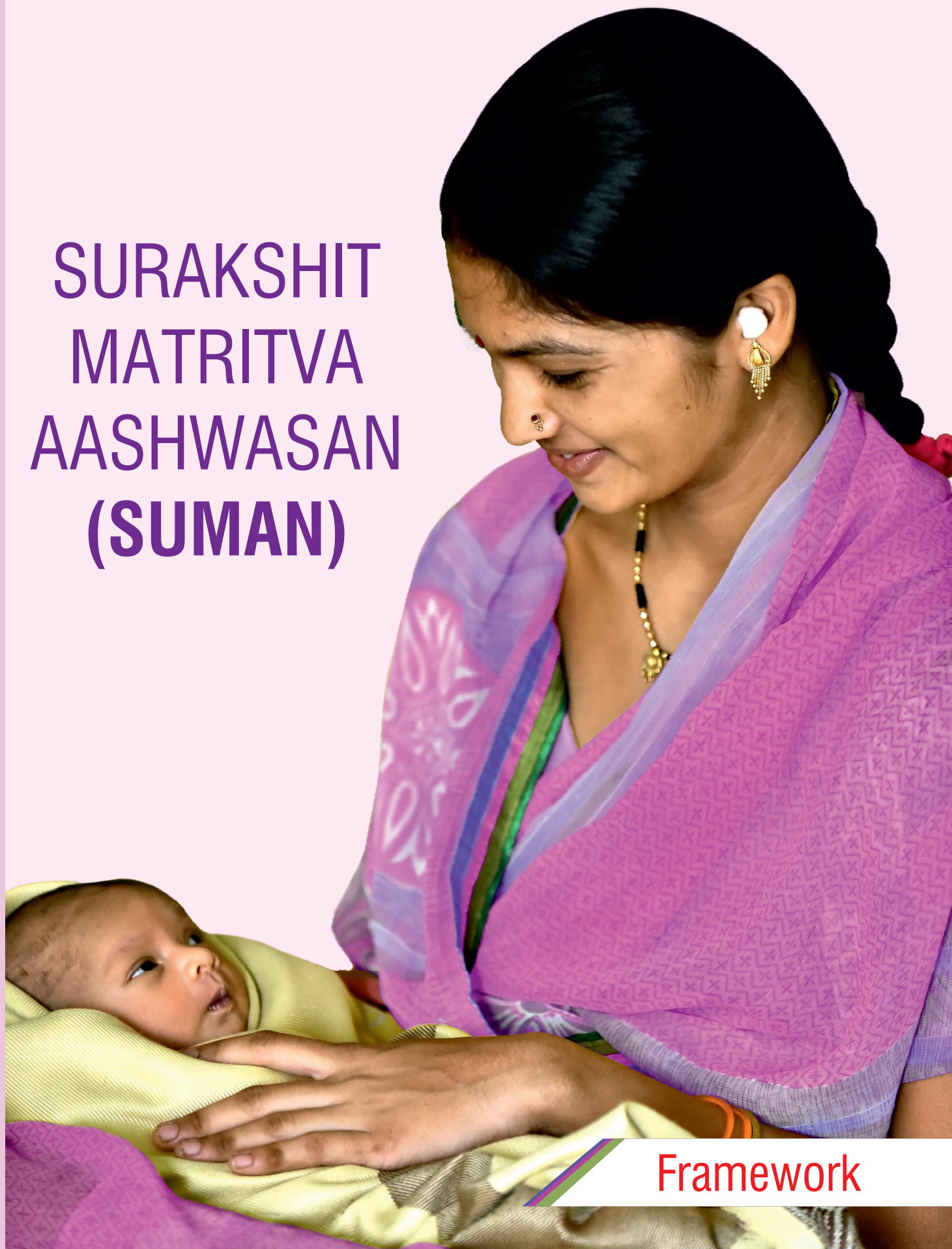


SURAKSHIT MATRITVA AASHWASAN (SUMAN)



Framework

SURAKSHIT MATRITVA AASHWASAN (SUMAN)



Framework



सबका साथ, सबका विकास, सबका विश्वास
Sabka Saath, Sabka Vikas, Sabka Vishwas



डॉ हर्ष वर्धन Dr Harsh Vardhan

स्वास्थ्य एवं परिवार कल्याण, विज्ञान और प्रौद्योगिकी
व पृथ्वी विज्ञान मंत्री, भारत सरकार

Union Minister for Health & Family Welfare,
Science & Technology and Earth Sciences
Government of India



Preface

We have made unprecedented progress in India when it comes to maternal health. Our Maternal Mortality Ratio (MMR) has fallen faster than the global decline. The compound annual rate of decline of MMR has increased significantly and India's current rate of MMR decline puts the country well on track to achieve the Sustainable Development Goal 3 (SDG 3) target of MMR below 70 by 2030.

2. Our government is committed to and is serious about improving the wellbeing of mothers, infants, and children and this has been an important public health goal. We, thus, want to go one step beyond the commitments under the SDGs. Evidences and deliberations with experts indicate that it is possible to end all preventable maternal and new-born deaths by ensuring that quality and comprehensive emergency obstetric and neonatal care is offered with zero expense to the women accessing health services at our health facilities. **Surakshit Matritva Aashwasan (SUMAN)** initiative is a commitment of the government for providing quality maternal & infant care services without any out of pocket expenditure for the beneficiaries. It has one goal, '**end all preventable Maternal & Neonatal deaths**'. I am sure that the initiative will be able to provide dignified, respectful and quality health care services to the mothers and infants and ensure a positive birth experience.

3. I would like to thank the Ministry officials for preparing the guidelines in a very short time, defining clear and articulated roles for various stakeholders, including PRIs and community. I am also sure that the States will find it useful in implementing the initiative and taking time-bound actions to ensure that the commitments made under SUMAN are fulfilled.

(Dr. Harsh Vardhan)

New Delhi, Nov. 13, 2019.

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सत्यमेव जयते

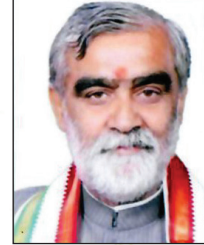
सर्वेसन्तु निरामया



एक कदम स्वच्छता की ओर

Foreword

स्वास्थ्य एवं परिवार कल्याण राज्य मंत्री
भारत सरकार
MINISTER OF STATE FOR
HEALTH & FAMILY WELFARE
GOVERNMENT OF INDIA



Improving the well-being of mothers, infants and children has been an important public health goal for all welfare societies and governments. Their well-being also determines the health and productivity of the next generation.

Under National Health Mission (NHM), India has made a concerted push to increase access to quality maternal and newborn health services and reduce the numerically large number of preventable, neonatal and infant deaths. Initiatives under Ayushman Bharat, IPHS, LaQshya have helped community in accessing various maternal and child health services at public health facilities.

Despite improvement in access, the reports from field indicated the need to focus on zero expense, high quality and respectful delivery services. The Government of India has thus framed a policy that is comprehensive, multi-pronged and integrated to ensure assured & free of cost service delivery. I am glad that the Ministry has taken initiative to convert the policy into action under the Surakshit Matritva Aashwasan (SUMAN) initiative that provides access to quality obstetric and newborn care to every pregnant woman & her child visiting public health facilities.

I believe that this initiative will go a long way in ending all preventable maternal and neonatal deaths in the country & make birthing a pleasant experience for all the women irrespective of their backgrounds.

(Ashwini Kumar Choubey)



प्रीति सूदन

सचिव

PREETI SUDAN

Secretary



भारत सरकार
स्वास्थ्य एवं परिवार कल्याण विभाग
स्वास्थ्य एवं परिवार कल्याण मंत्रालय

Government of India
Department of Health and Family Welfare
Ministry of Health & Family Welfare

Dated : 13th November, 2019



FOREWORD

A healthy woman forms the cornerstone of a healthy, dynamic and progressive nation. It is well-known that the health, nutrition and mental well-being of the pregnant mother have direct impact on the cognitive & physical development of her baby. Thus, it is important that care during pregnancy and child-birth should be optimal and delivered with respect and dignity.

Globally, India was one of the first countries to launch RMNCH + A programme under the umbrella of NHM to ensure continuum of care. Initiatives like PMSMA and LaQshya certification helped in improving the quality of care during ante-partum, intra-partum & post-partum period.

Various incentives and entitlements helped in reducing the expenses incurred by the beneficiaries at government health facilities. However, people accessing public health facilities (PHFs) still face challenges in getting complete and comprehensive care during pregnancy and childbirth and incur significant Out of pocket expenses (OOPEs).

Surakshit Matritva Aashwasan (SUMAN) has been launched with a vision to end all preventable maternal and neonatal deaths. SUMAN provides a platform for guaranteed access to good quality maternal and infant care services. There is zero tolerance for any negligence or denial of services defined in the guideline to any woman visiting public health facilities.

I am sure this guideline will help the states in planning and operationalizing safe motherhood services to ensure dignified and respectful care to the women seeking services at public health facilities.

(Preeti Sudan)

वन्दना गुरनानी, भा.प्र.से.

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FOREWORD

With concerted efforts made under RMNCH+A, India has made remarkable progress in the maternal & child health field. However, India still accounts for 12% of global maternal deaths. We have been able to increase our footfalls in government health facilities and various initiatives under NHM helped in improving the institutional delivery rate from 38.7% in NFHS-3 to 78.9% in NFHS-4.

Nevertheless, we still have a long way to go with regards to ensuring quality in service delivery. Similarly, assured delivery of services and assured management of complications without any expense to the family along with respect for women's autonomy, dignity, feelings, choices and preferences still remains a challenge.

Firm implementation of the programs is exactly what is needed to make further gains and achieve SDG targets. *Surakshit Matritva Aashwasan (SUMAN)* is a unique initiative by the GOI that focuses on assured delivery of maternal and new-born healthcare services encompassing uniform and free of cost access to quality care services with zero tolerance for denial of services, management of complications, assured referral support and commitment for respecting a woman's autonomy, dignity, feelings, choices and preferences during pregnancy and child birth.

I thank Ms. Preeti Sudan, Secretary, H& FW and Mr. Manoj Jhalani, SS& MD NHM for their continuous guidance and support in designing this initiative. The contribution and efforts of Maternal Health division of NHM and NHSRC are noteworthy in drafting this guideline based on wide range of deliberations and consultations with partner organizations.

(Vandana Gurnani)



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FOREWORD

Not just care, but quality care with respect and dignity must be the goal that we must pursue. This is particularly true when it comes to care provided to pregnant women and infants in the public health system. Improving the health and survival of mothers and infants and moving beyond institutional deliveries to a positive pregnancy experience is the need of the hour.

Surakshit Matritiva Aashwasan (SUMAN) is a critical initiative in this direction. It focuses not only on ending preventable maternal and neonatal mortality but also on humanizing birth. Several strategies have been envisaged, for operationalizing the service guarantee under the SUMAN initiative namely improving accountability through a robust grievance redressal mechanism and a client feedback mechanism, special focus on community engagement and maternal death reporting and review, a mega IEC/ BCC campaign on zero preventable maternal and newborn deaths and intersectoral convergence.

I hope that these guidelines inspire the health system to make every effort in order to realize the aspirations and dreams of each and every mother in the country.

7
13/11/2019

(Dr. Manohar Agnani)



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GOVERNMENT OF INDIA
MINISTRY OF HEALTH & FAMILY WELFARE
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Foreword

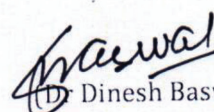
Pregnancy, birth and the postpartum period are milestone events in the continuum of life. These experiences profoundly affect women, babies and their families and have an important and long lasting effect on the society

The World Health Organization (WHO) defines Quality of Care for mothers and newborns as "the extent to which health care services provided to individuals and patient populations improve required health indicators. In order to achieve this, health care must be safe, effective, timely, efficient, equitable and people-centered."

SUMAN aims that every woman visiting a public health facility during her pregnancy and post-partum period gets assured, respectful, cashless and quality health care services with zero tolerance for any negligence or denial of services. I hope this initiative is able to ensure high quality maternity care to every woman with dignity and respect and end all preventable maternal early new-born deaths.

I would like to extend my sincere thanks to Ms. Preeti Sudan- Secretary (H&FW), Mr. Manoj Jhalani - Special Secretary, Ms. Vandana Gurnani - AS & MD (NHM) and Dr. Manohar Agnani - JS (RCH) for their continuous support and guidance. I would also like to thank Dr. Himanshu Bhushan, Dr. Kalpana and other team members from NHSRC.

Support given by partners like UNICEF, BMGF, WHO, Jhpiego, USAID, IPE-Global, PATH, C3, WRA and others is highly appreciated. My special thanks to Dr. Teja Ram, Dr. Salima Bhatia, Dr. Narender Goswami and Dr. Santosh Ojha for their valuable contributions.


13.10.19
(D) Dinesh Baswal

Healthy Village, Healthy Nation



एड्स - जानकारी ही बचाव है
Talking about AIDS is taking care of each other



Serial No.	TABLE OF CONTENT	Page No.
1	Introduction	1
2	Vision, Goal & Aim	4
	Conceptual Framework for SUMAN	5
3	Objectives	6
4	Guiding principles	7
5	Eligibility criteria	7
	Service Guarantee Charter & Entitlements under the Initiative	8
6	Benefits of Initiative	9
7	Operational Framework	15
8	Planning and preparatory activities	16
9	Institutional framework	16
10	Community linkages and support	26
11	Reporting and review of maternal deaths	29
12	IEC and communication	30
13	Creating web portal for generating data	31
14	Linkages with existing programs	32
15	Quality assurance in Maternal Health	32
16	Roles and responsibilities of program officers	33
17	Monitoring and supervision	33
18	Responsive call center	34
19	Dignity , respect and support to service providers	37
21	Annexure (A-F)	38



INTRODUCTION

Improving the well-being of mothers, infants and children has been an important public health goal for all welfare societies and governments. Their well-being also determines the health and productivity of the next generation. A healthy woman forms the cornerstone of a healthy, dynamic and progressive nation. Studies have shown that both cognitive and physical development of infants and children are influenced by the health, nutrition and behavior of their mother during pregnancy and early childhood. Safe pregnancy, child birth and postpartum period are important milestone events to achieve optimal maternal and neonatal outcomes. Investment in ensuring optimal health of women throughout pregnancy, childbirth and life course reaps rich dividends for women, infants and their families and helps in building prosperous societies and economies.

Studies show that the vast majority of maternal deaths are preventable (WHO), and it is imperative that the risk of mothers and babies dying during pregnancy and childbirth needs to be minimized to the extent possible. This is possible by concerted efforts to provide all pregnant women with equitable, timely, accessible and quality antenatal care and emergency obstetric and neonatal care.

Over the past decades, India has made significant progress in reducing the maternal mortality ratio (MMR) from 556 per 1 lakh live births in 1990 to 130 per 1 lakh live births in 2015 achieving the MDG 5 by achieving 77% decline, while the global MMR decline during the corresponding period was just 44%. India's current rate of MMR decline puts the country well on track to achieve the Sustainable Development Goal 3 (SDG 3) target of a MMR below 70 by 2030. It is even more heartening to note that socio-economically backward areas referred to as the Empowered Action Group (EAG) States have also registered significant decline in MMR over the last decade.

Similarly, Infant Mortality Rate (IMR) reduced by 63% during the same period. As per Sample Registration System (SRS) 2017 released by Registrar General of India (RGI), IMR is 33/1000 live births which was 89 in 1990. Globally, the IMR has decreased from an estimated rate of 65 deaths per 1000 live births in 1990 to 29 deaths per 1000 live births in 2017.

With the launch of various initiatives under National Rural Health Mission (NRHM)/ National Health Mission (NHM), India has made a concerted push to increase access to quality maternal and newborn health services. Programs like Janani Suraksha Yojana (JSY)-a demand promotion scheme and Janani Shishu Suraksha Karyakram (JSSK) that gives free entitlements along with ambulance facility to the expectant woman (under National Ambulance Services) helped in scaling up the institutional delivery rate from 38 % in 2005 to 79 % in the year 2015. The other entitlements under JSSK include free drugs, diagnostics, transport, diet, blood etc. and have helped in reducing the out of pocket expenditure (OOPE) on childbirth.

The government has also put in substantive efforts to facilitate positive engagement between public and private health care providers. Campaigns such as the Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA) have been introduced with good impact, allowing women access to comprehensive and quality antenatal check-ups by obstetricians/doctors so as to detect, track and treat highrisk pregnancies (HRPs) in a timely manner and reduce risk of maternal and neonatal

deaths. Improved implementation of such programs is exactly what is needed to make further gains and achieve SDG targets in each state. In light of the fact that the day of the birth of the child is of highest risk to the woman and the baby, LaQshya program has been launched to specially focus on improving the quality of care around childbirth.

While the progress has undoubtedly been impressive, in order to reduce the MMR to below 70 by all the states before 2030, systematic efforts need to be made to eliminate disparities in maternal health outcomes across the country. This requires adopting a comprehensive, multipronged and coordinated policy approach that incorporates a relentless focus on monitoring the implementation of Safe Motherhood guidelines. Simultaneously, an initiative addressing the existing inequities in newborn and infant health care services, that is inclusive of poorest of poor and accessible by all will accelerate the progress for child survival as well.

Indian Survey

In order to design program that respond to maternal needs, White Ribbon Alliance for Safe Motherhood, India interviewed approximately four lakh women about their needs for quality maternal and reproductive health care. The top five responses that were received are- (i) access to maternal health entitlements including enough supplies and services;(ii) dignity and respectful care;(iii) availability of skilled health providers like trained doctors;(iv) competent, compassionate and dedicated midwives and nurses, clean facilities, labour room and toilets; and (v) display of information on entitlements, schemes and services.

The World Health Organization (WHO) defines Quality of Care for mothers and newborns as “the extent to which health care services provided to individuals and patient populations improve desired health outcomes. In order to achieve this, health care must be safe, effective, timely, efficient, equitable and people-centered.”

Quality of care is increasingly being recognized internationally as a critical aspect of the unfinished maternal and newborn health agenda, mainly with respect to care during pregnancy, around labour and delivery, in the immediate postpartum period and infancy.

High quality coverage of care especially around the time of birth and care of small and sick newborns can save nearly 3 million lives (women, newborn and stillbirths) each year with only US\$ 1.15 per person in 75 high burden countries including India. This will have triple return on investment by saving women, newborns and addressing stillbirths.

Respectful application of evidence based guidelines with attention to women’s individual, cultural, personal and medical needs is essential to encourage them to seek quality maternal care. Studies have demonstrated that quality often influences a woman’s decision to seek care in a particular institution, thereby indirectly affecting maternal mortality. If she has a positive experience, she will tell her friends and family about it. If she has a negative one, she may simply stay home to give birth the next time, and warn others to stay away as well.



Globally several studies have been done by the researchers which indicate that healthier women and their children contribute to more productive and better educated societies. Development and economic performance of a nation depends partly on how each country protects and promotes the health of the women. Healthy mothers before, during and after childbirth and providing opportunities for family planning act as a catalyst for positive social development.

Studies conducted in several countries globally also indicated positive contribution to GDP where investment has been done for improving the health of women and children. Thus, evidences clearly indicate that the societies that prioritize women's health will likely have a better population health and will remain more productive for generations to come.

Meeting the ambitious goals endorsed under the new SDGs and the new Global Strategy for women's, children's and adolescent's health (2016-2030) will require universal, equitable and high quality coverage of essential, referral and emergency care for every woman and infant in every country with equity, accountability and linkages with other global and national plans.

In the wake of the above data, it is concluded that it is imperative to ensure delivery of assured, high quality, respectful maternity care (RMC) to achieve desired maternal and infant health outcomes. Community, family and service provider play a critical role in achieving positive pregnancy experience. A positive transition to safe motherhood begins with giving birth to a healthy baby in a clinically and psychologically safe environment and emotional support from the service providers who also act as a birth companion to the mother during the whole process. It also strives for implementing human rights based approach allowing the pregnant women to receive person centered and quality care for a positive birth experience.

In fact, birthing is a natural process and instead of controlling it by uneven augmentation, episiotomies or caesarian section, we need to support the process of birth by creating a mother-friendly environment to encourage normal deliveries. Every woman should be given the liberty to walk, choose her birthing position, etc., and service providers should be able to support and respect the mother's wish during this process. This will also translate into assured communication with the mother and her family during the childbirth and critical decision making while managing complications.

Safe and respectful delivery cannot be ensured in isolation but is closely linked from the time the woman or the family plans for the pregnancy, during pregnancy and till the time child achieves 1 year of age. This change also needs to be linked with a life cycle approach and continuum of care. GOI has already taken initiatives like RMNCHA (reproductive, maternal, newborn, child and

adolescent health) which is a lifecycle approach for a healthy mother and healthy baby. The launch of program initiatives like PMSMA to improve antenatal care and LaQshya (Labour Room Quality Improvement Initiative) certification to improve quality of care, has provided further impetus for timely identification of high risk pregnancies (HRPs) along with provision of safe and respectful maternity care.

Pregnancy, birth and the postpartum period are milestone events in the continuum of life. These experiences profoundly affect women, babies and their families and have an important and long lasting effect on the society

People accessing the public health facilities (PHFs) still find challenges in getting complete and comprehensive care during pregnancy and childbirth. Hence, it is important to formulate a proper policy, which not only promotes safe delivery and respectful maternity care, but also translates the entitlements into a service guarantee, which is more meaningful for the beneficiaries.

With this background, GOI decided to draft a policy framework to expand the maternal health care including delivery beyond entitlement to a guaranteed service delivery, which encompasses wider access to free, and quality care services, zero tolerance for denial of services, assured management of complications along with respect for women's autonomy, dignity, feelings, choices and preferences, etc. All these are applicable to the care of infant too.

Such a comprehensive approach, which guarantees access to good quality maternal and infant care services, will help in ending all preventable maternal, perinatal and early newborn deaths.

VISION

To ensure that every woman receives high quality of maternity care delivered with dignity and respect and the same is extended to her infant.

GOAL

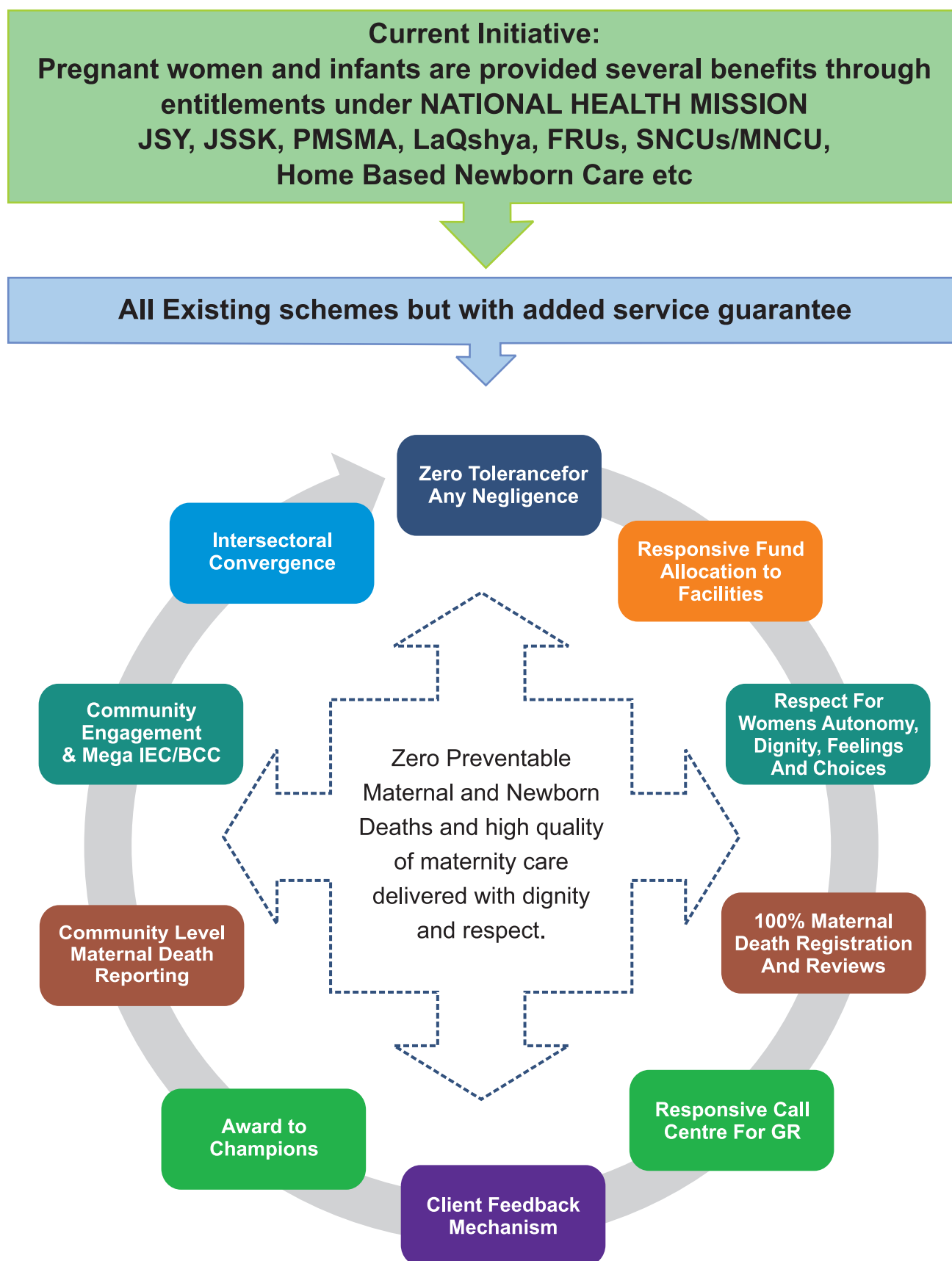
To end all preventable maternal and early infant deaths.

AIM

Assured, dignified, respectful and quality healthcare at no cost and zero tolerance for denial of services for every woman and newborn visiting the public health facility to end all preventable maternal and newborn deaths and morbidities and provide a positive birthing experience.

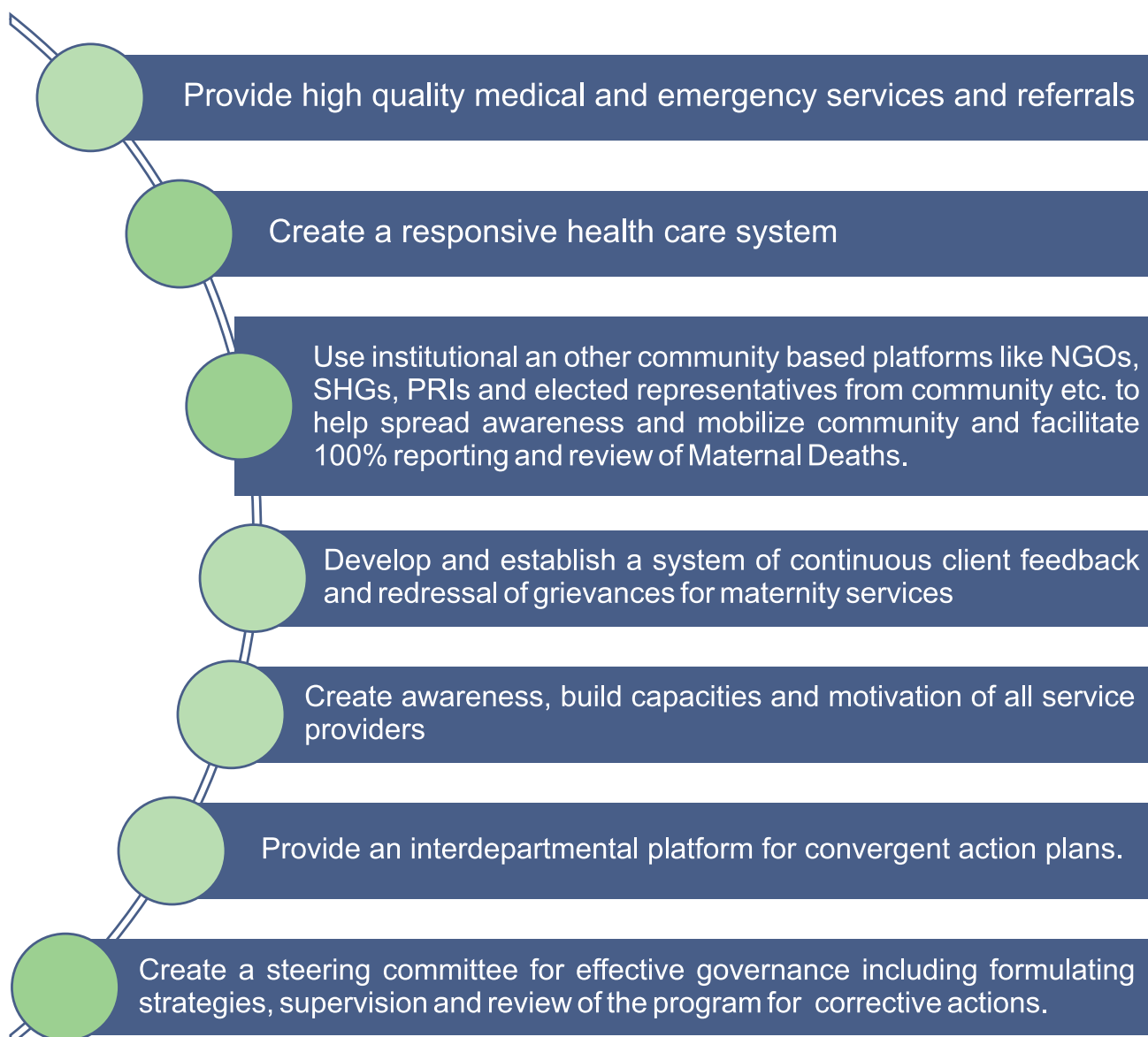


CONCEPTUAL FRAMEWORK FOR "SUMAN"



Under SUMAN all existing schemes for maternal and infant health have been brought under one umbrella in order to create a comprehensive and cohesive initiative which ***goes beyond entitlements and provides a service guarantee for the entitlements***. In order to operationalize the service guarantee and ensure zero tolerance for any negligence or denial of services several strategies have been adopted namely a responsive call centre for grievance redressal, a client feedback mechanism, special focus on community engagement, a mega IEC/ BCC campaign on zero preventable maternal and newborn deaths and inter sectoral convergence, responsive fund allocation to health facilities etc. It is envisaged that such an approach will accelerate the rate of decline of maternal and infant mortality and pave the way for Zero Preventable Maternal and Newborn Deaths and high quality of maternity care delivered with dignity and respect.

OBJECTIVES





GUIDING PRINCIPLES

- a. Focus on delivering **high quality services** through programs like LaQshya, PMSMA, Dakshata, Skilled Birth Attendant and Midwives, NSSK and JSSK.
- b. Placing a robust and user-friendly **Responsive call center service for registration and redressal of complaints/Grievances**
- c. Guaranteed and assured access for safe motherhood by programmatic **convergence** of various maternal and newborn care services and entitlements amongst beneficiaries.
- d. Addressing **equity** by prioritizing functionality of health facilities/delivery points in underserved areas.
- e. **Wide IEC and BCC** focused activities for improving awareness amongst beneficiaries and population. Establishing a mechanism of **interdepartmental convergence** for addressing both proximal (ANC, intrapartum and postpartum care, FP, nutrition) and distal drivers of maternal and newborn care (such as age of marriage, women's education and empowerment).
- f. Generating strong **political commitment** and **community ownership**

ELIGIBILITY/BENEFICIARIES OF THE INITIATIVE

- 1) All pregnant women irrespective of their age and parity.
- 2) All mothers upto 6 months post-delivery.
- 3) All sick infants (as defined in **Annexure B**)

ENTITLEMENTS UNDER THE INITIATIVE

A service guarantee charter outlining all the entitlements of the pregnant women and infants under the new initiative has been prepared.

Service Guarantee Charter Suman-Surakshit Matritva Aashwasan

All Pregnant Woman/Neonates visiting public health facilities are entitled to the following free services:

- At least 4 ANC checkups (including one checkup during the 1st trimester and at least one checkup under Pradhan Mantri Surakshit Matritva Abhiyan, Iron Folic Acid supplementation, Tetanus diptheria injection and other components of comprehensive ANC package) and 6 home based newborn care visits
- Comprehensive Abortion Care Services in line with the MTP Act
- Safe Motherhood booklet and Mother and Child Protection Card with service guarantee charter
- Free and zero expense access to identification and management of complications
- Free transport from home to health institutions (dial 102/108), assured referral services with scope of reaching health facility within one hour of any critical case emergency and Drop back from institution to home after due discharge (minimum 48 hrs)
- Zero expense delivery and C-section facility in case of complications at public health facilities
- Services for elimination of Mother to Child Transmission (EMTCT) of HIV, HBV & Syphilis.
- Quality care by trained personnel (including Midwife/SBA)
- Respectful care with privacy and dignity
- Delayed cord cutting
- Early initiation and support for breastfeeding
- Zero dose vaccination.
- Free and zero expense services for sick neonates and infants under JSSK
- Birth registration certificates from healthcare facilities
- Conditional Cash transfers/ direct benefit transfers under various central and state specific schemes.
- Post-partum family planning counseling
- Time bound redressal of grievances including responsive call center/helpline, web portal etc
- Counseling and IEC/BCC for safe motherhood



BENEFITS OF INITIATIVE

1. **At least 4 ANC checkups including and minimum 6 HBNC visits post-delivery.**

(In case the newborn is sick and is discharged from SNCU then the schedule of HBNC is followed up considering the day of discharge as day 1)

- All pregnant women will be entitled for at least 4 ANC's including early registration and one check up in the 1st trimester of pregnancy.
- ANC's will include basic medical test, medical examination, assessment of fetal wellbeing, fetal heart sound, lie, presentation etc. as annexed in the guideline.
- Benefits will be delivered using various platforms at different level like VHND at village level or at SC/PHC/CHC/DH/ Medical Colleges as per the location of the patient.
- 100% pregnant women to receive at least one ANC under PMSMA - Every patient in 2nd & 3rd trimester will get an additional check-up under PMSMA on 9th day of the month in order to detect high risk pregnancies and conduct any missed investigations.
- Irrespective of the place of the delivery (facility or home), every woman is entitled to 6 home visits, in the first 6 weeks of birth, by a trained health worker.
- 6 home visits in case of institutional delivery (ie on day 3, 7, 14, 21, 28 and 42 of birth). However, in case of home delivery, a total of 7 visits will be conducted (ie on day 1, 3, 7, 14, 21, 28 & 42 of birth)

The objective of the home visits will be to provide –

- ✓ Essential new born care.
- ✓ Special care to preterm/LBW babies.
- ✓ Identify illness in newborn and provide first level care.
- ✓ Referral to the appropriate health facility.
- ✓ Counsel mother regarding essential newborn care, breast feeding, need to have balanced diet & adequate rest.
- ✓ Counsel mother on post-partum family planning methods etc.

2. **Free and zero expense delivery and C-section in public health facilities.**

- All deliveries including complications and C-sections shall be absolutely free with no expenses incurred by the beneficiaries at public health facilities.
- All medical colleges willing to participate would also provide free SUMAN services
 - ✓ Adequate number of First Referral Units would be operationalized as per the population norm of 1/ 5 lakh population. These norms would be relaxed based on geographical considerations to ensure that CEmONC services can be accessed within an hour from all health care facilities in line with the time to care approach.

3. Deliveries by trained personnel (including Midwife/SBA)

- All deliveries conducted at any health facility shall be conducted by a skilled birth attendant²/Midwife irrespective of level of facility.

4. Identification and management of maternal complications

- All the maternal complications arising during the ante-natal, intra-natal & post partum period will be managed by nurse practitioners in midwifery³, trained doctors or Obstetricians at the healthcare facilities without any expenses being incurred on the beneficiary or her family.
- Any expense in this regard shall be completely borne by the healthcare facility with the support of the governments under the NHM.
- An IT application would be developed to act as a job aid and a decision support tool for health care providers in order to improve the quality of care and enable early identification and management of complications.

5. Early initiation and support for breastfeeding

- Every pregnant woman will be counseled during Antenatal and Intra natal period on the benefits of breast milk especially colostrum.
- Awareness regarding importance of breastfeeding will be promoted within the facility and community. Benefits of early initiation and exclusive breast feeding will be explained to the mothers and their families like-
 - ✓ Prevents 20% of newborn deaths
 - ✓ Prevents 13% of under-five deaths
 - ✓ 11 times lesser chance of diarrheal mortality
 - ✓ 15 times lesser chance of Pneumonia related mortality
 - ✓ Benefits on raising I.Q.
 - ✓ Prevention of non-communicable diseases,
 - ✓ Lesser hospital stay of newborns,
 - ✓ Maternal benefits (cancer prevention).
- The woman will be encouraged to initiate breast feeding at the earliest, and certainly within 1 hour of birth.

Breast feeding increase the chances of survival, reduces the morbidity caused due to infectious diseases like diarrhea and pneumonia, and prevents non- communicable diseases. It also helps on raising I.Q, reduces hospital stay of newborns and prevents maternal cancer prevention.

²Health Professionals who have received additional in-service training for intrapartum care

³Immediate management, stabilization and referral



- In cases in which breast feeding is not possible owing to complications such as inverted nipple, breast abscess etc., she will be supported in expressing milk or in retraction of nipple etc.
- Lactation support and management services at health facilities, counselling, and support for breastfeeding at VHSNDs.

6. Respectful Maternity Care

- Every pregnant woman delivering in healthcare facilities is entitled to respectful maternity care during labour. The various components that define 'Respectful Maternity Care' will be provided to the mothers-

The various components that define '**Respectful Maternity Care**' are:

- ✓ Privacy
- ✓ Freedom from verbal and physical abuse, and polite behavior by service providers
- ✓ Relaxing environment (Dim light, quiet, physical comfort in the labor room).
- ✓ Presence of a birth companion.
- ✓ Options for alternate birthing positions.
- ✓ Informed consent
- ✓ Avoiding unnecessary examinations.
- ✓ Delayed cord clamping (not less than 5 mins or until cord pulsations ceases)
- ✓ Provision of proper and clean washroom facility (With hand washing and bathing area and wall mounted western style toilets with grab bars).

The various components that define '**Respectful Newborn Care**' are:

- ✓ Register every birth, newborn death and stillbirth
- ✓ Nursing with mother and avoid unnecessary separation of mother and newborn
- ✓ Safe and Relaxing environment- ensure light and sound comfort in the labor room, postnatal ward and newborn care unit and safety of newborn
- ✓ Right to be breastfeed- no one may interfere with the mother's right to breastfeed the child and give full support in case required including privacy for mother.

Platforms like "Mera Aspatal" will be utilized to take regular feedback from the mothers and their families whether RMC is being practiced in the health facility or not.

Parent's experiences or apprehensions of abuse and disrespect act as a disincentive to seek necessary care. Newborn and infants have the right to be breastfed that no one may interfere with the mother's right to breastfeed the child" thus, facilitation of early initiation of breast-feeding

as a right. On several occasions the newborn are not visited daily in the facility, unnecessarily separated from their mothers after birth, referrals/transferred to other facilities without proper communication/consent of the parents, unsafe early discharge of women and their infants due to limited space & failure to meet professional standards of care.

7. Management of sick infants and neonates.

- All sick newborns and infants would be managed at the health facilities without any expense incurred by the family of the baby.
- The management of complications & services covered under the initiative are placed at Annexure B.
- Availability of assured newborn services at various levels-
 - ✓ Provision of essential newborn care: establishing respiration if requires assistance at a functional New Born Care Corner (NBCC) in LR and OTmanned by trained (SBA/NSSK) provider, maintaining the warm chain and prevention of infection .
 - ✓ Prereferral stabilization, management of common conditions like provision of breast feeding support, access to antibiotics and phototherapy in acse of jaundice at New born stabilization units at CHCs/FRUs. by trained medical officers and nurses
 - ✓ 24*7 comprehensive newborn care services at Special New Born Care Unit (SNCU)at the DH and a trained pediatrician or Medical officers. Provision of Mother newborn care units at high caseload facilities for promoting developmentally supportive care and breast feeding
 - ✓ Identification, management of newborn complications at all levels and prompt referral to appropriate level.

8. Zero dose vaccination.

- ✓ All babies delivered at public or Government health facilities will be entitled to receive OPV, BCG and Hepatitis B vaccine (zero dose vaccines) at the earliest, and certainly within 24 hours of birth.

9. Free transport from home to health facility, dial 102(108)

- Every expectant woman will be entitled to free transport from her home to the health facility during any complication or for delivery. Similar entitlement will extend to sick newborn.
- She should know the toll-free number for calling the ambulances.
- Her ASHA/ ANM will give her the toll free number and also guide her to appropriate health facility

10. Assured referral services with scope of reaching referral health facility preferably within 1 hour of any critical case emergency.

- Every pregnant woman and parents of newborn shall be informed about her nearest referral facility both for her delivery and for managing complications.



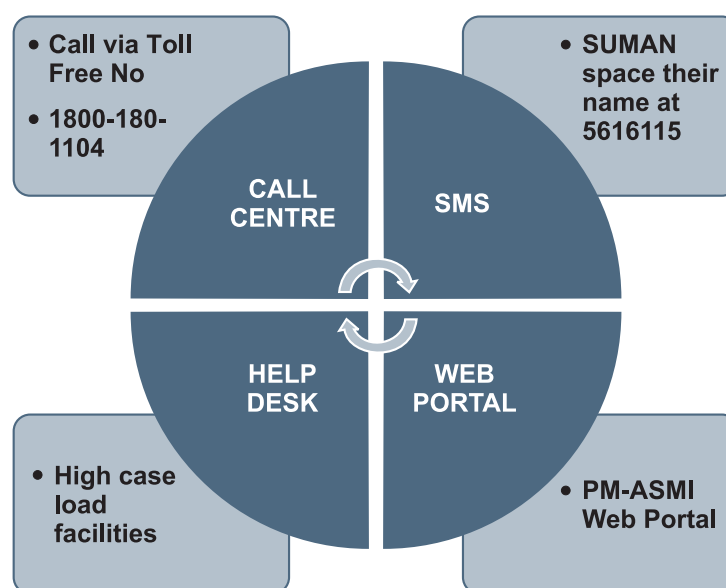
- She will also be given the Toll free number of a centralized call center which will be able to send ambulance as and when required.
- These ambulances will take her to the nearest functional and appropriate health facility or delivery point for getting appropriate and timely services.
- Every district will ensure availability of assured ambulance services.
- In case of complications, it would be the responsibility of the hospital in-charge to organize inter- facility transport, ensure assured referral of pregnant woman to the appropriate level of healthcare facility and inform the referral facility in advance.

11. Drop back from institution to home after due discharge (minimum 48 hrs)

- All women delivering in healthcare facilities and getting discharged after a minimum 48 hours of delivery would be entitled to safe transport from institution back to her house.
- No expense in this regard would be borne by the mother or her family.

12. Mega IEC/BCC- "Zero Maternal Death Campaign "

- A mega campaign on 'zero maternal death' to spread awareness on high number of maternal deaths due to preventable causes and aim of reducing such deaths to zero, will be launched.
- IEC/BCC material in all modules e.g. video films etc. in local languages will be prepared and disseminated among the expectant woman, families and communities.
- The healthcare workers or the volunteers and champions of the area will focus on advocacy and awareness generation on maternal health, maternal health services and maternal death reporting).



- This will facilitate 100% maternal death reporting. (Every reported maternal death will be systematically reviewed by the health system as per the Maternal Death Surveillance and Response Guidelines to identify clinical and social reasons so as to prevent their recurrence in future).

- The safe motherhood booklet and MCP card would be used to generate awareness about the entitlements under the initiative.

13. Provision of birth registration certificate soon after delivery.

- All the beneficiaries delivering in healthcare facilities will be issued birth registration certificate
- Wherever the health department is given the role of birth registration, the health facilities will be encouraged to issue the birth certificate of the newborn before discharge
- However, wherever other departments do the birth registration, then a certificate for institutional delivery would be provided to the mother before discharge.

14. Time bound redressal of grievances through a responsive call center/helpline.

- In case of any concerns regarding the delivery of services to the beneficiary as entitled under the initiative , e.g. denial of services, quality issues etc., the beneficiary, her family or anyone from the community would be able to register a complaint through a responsive grievance redressal system.
- The grievances could be registered either through a help desk, a web portal, sms or through a call center depending upon the facility level.
- Registered complaints would be forwarded to the nodal person at the facility for the timely resolution of the complaint with information to the complainant.
- The registered grievances would be triaged into urgent and non- urgent and efforts would be made to ensure that urgent grievances are resolved within 24 hours.
- Non – urgent registered complaints would be escalated to higher levels if not resolved within seven days.
- In States that already have 104 services/ call centres, the existing call centres would be used for registration of complaints and feedback to the clients. States that do not have an existing call centre, would be provided the requisite support for establishing the call centre. An existing National level call centre would be operationalized for Grievance redressal as an interim measure.
- Beneficiaries if not satisfied would be given an option to reopen the complaint at higher level
- Detailed strategy for grievance redressal system has been outlined later in the document.

15. Disbursal of conditional cash transfers under various central and state specific schemes.

- The pregnant woman will be entitled to all the conditional cash transfers falling under various central and state schemes.

16. Post-partum FP counseling

- The ASHA/ANM and health care provider will provide family planning counseling as part of childbirth care to the expectant mothers to prevent unwanted or closely spaced pregnancies through the first 12 months after child birth.



- The expectant woman would be informed and educated about the various methods of contraception, for spacing or limiting future pregnancies, during the ante natal visits, immediately after the delivery and before discharge from the health facility.
- She would be encouraged to adopt the family planning method of her choice, during the home based neonatal visits by the health care worker by ASHAs/ANM.

17. Provision of MCP card and Safe motherhood booklet with Service Guarantee Charter

- At the time of 1st registration, all the expectant women will be informed about her various entitlements under the initiative for delivering at a public healthcare facility.
- The entitlements under the initiative would become part of the safe motherhood booklet and MCP card.

OPERATIONAL FRAMEWORK

Adequate planning and proper implementation is crucial for the success of this initiative. **At the outset, facility level service guarantee would be ensured at LaQshya certified facilities and then expanded across the higher-level health care facilities. This would be followed by expansion of service guarantee to primary healthcare facilities.**

BROAD PILLARS OF THE INITIATIVE

SUMAN INITIATIVE

- Free ANC, delivery and Post natal care.
- Free management of sick infants and neonates.
- Assured delivery plan for the High Risk Pregnant women.
- Ensuring Quality standards at all levels of delivery Points.

Service guarantee	Community awareness	Health system strengthening	Monitoring & reporting	Incentives and Awards	IEC/BCC
<ul style="list-style-type: none"> • JSSK • JSY • PMSMA • Laqshya • MAA • Dakshta • SNCU care for sick & small babies. • Home based care for mothers & newborn (HBNC) 	<ul style="list-style-type: none"> • Involving VHSNC and SHGs for better community engagement. • Interdepartmental convergence • Champions • Village volunteers. • Use of Safe motherhood booklet and MCP card. 	<ul style="list-style-type: none"> • Infrastructure- LDR, OT, Obstetric HDU/ICU, NBCC, NBSU, SNCU/MNCU • Human resource • Drugs and diagnostics. • Assured Referral systems • Creating centre of excellences. 	<ul style="list-style-type: none"> • Responsive call center for better Grievance redressal and reporting. • MCP card and Safe motherhood booklet with Service Guarantee Charter • Monthly reporting. • HMIS analysis. • Formation of National, State level monitors . • Maternal and infant death reporting 	<ul style="list-style-type: none"> • Awards and recognition to performers. • First responder of maternal death to get Rs 1000/-. 	<ul style="list-style-type: none"> • Mega IEC/BCC activities promoting "zero preventable maternal & newborn deaths"

PLANNING AND PREPARATORY ACTIVITIES

- a) Establishment of National, State, District and Block Level Committees to provide policy direction (at National level), implementation and monitoring.
- b) Sensitization meeting under the chairmanship of the Principal Secretary, Health & Family Welfare at the State level, and District Magistrate at the district level.
- c) Orientation and capacity building of stakeholders and service providers.
- d) Planning for logistics like HR, availability of drugs, diagnostics, etc., for target beneficiaries.
- e) Creating platform for inter-sectoral coordination through the committees at all levels.
- f) Planning for creating Centre of Excellence (CoE).
- g) Community mobilization and awareness activities.
- h) Creating and implementing IEC (Information Education Communication) and BCC (Behavior Change Communication) awareness campaigns intended to reach wide audiences.
- i) Adaptation of the IEC materials shared by GOI and contextualized as per local needs.
- j) Every state/union territory will ensure provision of adequate funds so that there is no denial of maternity and newborn care services at Public health facilities.
- k) Existing health helpline with a responsive call center and web portal for Grievance Redressal and maternal death reporting shall be utilized for the initiative.
- l) Provision of adequate budget and timely release of funds.
- m) Planning for monitoring and evaluation activities.
- n) Entitlements to be clearly indicated in the safe motherhood booklet and MCP (Mother and Child Protection) card.

INSTITUTIONAL FRAMEWORK

A. Formation of Committees

National Level Committee

The Program Steering Committee at the National Level would be a high power committee, which will be responsible for providing policy direction; course correction; solving any issues, if need be; and ensuring that the service guarantees under the initiative are available to every pregnant woman, newborn and infant. It will help create an enabling framework, policies and systems so that the goal of the initiative can be reached. The body will also be supported by a working group comprising of technical experts drawn from various disciplines related to RMNCHA.



The National High Power Committee would act as an oversight committee and comprise the following members:

- (a) The Union Health Secretary: as the Chairperson
- (b) Additional Secretary and Mission Director –NHMas Convener
- (c) Joint Secretary - RCH (Reproductive Child Health):as Member Secretary.

Officers of the rank of Joint Secretary from the following Ministries - as members:

- (i) Women and Child Development
- (ii) Social Justice and Empowerment
- (iii) Panchayati Raj
- (iv) Rural development.
- (v) Information and Broadcasting
- (vi) AYUSH (Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homoeopathy)
- (vii) Any other expert nominated by the Chairperson
- (d) Nominees from the following organizations:
 - (i) Indian Council of Medical Research (ICMR)
 - (ii) Directorate General of Health Services (DGHS)
 - (iii) National Centre for Disease Control (NCDC)
- e) Three State Principal Secretaries by rotation
- f) Special invitees(need-based) from social sector/professional bodies/international organizations
- g) In case any other additional member is required from the concerned department they can be co-opted with approval from chairperson.

The national level working group will be responsible for implementation of the decisions taken by the national committee. It will also provide guidance, course correction and ensure sufficient funding for implementation of the SUMAN. They will also monitor and review the functioning of the health facilities. The working group shall take the corrective actions for filling the gaps. They will also make recommendations/suggestions for improvement of the initiative for consideration by the National Committee based on field level data. They will meet every quarter for review.

The National working committee will consist of the following members:-

- a) Joint Secretary - RCH: as Chairperson
- b) Commissioner MCH - Convener
- c) Joint Commissioner –Maternal Health as Co-Convener

- d) Joint Commissioner – Child Health(CH): as Co-Convener
- e) Joint Commissioner (Immunization)
- f) Three State Mission Directors by rotation
- g) Nominee from National Health Systems Resource Centre(NHSRC)
- h) Nominee from DGHS and centrally funded medical colleges
- i) Nominees from Aspirational district unit.
- j) Nominees from development partners – WHO, UNICEF, IPE Global, Jhpiego, BMGF and any other agency supporting Aspirational districts or high focus states
- k) Representatives of professional bodies
- l) Representatives from WRAI and other social organizations.

State Level Committee

The State level Committee will be the body responsible for the implementation of the scheme in the State. It will handhold the districts in development of their plans as well as review their implementation. The existing committee formed under PMSMA would be subsumed under this committee.

The Committee will comprise of the following members:

- a) Chief Secretary: as Chairperson
- b) Addl. Chief Secretary / Principal Secretary - Health & Family Welfare: as Member Secretary
- c) Mission Director - NHM: as member

Nominees from:

- d) Directorate of Health Services & Medical Education
- e) Departments - WCD-ICDS, Rural development, Urban development, Department of Information.
- f) City corporation commissioners.
- g) State Institute Of Health And Family Welfare (SIHFW)
- h) State Program Officer.
- i) NHM - Nodal Officers for Maternal health and Child health.
- j) Representatives from departments of OBGY, Neonatology, Pediatric& PSM in Medical Colleges
- k) Development partners working in the field of maternal and child health.
- l) Representatives from WRAI and social organizations.
- m) In case any other additional member is required from the concerned department they can be co-opted with approval from chairperson.



The Committee will be responsible for the following:

- ✓ To develop a road map and action plan for implementation of the initiative with the aim to ensure that the RMC and entitled services are delivered free, as part of service guarantee for maternal, newborn and infant care.
- ✓ To strengthen the health system by ensuring Assured availability of required HR, Specialists, Drugs, Diagnostics, Referral services, responsive allocation of funds to healthcare facilities etc. in the state.
- ✓ To ensure that there are adequate number of CEmONC facilities/ First Referral Units that are so geographically distributed that they can be accessed within an hour from all health care facilities in line with the time to care approach.
- ✓ To ensure 100% registration of all maternal deaths and ensuring systematic maternal death review (facility and community based) are undertaken as per the Guidelines for Maternal Death Surveillance and Response and corrective measures undertaken to address the systemic gaps.
- ✓ To provide enabling environment including capacity building of providers so that they joyfully provide the RM & NC
- ✓ To ensure that all delivery points above CHCs have Laqshya Certification, preferably by 2021-22
- ✓ To map HR status in the state and timely recruitment against the vacancies using NHM flexibility
- ✓ To ensure that necessary budgetary provisions for the SUMAN are made in the state annual PIPs and are disbursed responsively (online/ otherwise) to the facilities to ensure assured availability of adequate funds at all times
- ✓ To ensure timely and smooth release of funds to the health facilities through online/ software so that resources are not a constraint for delivery of entitlements.
- ✓ To do **output oriented review** of all the districts to ensure that all the entitlements are being provided to the pregnant women in the state.
- ✓ To develop strategies that will ensure community awareness and participation.
- ✓ To undertake special orientation for PRIs and social groups including SHGs to generate awareness, ownership and highlighting the facilities which are performing well and those who need further support.
- ✓ To identify Champions from the community and felicitate them suitably.
- ✓ To conduct interdepartmental convergence meetings highlighting the role of other departments in supporting the timely access for the services E.g. good quality road connectivity, uninterrupted power supply, support in community awareness, ensuring privacy and enough space during VHNDs, organising peer groups for support etc.
- ✓ To ensure that district hospitals are utilized for capacity building of service providers for delivering quality MCH services with an ultimate goal to become knowledge hub.

- ✓ To develop Center of Excellences so that they can provide guidance, mentoring and capacity building to the respective districts.
- ✓ To ensure that primary care for MCH services are delivered comprehensively at HWCs/ PHCs/ SCs.
- ✓ To support districts in translation of IEC material & operational guidelines.
- ✓ To develop training materials and ensure its availability at district/sub district level.
- ✓ To ensure that facilities above CHCs in the state get quality certified.
- ✓ To monitor status of implementation of the initiative through HMIS reports and field monitoring visits by state team/district officials.
- ✓ To follow up with districts and sub district /blocks for timely submission of reports and coverage data.

The committee members will meet every quarter to review the progress, grievances, bottlenecks and solutions to overcome it.

District Level Committee

The actual implementation of the initiative is at the district level. A committee formed at the district level under the chairpersonship of the District Collector and Chief Medical Officer (CMHO- Chief Medical and Health Officer/DHO-District Health Officer) as Secretary will spearhead the implementation.

The Committee members will be:

- a) District Collector: Chairperson
- b) Chief Medical Officer: Secretary
- c) CMS/MS of the Medical College and district hospital
- d) District RCH Officer
- e) District Program Managers (DPM, DCPM, DAM, DDM)
- f) Nodal Officer from ICDS department
- g) Nodal Officer from Health Education department
- h) Nodal Officer from PRI
- i) Nodal Officer from Road and Transport department
- j) Nodal Officer from Department of Information and Broadcasting
- k) Development partners working in the field of maternal and child health.
- l) Nominee of any NGO working in MCH area having presence in the district
- m) Representatives from womens' rights groups and other social organizations.
- n) Any other expert nominated by the District Collector



- o) In case any other additional member is required from the concerned department they can be co-opted with approval from chairperson.

Block Level Committee

Chairman will be decided by state as per the local context and Block Medical Officer will be the member secretary. The Committee will undertake monthly meetings to review the progress.

The Committee will have the following members:

- a) Block Community Mobilizer
- b) A proactive CHO (Community Health Officer) or Middle Level provider
- c) A senior nurse or a pharmacist or lab technician
- d) Block Accounts Manager
- e) Representatives from ICDS-CDPO(Child Development Project Officer), Education department, PRI, etc.
- f) Nominee from any development partner having presence in the block or district
- g) Nominee of any NGO working in MCH area having presence in the block or district

The district and block level committees will be responsible for real time implementation of the initiative and hold monthly meetings to review the progress. They should have a clearly drawn road map for services being rendered at each facility conducting deliveries. Every block will ensure that HRPs are identified and its line listing is available for management and follow up as envisaged under PMSMA. Mapping of HR, Infrastructure, Equipment, Drugs and Diagnostics should be available facility wise. In case of any gap, proposals and action plans need to be submitted at the appropriate level.

In addition to the above, some of the critical responsibilities of the **district level committee** would be:

- ✓ Regular **outcome oriented review** of the SUMAN initiative.
- ✓ Monthly review of the initiative based on the HMIS data, supportive supervision visit findings and reports.
- ✓ Orientation and capacity building of the service providers and stakeholders on SUMAN.
- ✓ To ensure that there are adequate number of CEmONC facilities/ First Referral Units that are so geographically distributed that they can be accessed within an hour from all health care facilities in line with the time to care approach.
- ✓ To ensure 100% registration of all maternal deaths and ensuring systematic maternal death reviews (facility and community based) are undertaken as per the Guidelines for Maternal Death Surveillance and Response and corrective measures undertaken to address the systemic gaps.
- ✓ To ensure that all delivery points above CHCs have Laqshya Certification, preferably by 2021-22

- ✓ Facilitating interdepartmental convergence and ensuring use of community-based platforms like VHND and VHNSC (Village Health, Nutrition and Sanitation Committee) for holding meetings, and Gram Panchayats for community mobilization and mass awareness.
- ✓ Developing strategies that will ensure community mobilization, participation and monitoring, so that community ownership can be generated.
- ✓ Ensuring that all the district health facilities are NQAS quality certified.
- ✓ Ensuring time-bound redressal of grievances.
- ✓ Filling of all gaps for ensuring hassle-free access to the services and deliverance of entitlements will be the responsibility of both district and block level committees.

Some additional critical responsibilities of the **block level committee** would be:

- ✓ Ensuring that assured service guarantee (including 4 ANC checkups), assured referral services, post natal home visits etc, are being provided to the beneficiaries.
- ✓ Ensuring the availability of EDL (Essential Drug List) at the desired facility level.
- ✓ Ensuring that all SCs and PHCs are converted in HWCs and providing services as per comprehensive primary health care guidelines.
- ✓ Ensuring that guidelines of the initiative are adhered to and respectful maternity care is being provided at the facilities.
- ✓ To ensure 100% registration of all maternal and Child deaths and ensuring systematic maternal death review (facility and community based) are undertaken as per the Guidelines for Maternal Death Surveillance and Response and corrective measures undertaken to address the systemic gaps.
- ✓ Holding interdepartmental convergent activities.
- ✓ Ensuring use of community-based platforms like VHND, VHNSC for holding meetings, and Gram Panchayats for community mobilization and mass awareness.
- ✓ Ensuring that facilities are compliant with NQAS quality certification and standards.
- ✓ Ensuring regular need base training of the service providers based on finding from supportive supervision visits.
- ✓ Making appropriate usage of health care technology in reporting, recording and service provision, e.g., usage of tablets by ANMs.
- ✓ Identifying champions and best performers in the block/village level and recognizing them on village level platform.
- ✓ Generating monthly reports on initiative performance and regular analysis of the same.

B. Creating National and State Level Centre of Excellences (CoE)

Extending service guarantee becomes a commitment of the state towards the beneficiaries of the initiative. Hence, it becomes imperative to place a mechanism for guidance, mentoring and capacity building of the service providers and public health institutes delivering maternity care services.



States will identify institutions, which will provide technical support in implementation of SUMAN. These institutions will guide, mentor and do capacity building of the service providers

It is hence, envisaged that the CoE will be developed at both national and state levels. Priority can be given to all AIIMS, MGIMS, Central institutes like BHU, AMU, PGI, JIPMER, VMMC etc., along with MCH centres and Medical colleges in the states. The faculty and service providers of these institutes will be trained and oriented to achieve LaQshya certification. Such identified facilities will undertake self-assessment, find gaps, if any, as per the LaQshya and IPHS (Indian Public Health Standards) guidelines, and then reflect budgetary requirements in the PIP. Post which, they are expected to take corrective actions for filling in the gaps identified and then getting LaQshya certified. Those certified as platinum holders will be the CoE for MCH care and will help and support the states and districts in their jurisdiction for delivering quality maternity care.

State committee will identify at least one Medical college/MCH centre as a CoE and the Professors & HOD of OBGY and paediatrics department of that centre will be the nodal person to coordinate activities of that CoE. The roles and responsibilities of the CoE are listed in **Annexure -C**

Budgetary support to these Centre of excellences shall be provided through state PIPs.

Role of National Mentors

The Center of Excellences are like the role models, which can be replicated at various levels for providing safe, respectful and quality maternity care. Replication of good practices will need not only the capacity building but also the mentoring of the service providers. So under this program creating national and state level mentors is one of the critical component.

The national mentor can be technical experts from the field of maternal and newborn health. They can be from Government Institutions, Medical colleges, Universities, Developmental partners and Social sector etc and having an expertise in the field of Maternal and newborn health care. These mentors will conduct periodic hand holding mentoring visits to the public and government health care facilities giving services of SUMAN initiative and support in better performance of the facilities.

There will also be national mentors from the Civil society and academic organizations (like TISS, IIMR, PGI, JIPMER) who will visit states periodically for monitoring the implementation of the initiative, including the entitlements being received by the beneficiaries, take their feedbacks, assess the gaps in service delivery and suggest ways to improve the services.

During each mentorship visit the mentors will observe practices by the provider and will provide on-the-job hand holding for improving it. They will also observe the quality of care being provided and guide the facility staff if further improvement is required.

The national mentor going in the field should not be stand alone. The existing mentors identified and created under NHM shall be utilized for mentoring this initiative also. Their TA/DA will be part of the NHM budget.

Role of Research and Training Institutes

Improving maternal and child health outcome is a continuous endeavor where the medical colleges and public health institutions are already contributing. Their expertise will be leveraged to implement and improve SUMAN in the states. These institutes will help the states in undertaking pilots, conducting operational/implementation research and suggesting innovations to improve the outcome.

C. Facility Level Service Guarantee

Under this initiative all public health facilities will have to be made operational with a service guarantee for maternal and infant care. This may be achieved in phases, but every state and district will have to come out with a well-defined road map and vision to achieve this. All such facilities will have to be certified under LaQshya and also by the state for provision of maternity and infant care services as defined for the respective level of the facility. All efforts would be made to operationalize adequate number of First Referral Units as per the population norm of 1/ 5 lakh population. These norms would be relaxed based on geographical considerations to ensure that CEmONC services can be accessed within an hour from all health care facilities in line with the time to care approach.

Medical Colleges and District Hospitals

All medical colleges and district hospitals will provide comprehensive essential and emergency obstetric care and newborn care services along with management of any complication. These centres will not deny any referral-in case. Also, all referral-out cases must be brought to the knowledge of the hospital in-charge within 24 hours of referral. These centres must have Obstetric HDU, SNCU and obstetric ICU and Neonatal ICU (NICU) or a Hybrid HDU(High Dependency Units). EmOC trained doctors available round the clock in LR/LDR/HDU/ICU can support them. All the Medical colleges and district hospitals must have Midwifery/SBA care available round the clock in the LR/LDR. It is expected that the midwives shall conduct all normal deliveries while the Obstetricians and doctors can manage the complications. Additionally the facility would be responsible for provision of ANC and PNC services.

SDH and CHC

All identified First Referral Units including SDHs (Sub-Divisional Hospitals) and FRU-CHC (First Referral Unit-Community Health Centre), will be responsible for provision of essential and emergency obstetric care and newborn care services and procedures as defined under IPHS. They will function as support and referral-in facilities for non- FRU facilities. Referral-out can be done for the obstetric complications for which facilities are not available in-house in these First Referral Units. However, all these facilities must have Midwifery/SBA care available round the clock in the LR/LDR. EmOC trained doctors available round the clock in LR/LDR can support them. They should have a functional NBSU (newborn stabilization unit) for immediate care of small and sick newborns. They should also use the IT application that would be introduced to act as a job aid and a decision support tool for health care providers in order to improve the quality of intrapartum and immediate post partum care and enable early identification and management of complications. Additionally the facility would be responsible for provision of ANC and PNC services.



Non- FRU CHCs, PHCs, UPHCs and PHC – HWCs:

All facilities that are not functioning as First Referral Units (such as Non- FRU Community Health Centres, Primary Health Centres and Primary Health Centre Level – Health and Wellness Centres), if conducting deliveries, shall be responsible for providing Basic Emergency Obstetric Care services and essential newborn care and resuscitation services. Referral out can be done for the obstetric and newborn complications for which facilities are not available in house. However, all these facilities must have skilled birth attendant care available round the clock. BEmOC/Dakshta trained healthcare providers must be available round the clock in the LR/ LDR. A functional newborn care corner for essential newborn care resuscitation and stabilization of sick new born and referral services must be available. Additionally the facility would be responsible for provision of ANC and PNC services. The facility must also oversee the work of the attached Subcentre/Health & Wellness Centre. The Subcentre/HWC would be responsible for line listing of all pregnant women, their registration, ensuring antenatal and postnatal care, ensuring institutional deliveries, timely immunization, counselling and other preventive and promotive care. If a PHC/UPHC/PHC- HWC does not conduct deliveries, the facility would be responsible for providing ANC and PNC services and overseeing the work of the attached Subcentre/Health & Wellness Centre. Most importantly, the facility would be responsible for providing assured referral to appropriate level of healthcare facility.

Sub Centre/ HWC

The SCs being converted into HWCs have a vital role in provision of primary level care for maternity care services. The CHO/MLHP (mid-level healthcare providers) shall be the nodal officer and she/he will ensure provision of the services through the ANMs and ASHAs working with her/ him. She/ He will coordinate with AWW (Anganwadi Worker) and their supervisors for utilizing the AWCs (Anganwadi Centers) for MCH services.

Line listing of all pregnant women, their registration, getting all designated antenatal and postnatal care, institutional deliveries, timely immunization, counselling and other preventive and promotive services are some of the core activities under HWC. Hence, the role of the CHO/MLHP becomes very important in not only sensitization of the community and the family, but also in bringing pregnant women under the fold of institutional care. All the referral facilities of HWCs will be sensitized to honour and prioritize the referrals made by the CHO/MLHP. They will also be responsible for informing the CHO/MLHP of their respective jurisdiction when a pregnant woman or the newborn is discharged after having provided the necessary care to them. This will help in assured and good quality follow up. Some of the key activities to be undertaken at HWC are indicated below-

- Post-marriage counselling (including family planning) for promoting use of modern contraceptives and delaying first pregnancy.
- Sensitization of family members on the importance of providing stress-free environment to the mother.
- Information and awareness on free services/cash entitlements and other benefits for delivering at government health facilities.
- Commitment to provide the prerequisites of MCH, i.e., timely and quality ANC services with early registration of pregnancy.

- Identification of high risk, if any, and assured birthing plan and management of all identified high risks.
- Access to high quality midwifery/SBA care.
- Provision of quality postnatal care to both mother and newborn.

Mid-Level Health Care provider would primarily be responsible for ensuring availability of services including manpower and material at the outreach sites. The MLHP would be responsible for monitoring and ensuring that services reach all beneficiaries in his/ her catchment area. She/He would also be responsible for ensuring follow up and management of high risk pregnancies. In comparison, MPW (Female) would be responsible for service delivery including antenatal care, counseling, awareness generation, high risk pregnancy identification and follow up, providing post natal care, home based newborn care etc. If the HWC is also involved in conducting deliveries, the MPW (Female) would also be involved in providing skilled birth attendance and essential newborn care and stabilization of sick new born. The MPW (F) will also be responsible for providing family planning counselling and basket of choice for contraceptive services.

COMMUNITY LINKAGES AND SUPPORT

A. Community Participation

Risks to health do not occur in isolation. Proximal factors mostly act directly to cause morbidity and mortality whereas distal factors are mostly those which has indirect effect and are widely known as social determinants of health. Addressing both proximal (ANC, Intrapartum, and postpartum care, FP, Nutrition) and distal drivers of maternal deaths (such as age of marriage, woman's education and empowerment) are an important aspect of the SUMAN initiative.

The impact of medical factors is considerably altered by the role of social determinants. While health is mainly responsible for proximal driver but most of the distal drivers are interdepartmental.

For example in many communities, early age of marriage is still a norm. Marriages before the age of 18 carries a much higher likelihood of maternal mortality and hence a very important driver of maternal health which needs to be tackled systematically by involving WCD, HRD, MoSJE etc. There are various other departments which influences other social determinants. The members of SUMAN committee at all levels are therefore representing various departments.

The SUMAN initiative needs to be scaled up to the village and Panchayat level with support from public representatives and community. They need to be sensitized to take cognizance of the fact that maternity and infant care are part of health services and should be available at their respective Sub-center, PHC, CHC or HWC. Therefore, it is important that public leaders take positive interest in ensuring that the health facilities are functional and requisite services are being delivered.

The PRIs and Community leaders need to undertake and monitor the following activities:



1. Raising awareness about the cashless care during pregnancy, child birth and postnatal period, including care of newborn and infants at public health facilities.
2. Sensitizing the family on the importance of getting timely ANC checkups and ensuring stress-free environment for a pregnant woman for healthy pregnancy outcomes.
3. Organizing periodic meetings to generate awareness.
4. Celebrating motherhood and no gender discrimination.
5. Ensuring 100% registration and social review (verbal autopsy) of maternal deaths and addressing the social causes of maternal deaths
6. In events of having problem in getting referral transport on time, the Panchayat/community to come forward and provide it.

The villages/ panchayats who have done excellent work in the field of maternal health would be awarded. The criteria outlined under the Performance Based Incentive programme such as 1. Early ANC registration within 12 weeks - >80% pregnant women out of total registered 2. Four (4) ANC check-up - >80% of pregnant women out of total registered 3. Exclusive breastfeeding for 6 months >75% for infants (>6 months), 4. Growth monitoring of all the eligible children as per MCP cards >90% 5. Complete vaccination of the children up to 1 year >90% etc. Detailed criteria for awards would be defined and notified and a mechanism for awards would be developed.

B. Generating awareness among beneficiaries and their families.

- Appeals from Hon'ble Chief Ministers and Health Ministers of States/ UTs through TV/ radio/ print media would be significantly beneficial in generating awareness about SUMAN and in mobilizing large number of beneficiaries.
- Partnerships would be established with NGOs for seeking their support in generating awareness about the initiative.
- The MCP card and safe motherhood booklet would be utilized to generate awareness regarding entitlements of the initiative to the beneficiaries
- In line with the Hon'ble Prime Minister's dream of 'Digital India', a mobile application for SUMAN would be developed for information on key pregnancy related IEC messages and 1000 day messages to pregnant women and family members. The mobile application is expected include several features for pregnant women as well as volunteers.

C. Identification and Felicitation of Champions

A volunteer or village representative will be such person who will support a pregnant woman in getting all the services as per her entitlement. Such volunteers shall be oriented on the expected services at the various levels of health facilities to enable them to monitor the availability and quality of services being delivered.

These volunteers will -

- Use BCC and IPC methods using printed flip charts/flash cards to mobilize the pregnant woman's family.
- Organize FDGs with different population groups to counter and find remedies for the social determinants of health.
- Report about achievements and deficiencies in services, upload photographs/pictures, service delivery activities etc. on social media or on the web portal of this program.
- Interact and support pregnant women and their families during antenatal and post natal period.
- Facilitate the pregnant woman's or sick infants transport to the health facility.
- Help spread awareness and mobilise the family in better access to all government entitlements.

Self Help Groups would also be actively involved for taking on the roles described above including awareness generation and improving access to entitlements.

Such volunteers/ Self Help Groups doing exemplary work will be felicitated as Champions at the Gram Sabha level. Also volunteers/ self-help groups who ensure that all pregnant women in their defined area get access to safe delivery services will be felicitated at District or State level.

Criteria for a selection of volunteer/ self-help group –

- He/She/ It will be willing to adopt a village or pregnant women and commit that all women in the village get quality delivery care services at the facility.
- An active member of the society working in the field of social sector.

D. Adopting Health Facilities

Public leaders and public/private companies under CSR can adopt health facilities at various levels, in order to support it in getting LaQshya certification so that all designated maternity services are delivered as expected.

1. Community leaders like MPs, MLAs, Zila Parishads and Block Pramukhs to be sensitized to adopt a health facility and ensure that it is operational and able to provide the designated services. The funds available with MPs, MLAs, Zila Parishads, Panchayats, etc. can be leveraged for keeping the facility operational.
2. Adoption by companies under CSR.

E. Role of Women's Groups, Civil Society Organizations and Professional Bodies

It is important to rope in civil society organizations like women's groups, self-help groups, NGOs, White Ribbon Alliance and community based organizations, for extending their support for community mobilization on safe maternity care, including delivery and care to the infants.



These groups are to be identified by the state and the district and oriented on the entitlements under the program. A similar role can be taken up by professional organizations like FOGSI, IMA, IAP, NNF, IAPSM, etc.

The social organizations or professional groups, which perform exceedingly well, will be recognized as champions of safe motherhood and will be felicitated by the state/district administration.

Some of the roles/responsibilities of social organizations and professional bodies are indicated below:

- ✓ Participating regularly in the State or District level review meetings and understanding their roles and responsibilities for strengthening maternal health.
- ✓ Volunteering to become a Trainer or Supervisor on safe delivery and respectful maternity care.
- ✓ Facilitating 100 % maternal death reporting and participating, as required, in investigation of maternal deaths and maternal death reviews.
- ✓ Interacting with unsatisfied beneficiaries, suggesting actions for improvement and sharing the feedback with respective committees and CoE.
- ✓ Participating regularly at village or block level for community mobilization activities to meet increased demand for safe delivery and respectful maternity care.
- ✓ Taking up any other role as per the local situation.

REPORTING AND REVIEWING OF ALL MATERNAL DEATHS

Despite more than one third reduction, India remains one of the major contributors to maternal deaths in the world. For every death, many more suffer varying degrees of morbid conditions. However, in many cases of maternal deaths, the newborns also die for want of care due to causes such as preterm birth complications and intrapartum-related complications. Pregnancy-related mortality and morbidity continues to have a major impact on the lives of women and their newborns.

Levels of maternal mortality vary greatly across regions, due to variations in access to health care services, such as emergency obstetric care, antenatal care, and variations in social determinants of health like nutrition, education, and other factors. Approximately 65-75% of the total estimated maternal deaths in India occur in a handful of states – Bihar, Madhya Pradesh, Rajasthan, Uttar Pradesh and Assam. Analysis of these deaths can identify the cause of delays that contribute to maternal deaths at various levels and the information gathered can be used to adopt measures to fill the gaps in service delivery.

GOI introduced MDR(Maternal Death Review) and later MDSR(Maternal Death Surveillance and Response), which is a continuous cycle of identification, notification and review of maternal deaths followed by actions to improve quality of care and prevent future deaths. However, the reporting of maternal deaths is still very low and its review for corrective action is negligible.

Ensuring 100% reporting of maternal deaths is one of the expected outcomes of the initiative and this will help in identifying and closing the gaps to prevent future maternal deaths. Following actions are needed for its compliance:

1. Linkages with existing call center for reporting of all i.e. 100% maternal deaths.
2. Identifying and promoting volunteers who report maternal deaths.
3. Cash incentives to any volunteer for first reporting of maternal deaths.
4. Creating national and state teams for periodic field visits to assess and analyse every maternal death.
5. Incentives/certificates/awards to the districts for achieving 100% reporting and reviewing of maternal deaths.
6. GOI guidelines on Maternal Death Surveillance and Response need to be followed for such reporting and review.

Strengthening Reporting and Review of Maternal Deaths

The maternal death reporting will include both facility based reporting and community based reporting as in MDSR system. However for incentivizing the informer/reporter of the death only such deaths which have taken place in community shall only be considered. Once a call is received the call will be forwarded to the respective State for verification by a block medical official and on his verification as the first reporter of death the caller/reporter can be incentivized as per the initiative guideline.

An incentive of Rs 1000/- will be given to any informer who calls to give the information about the maternal death in the community. The call will be redirected to the designated call center. Which in turn will forward it to the block MO in-charge. Once verified the payment can be made to the caller.

IEC AND COMMUNICATION

Community participation is a key factor for the success of any public health program. Unique, segmented and effective IEC and BCC strategy would play a crucial role in creating awareness and demand generation among the masses for utilizing the services provided under SUMAN and promoting “Zero Maternal Death” agenda. Separate IEC/BCC strategies should be developed to cover the unreached beneficiaries. The key message to be given should be simple, catchy and effective in connecting the masses with the program.

The information and awareness about cashless maternity care and delivery services needs to be widely disseminated using various media modes and platforms. Media plan shall be developed at National and State level along with the designing of communication material, radio and TV spots, posters, badges, etc. Use of social media shall also be undertaken for positive and wider communication to the people. Some of the actions to be prioritized are indicated below:



- Develop media plan and IEC/BCC materials.
- Translate IEC/BCC materials in the respective language of the States.
- Use these materials to generate awareness amongst the communities.
- States will ensure to play the IEC/BCC material on TV and radio spots.
- Orient ASHAs and ANMs on IEC/BCC materials so that they use this for community mobilization activities during VHNDs, immunization sessions, at ANC clinics, etc.
- Good performing facilities will also be rewarded by either incentivizing the service provider with additional logistical and infrastructure support or by certifying them for doing good work.

CREATING A WEB PORTAL FOR GENERATING DATA

As a step towards Hon'ble Prime Minister's dream of 'Digital India', a mobile/ web based application for registration of social workers/active society members willing to volunteer for the SUMAN would be created at the National level. The SUMAN web portal would be linked to the existing PMSMA portal and the architecture and features of PMSMA portal would be leveraged to enable volunteer registration for SUMAN.

Such volunteers would be in a position to register for contributing in the initiative through any of the following mechanisms:

*Toll Free Number – **Volunteers can call 18001801104 to register***

*SMS- **Volunteers can SMS 'SUMAN' <Name> to 5616115***

*Portal- **Register at www.pmsma.nhp.gov.in/ new portal for SUMAN***

Register using the 'Volunteer Registration' Section of the Mobile Application

The portal will be used to create awareness on the SUMAN including the message from honorable Prime Minister, and Health Minister. The portal would be instrumental in generating and compiling various data related to the program. The web portal will also be used for uploading photographs; program activities; achievements of various groups, individuals and professionals; the facilities available; and highlighting the work done by the champions. Progress of the program can also be monitored through this portal.

Nearest SUMAN Facility Search:

The mobile/ web based application would include a feature to help pregnant women find their nearest **SUMAN** facility by visiting the website or downloading the 'SUMAN' mobile application.

LINKAGES WITH EXISTING PROGRAMS

Several program initiatives had been taken since the launch of the National Health Mission (NHM), which were helpful in scaling up, improving newborn, and child survival rate. Programs like Janani Suraksha Yojna (JSY), Janani Shishu Suraksha Karyakram (JSSK), provisions under operationalization of FRUs, NAS etc. and newer initiatives under the Pradhan Mantri Surkashit Matritva Abhiyan (PMSMA), LaQshya, Pradhan Mantri Matritva Vandana Yojna (PMMVY), Midwifery-led Care etc. have helped in providing quality maternity and newborn care services..

Each of these programs will continue to remain in place and shall be part of the initiatives under this initiative. A brief about these programs and actions required under the newer initiatives have been placed at **Annexure -D**

QUALITY ASSURANCE

Quality is the core and most important aspect of services being rendered at any health facility. MoHFW launched the program LaQshya to improve the quality of care in the labour room and maternity Operation Theatre (OT). The program focuses on improving quality of care for pregnant women in the labour room, maternity OT, Obstetric Intensive Care Units (ICUs) and High Dependency Units (HDUs). Steps like infrastructure up-gradation, ensuring availability of essential equipment, providing adequate human resources; capacity building of health care workers and improving quality processes in the labour room are being undertaken under the initiative. It also focuses on operationalization of Obstetric ICUs at Medical College Hospital level and Obstetric HDUs at District Hospitals.

Quality ANC is generally measured by provision of services such as general examination (BP, weight, Hb estimation, urine sugar and abdominal examination), scheduling appointments for all checkups with the various departments, investigations, and providing TT/Td (Tetanus Toxoid/Tetanus toxoid & diphtheria) injections, iron and folic acid (IFA) tablets, etc.

Quality of ANC depends on the knowledge, skills and abilities of the service providers particularly ANM, Nurses and MO for abdominal and pelvic examination to detect the fetal condition. ANC is one of the evidence-based interventions to decrease the probability of any adverse health outcomes for mothers and their newborns. Effectiveness of antenatal care, however, relies on the quality of care provided during each antenatal care visit.

The combined availability of five key antenatal functions, relevant screening tests, availability of skilled health workers (doctors, midwives/nurses), as well as availability of other pertinent services in the continuum of care (delivery care, prevention of mother-to-child transmission - PMTCT) represents various dimensions of quality of care provided at antenatal care services.

Regular clinical audit of cesarean section should be undertaken in higher C-section case load facility.



Similarly, the services at SNCU/ pediatric care unit may be audited for performance on quality indicators, survival rates and referral rate.

Some of the Indicators which can be suggested for measuring quality services during ANC, delivery and post natal period are suggested in **Annexure E**

ROLES AND RESPONSIBILITIES OF PROGRAM OFFICERS AT STATE/DISTRICT/BLOCK LEVEL

Giving any service guarantee and transforming this guarantee to the beneficiaries by delivery of services ,needs clear vision and supporting action. Transforming the guarantee into cashless and quality delivery of services has various complexities like adequacy and availability of HR, issues of governance, various types of logistics including procurement processes for drugs, equipment etc. This needs not only the budgetary support, but also the involvement of various departments and institutes.

Basically, both political and administrative commitments are essential vehicles which will run on the effective wheels of the program officers. It is thus important to clearly define the roles and responsibilities at national/state/district and block level. Some of the important roles have been defined and listed in **Annexure - F**. However, these are not exhaustive, and as the programmatures various other responsibilities will be gradually included.

MONITORING & SUPERVISION

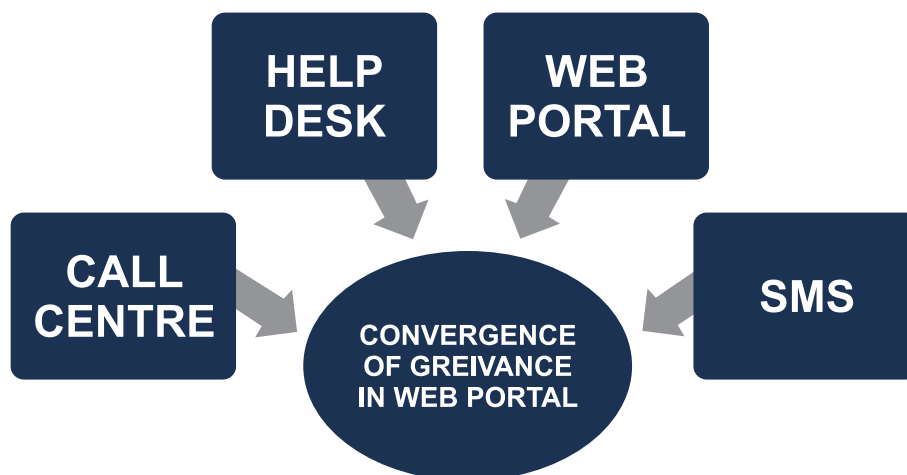
Monitoring mechanisms such as field visits, e –Supportive supervision, program indicators, effective Grievance Redressal System, checklists, rounds by the facility in-charge, and visits by state district and block program officers would be institutionalized and data from various mechanisms would be analyzed&reviewed for corrective action.

Additionally, community-based monitoring would be strengthened for good quality tracking and corrective action by public health facilities.

GRIEVANCE REDRESSAL

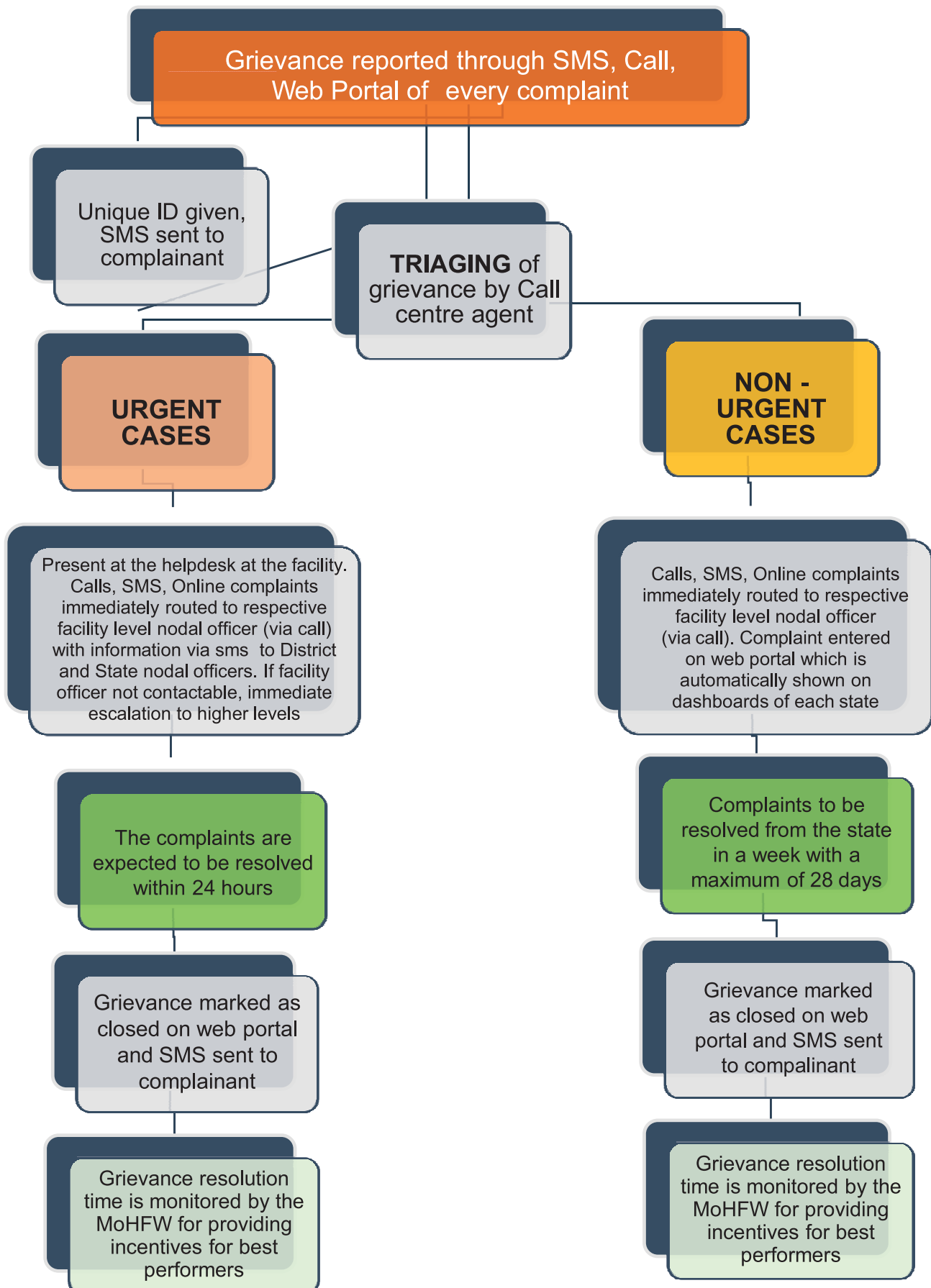
It is important to create an effective and responsive system for redressal of grievances. Any beneficiary accessing a public health facility for care during pregnancy and childbirth should be provided with a dignified and respectful maternity care. The beneficiaries or the attendants have the right to register, complain or raise grievances if the entitlements/services are not as per their satisfaction.

Under this initiative, for effective redressal of such grievances, the grievances would be registered either through a help desk, a web portal, sms or through a call center. Help desks would be established in high volume facilities such as Medical Colleges, District Hospitals and Sub District



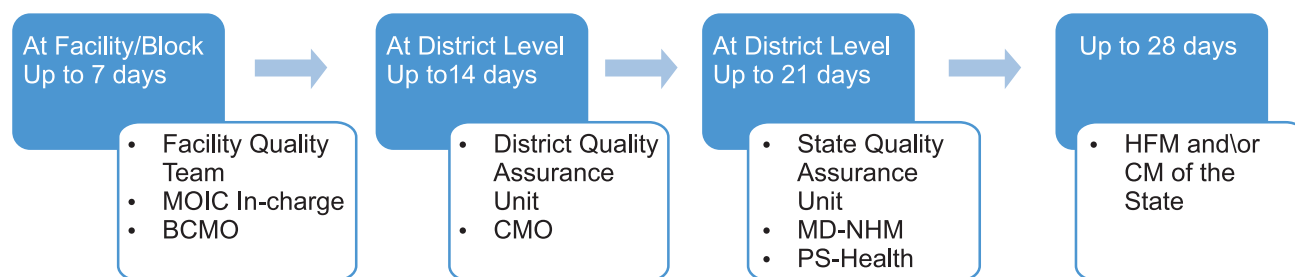
Hospitals/based on criteria given in Operational Guideline. Budget for HR for establishing the help desks would be provided through the National Health Mission. In States that already have 104 services/ call centres, the existing call centres would be used for registration of complaints and feedback to the clients. States that do not have an existing call centre, would be provided the requisite support for establishing the call centre. An existing National level call centre would be operationalized for Grievance redressal as an interim measure especially for addressing the requirements of States/ UTs that do not have their own call centre. The information regarding the grievance would be shared with the district for redressal.

The following process flow is proposed for resolution of grievances:



Once registered they would be segregated into – urgent and non-urgent grievances. The algorithm above outlines the processes to be followed for redressal of both urgent and non urgent grievances. The triaging of grievances into urgent and non urgent would be done based on pre-defined parameters and algorithms. Based on the urgency, the call will be forwarded to the concerned facility nodal person for immediate redressal of grievances. Information of the grievance shall be given through SMS to higher authorities for appropriate follow up and action. If facility officer not contactable, immediate escalation to higher levels would be ensured. All urgent calls would be resolved immediately and certainly within 24 hrs. Beneficiaries would be informed about the progress of the complaint through SMS/call.

All non-urgent calls Calls, SMS, Online complaints would be immediately routed to respective facility level nodal officer (via call) .Additionally, the complaint entered on web portal which is automatically shown on dashboards of each state. The timeline for redressal of grievances shall be a maximum of 7 days at each level. After 7 days, the grievance would automatically escalate to next higher level for resolution. Steps would be taken to resolve the grievance. Beneficiaries if not satisfied can reopen the complaint at higher level.



State and District health society will monitor the performance indicators such as the number of urgent and non-urgent grievances received, number resolved, time taken in resolving the grievances and quality of grievances.

Facilities who could resolve the grievances on time would receive recognition in the public domain and names of such facilities where grievance redressal was delayed would also be put on the public domain. Awards/ recognition of facilities would be based on parameters such as time taken in resolving the grievances. An independent committee would be established to define the parameters for National, State and district level awards and virtual recognition. Additionally, incentives/ penalties based on performance under the grievance redressal system would be introduced as part of the conditionalities for performance based funding under National Health Mission.

Both at center and state level, a directory of facility nodal officers from Medical colleges to SDH needs to be maintained for quick referral of grievances after triaging.

Grievances redressal mechanism is envisaged to be a key step towards community involvement. It is expected to improve the functioning of public health system and improve its accountability.



DIGNITY, RESPECT AND SUPPORT TO SERVICE PROVIDERS

Any effort towards provision of respectful maternity care which is free, cashless and delivered with dignity will not succeed unless there is full support and willingness on the part of the service providers (doctors, nurses and support staff). Ensuring this support remains a major challenge; however, evidence suggests that if the system is providing care and dignity to their own staff and if they are satisfied, the same sentiment spontaneously radiates to the people and beneficiaries who come to avail the services at the Public health facilities.

Hence, it is imperative that every state and district should be proactive in providing some of the initiatives and services indicated below:

1. Improving ambience and work environment.
2. Creating an enabling environment so that the providers feel joy in rendering quality RMC services
3. Ensuring availability of adequate drugs, equipment and infrastructure.
4. Provision of faculty/staff room, seminar halls, library, pantry, tea/coffee, drinking water, clean restrooms and washrooms for the staff.
5. Provision of dress, uniform and apron as per the policy, name badge, etc., reflecting a professional attitude and behavior of the institute and staff.
6. A system of recognition, award and reward to appreciate performers and generate healthy competition to perform better.

Grant duty leave and support to attend seminars, workshops and conferences to those who are performers and have delivered services as per the defined parameters.

SERVICE PACKAGES UNDER ANTE NATAL CARE

Assessment of All Pregnant Women (PW)	
•	ANC (minimum 4 ANC)
•	Routine investigations for all pregnant women
•	Prophylaxis and preventive measures
•	Counseling
•	Danger sign identification and management of HRP
•	Referral services

- **Minimum 4 ANC –**
 - **Physical Examination:** Physical examination of all pregnant women will be performed by a trained service provider during all ANC visits. All vitals should be checked and recorded especially height, weight, BP, pulse, temperature, per abdomen examination should be performed every time and recorded in MCP card. Examination of the breast to be conducted during ANC visits in 3rd trimester for diagnosis and management of difficult breast conditions (Inverted/Cracked nipples).
 - **Screening of Pregnant women-** All pregnant women should be screened for possible conditions (Viz anemia, Hypertensive disorder, GDM, RTI/STDs, Hepatitis B etc) during pregnancy to identify high risk pregnancies and their timely referral and management
 - **Management of common physiological conditions during pregnancy-** Common condition during pregnancy like Nausea and vomiting, heartburn, constipation varicose veins and edema, palpitations, fainting, dyspnea, low back and pelvic pain leg cramps should be identified and treated accordingly in order to ensure positive pregnancy experiences.
 - **Recording and Reporting-** All pregnancies should be registered with in 1st trimester and all pregnant women should be provided MCP card. The pregnant women should be counseled to carry her card during all ANC visits and delivery. Other reporting formats like RCH Register, ANMOL, RCH Portal, HMIS and PMSMA portal formats should be updated on time to time basis.

- **Routine Investigations-**

Hemoglobin estimation for identification of anemia and urine albumin and sugar should be performed during each ANC visit. Blood group-ABO Rh, HIV, HBs-Ag, VDRL/RPR, Ultrasonography (USG) (18-20 weeks) and OGTT (Repeat 24-28 weeks, if negative) should be performed once during pregnancy. In malaria endemic area all pregnant women should be screened using thick/thin smear/RDT- malaria.



• **Prophylaxis and Preventive Measures-**

All pregnant women should be provided supplementation of Folic Acid during 1st trimester for prevention of neural tube defects, Iron-folic acid (IFA) and Calcium during 2nd and 3rd trimester, Injection Tetanus Toxoid & Diphtheria (Td). Promotion of consumption of iodized salt daily during entire pregnancy to prevent Iodine deficiency/goiter. In malaria endemic areas Insecticide Treated Bed Nets (ITN) should be provided.

• **Counseling**

All pregnant women should be provided counselling on-

- ✓ Adequate rest and exercise and keeping physically active,
- ✓ Healthy eating & supplementation (Dietary diversity, Essential nutrients, IFA & calcium supplementation, consumption of iodized salt and deworming),
- ✓ Birth preparedness and complication readiness.
- ✓ Encourage father's (male) involvement in ANC.
- ✓ Importance of early initiation of and exclusive breastfeeding and its benefits for mother and baby

- **Danger sign identification and management of HRP-** Identify pregnant women at risk for developing complications or those having onset of complications during their pregnancy. All pregnant women and their family members should be informed about danger signs during pregnancies. Timely identification of High risk pregnancies, line listing of HRPS, timely management and appropriate birth preparedness plan

- **Referral services-** Each pregnant woman and her ASHA worker should be provided with contact details of the call center/ relevant transport provider and an additional list of escalation/ alternative transport option to reach out in case the primary transport provider doesn't respond.

SERVICE PACKAGE UNDER INTRAPARTUM CARE

Services including normal delivery, assisted delivery, C-Section delivery and management of complication at appropriate level of facility including essential newborn care.

SERVICE PACKAGE UNDER POST NATAL CARE

- **Postnatal check-ups-** Four PNC visits should be provided at 1st (within 24 hrs.), 3rd, 7th day and 6 weeks after delivery. There should be three additional visits in case of babies with low birth weight on day 14th, 21st & 28th (as per the Integrated Management of Neonatal & Childhood Illness (IMNCI) guidelines). The first 48 hours following delivery are the most critical in the entire postpartum period check mothers for bleeding, temperature, signs of infection and provide breastfeeding counselling.

Look for the following in the PNC check-ups-

- o **Relevant History:** Ask for the history of any complications during delivery e.g. excessive bleeding, convulsions etc. Ask for any present complaints like- ongoing heavy bleeding, abdominal pain, pain in legs, foul smelling discharge PV, difficulty in passing urine or stools etc.
- o **Physical Examination-** Check for Pulse, BP, Temperature, Pallor & RR of the mother. Do abdominal examination to check for adequate involution of uterus and to rule out any uterine tenderness.
- o **Timely Identification & Management of Complications** both in the mother & the new born
- o **Breast feeding-** Ask if the mother has started breast feeding or if there is any difficulty in initiation of the same such as breast tenderness etc. Explain the correct position, attachment & frequency of breast feeding especially during night hours. Also emphasise if requires any support in skill of breast milk expression, using palladi for feeding, upon the need of Exclusive Breast Feeding for first 6 months of birth.
- o **Care of New Born-** Explain about the new born care, importance of rooming in, how to bathe the new born etc. to the mother. Also to inform danger signs to the mothers. Ask for any history of illness in the child e.g. not feeding, fever etc.
- o **Counseling of the mother on** Hygiene, Full Immunization, Contraception, Birth registration, Danger signs in mother & child both, Diet & Rest etc.
- o **Issuing IFA & Calcium tablets & ensuring compliance.**



ANNEXURE - B

Services package for Newborn

Facility Based Newborn Care (FBNC) along with Home Based Newborn Care (HBNC) establishes a continuum of newborn care to ensure that every newborn receives essential care right from the time of birth and first 48 hours at the health facility and then at home during the first 42 days of life.

Overview of services at different levels of newborn care

1. For all newborn – essential newborn care will be provided at all levels.
2. For sick and small newborns-
 - a. Identification and prompt referral of 'at risk' / sick and small newborns.
 - b. Stabilization of newborns presenting with emergency signs and management of sick newborns (as per the guideline)
 - c. Comprehensive care to all sick and small newborns (except for ventilator support* and surgery)

Details of the services for the newborn provided at each level.

1. Essential care for all newborns including resuscitation, when required.
 - ✓ Prevention of infection
 - ✓ Provision of warmth (skin to skin contact)
 - ✓ Resuscitation (when required)
 - ✓ Early initiation of breastfeeding
 - ✓ Weighing
 - ✓ Vitamin K administration
 - ✓ Injection Vitamin K administration within one hour of birth
2. Identification & prompt referral of 'at risk' and sick newborns to appropriate level of care.
3. Stabilization of newborns presenting to FRU/NBSU with emergency signs.
4. Management of newborns with emergency signs:
 - ✓ Apnoea (Not breathing at all) or gasping respiration
 - ✓ Severe respiratory distress (RR > 70/min, Grunting, moderate retractions)
 - ✓ Central Cyanosis
 - ✓ Shock
 - ✓ Convulsions/ Unconsciousness
 - ✓ Hypothermia (Temp. < 35.5 degree C)

Service Package under Post Natal Care

Facility follow up of SNCU discharge child: Five scheduled visits on SNCU .First visit during day 8 after discharge and later on as per prescription of doctor.

Home based Newborn Care (HBNC) – Six scheduled incentivized visits on **Day 3, 7, 14, 21, 28 and 42 days** .In case of Home Delivery visit on Day 1 is mandatory. In case of LBW babies /sick baby additional visits may be conducted.

Follow up of SNCU discharges and LBW at community– ASHA to continue the same schedule of HBNC in SNCU discharge babies considering the day of discharge as day of birth. After 42 days quarterly visits starting from 3rd month to be conducted till one year of age.

Home Based Care of Young Child (HBYC)- All children **beyond 42 days** will be visited by ASHA every quarter starting from 3rd month onwards till 15 months of age. The program will be rolled out in aspirational districts to begin with.

An overview of the package for PNC is provided below:

Preventive care	
•	Details at birth to be documented- Time of birth, weight at birth, Sex at birth
•	Cord dry and clean
•	Exclusive breast feeding and breast feeding support
•	Kangaroo Mother Care for Stable LBW babies
•	Vaccinations at birth - Oral polio, Inj Hep B , BCG
Preventive Measures	
•	Injection Vitamin K
•	Oral Supplements Vit D
•	Calcium supplements
•	Iron supplements
•	Multivitamin
Counselling care	
•	Keeping the newborn warm –specially covering the head and feet
•	Hand washing
•	Exclusive breast feeding
•	Delayed bathing
•	Danger sign
Management of common physiological conditions during Neonatal period	
•	Mastitis Neonatorum
•	stool pattern
•	Vaginal Bleeding / Thick discharge
•	crying
•	Tongue tie
•	umbilical hernia
•	Non retractable prepuce
•	Hymena tags



Investigations

1. Normal healthy newborn- Blood group-ABO./Rh, Random blood sugar ,Liver Profile : Serum bilirubin total & direct.
2. Sick newborns- list of investigations as per FBNC training package like complete haemogram , kidney profile , X-Ray etc.

Services package for Infant

Facility Based Infant Care-

- All the infants coming will be provided with OPD & Emergency, Triage and Treatment (ETAT) at all facilities providing 24*7 facilities PHC(HWC) onwards.

Service package under Post natal care –

- Follow up of SNCU discharges and LBW
- Home based Newborn Care (HBNC) by ASHA up to 42 days and
- Home Based Care of Young Child (HBYC)

Preventive Measures

Oral Supplements Vit D , Calcium ,Iron, Multivitamin,
Prophylactic ORS distribution ORS
Nebulization facilities should be available

Sick Infant

1. OPD - drugs for management of childhood illness as per IMNCI Guidelines – Paracetamol, oral amoxicillin, Zinc tablets , Antimalarials as per NMEP guidelines etc
2. ETAT, HDU & IPD management : Treatment specially of **ARI/Bronchitis Asthmatic, Diarrhoeal Diseases, Severe acute malnutrition, vitamin deficiencies and micronutrient deficiencies, Pyrexia of unknown origin, Haematological Disorders & Diseases of Bones and Joints etc. and others**

Essential Lab Tests

Haemogram with peripheral smear, Blood grouping & cross matching
Routine microscopy urine
Rapid diagnostic test for malaria
Blood glucose
Test for typhoid
Serum bilirubin

Preventive care

- Play and communication with child
- Use of MCP card for tracking development of child
- Regular growth monitoring at nearest AWC
- Awareness about danger signs and accessing free referral and services under JSSK
- Age appropriate Vaccinations
- Prevent accidents and injuries by keeping sharps and dangerous items away from the reach of child . Never leave them unattended near fire/water/road
- Continue treatment and return to facility for follow up as advised by the service provider

Counselling care

- Keeping the infant warm –specially covering the head and feet
- Hand washing
- Exclusive breast feeding till 6months
- Age appropriate and adequate complementary feeding with continued breast feeding
- Continue feeding during illness
- Keep the children away from people with infectious diseases and report for screening specially in case of TB/HIV in the family
- Use insecticide treated bednets in the malaria infested area and follow all personal protective measures to avoid vector borne diseases

Management of common physiological conditions during infancy

Infants may have physiological anemia at 2-3 months of age.

Pain in abdomen/Colic

Growing pains



Overview of services at different levels of infant care	
Paediatric OPD	<p>Early diagnosis & curative services for common childhood ailments</p> <p>Screening for admission to hospital</p> <p>Follow up care & care after discharge</p> <p>Preventive healthcare services through provision of immunisation, screening, counselling</p> <p>Promotion of overall growth & development by health & nutrition counselling</p>
ETAT	<p>Assessment of children for emergency signs</p> <p>Triage by qualified health professional</p> <p>Management of emergency conditions e.g. for convulsions, shock, respiratory distress</p> <p>Stabilization before transfer to inpatient ward/onward referral</p>
High Dependency Unit	<p>Provision of close observation, monitoring of children who are physiologically unstable</p> <p>Management- oxygen therapy, cardio respiratory monitoring , ionotropic support etc.</p>
Paediatric ward	<p>Investigation and treatment of admitted sick children as per national standard (F-IMNCI)</p> <p>Supportive care for sick children</p> <p>Identification & referral of children requiring care at tertiary facilities</p>
PICU	<p>All the referrals from HDU/ETAT directly with danger signs, ventilatory support</p>
Diarrhoea treatment units	<p>Assessment of dehydration</p> <p>Management according to degree of dehydration</p> <p>Rational use of drugs in children with diarrhoea/dysentery</p> <p>Demonstration of ORS preparation</p> <p>Counselling on feeding, danger signs, prevention of diarrhoea</p>
Isolation room	<p>Segregation and management of children with infectious diseases (source isolation)</p> <p>Prevent susceptible paediatric patients from being infected (protective isolation)</p>
ANCILLARY & AUXILIARY SERVICES	
Kitchen, Play area, Laboratory	<p>Family Centred Care : basic amenities for family members</p> <p>Kitchen : equipped to provide diet for children of different age groups</p> <p>Child friendly care : Play area for recreation of children during convalescence</p>

ROLES AND RESPONSIBILITIES OF CENTERS OF EXCELLENCE

These Centres of Excellence (CoE) will act as a resource center for: -

- i. Technical, programmatic and monitoring support to public health facilities for implementation of the SUMAN.
- ii. Orientation, training and supporting service providers for creating a mother-friendly environment at facilities to provide safe delivery and respectful maternity care.
- iii. Creating an ideal demonstration model for training and counselling the center to train all the service providers on quality ANC, PNC, Safe delivery and Respectful maternity care.
- iv. Guiding and conducting training for provision of quality infant care including complication management.
- v. Identifying State Trainers and Supervisors to monitor these activities, in collaboration with the State Committee,
- vi. Creating a pool of Master Trainers to train service providers on highlighting the connection between human rights language and key program issues relevant to safe maternity care.
- vii. Ensuring that each and every maternal death is reported and investigated as per the GOI MDSR guidelines.
- viii. Conducting regular referral audit of all unnecessary referral cases or refusal to admit complicated pregnancies at PHC, CHC, FRU, district hospitals and other medical colleges.
- ix. To establish a CoE, the respective medical college will get all necessary budgetary support through State PIP.
- x. CoE will meet on a monthly basis with State Committee to update, discuss the progress or any implementation challenges, so as to get necessary support from State.
- xi. Generate actions to support changes in provider behavior, clinical environments and health systems to ensure that all women have access to respectful, competent and caring maternity health care services. This can include social support through a companion of choice, mobility, access to food and fluids, confidentiality, privacy, informed choice, information for women on their rights, mechanisms for redress following violations, and ensuring high professional standards of clinical care.

**ANNEXURE - D**

LINKAGES WITH EXISTING PROGRAMS

Janani Suraksha Yojna (JSY)

JSY is a demand promotion scheme which provides conditional cash transfer of incentives to pregnant women coming into the institutional fold for delivery. It ensures timely antenatal care (ANC), institutional delivery and postnatal care (PNC).

Under this program, the facility in-charge and program officers will ensure that all entitled beneficiaries get the payment through DBT (direct benefit transfer) at the time of discharge from the hospital.

Janani Shishu Suraksha Karyakram (JSSK)

JSSK is operational in the entire country from the year 2011. It provides free and cashless maternity services and infant care in all government healthcare institutions including diet, so that no out-of-pocket expenditure is incurred by the beneficiary on drugs, disposables, diagnostics, blood transfusion, referral transport and drop back facility. Under this program, it is the responsibility of the facility in-charge from tertiary to primary care center to ensure provision of all entitlements so that there is zero expense by the beneficiaries on care during pregnancy, childbirth and post-natal period, including infants.

Pradhan Mantri Surkashit Matritva Abhiyan (PMSMA)

PMSMA has been launched to provide quality antenatal services to women in the 2nd and 3rd trimesters of pregnancy on the 9th day of every month across the country by the Medical Officer/OBGY specialists. These doctors (volunteers) can also be from private health facilities. The program has a focus for identification and line listing of HRPs so that assured care can be provided to the identified HRPs.

Under this program it will be the responsibility of program officers at all levels to ensure that every pregnant woman receives ANC/PNC and in case she is identified as HRP, her line listing and delivery plan is prepared and executed.

LaQshya

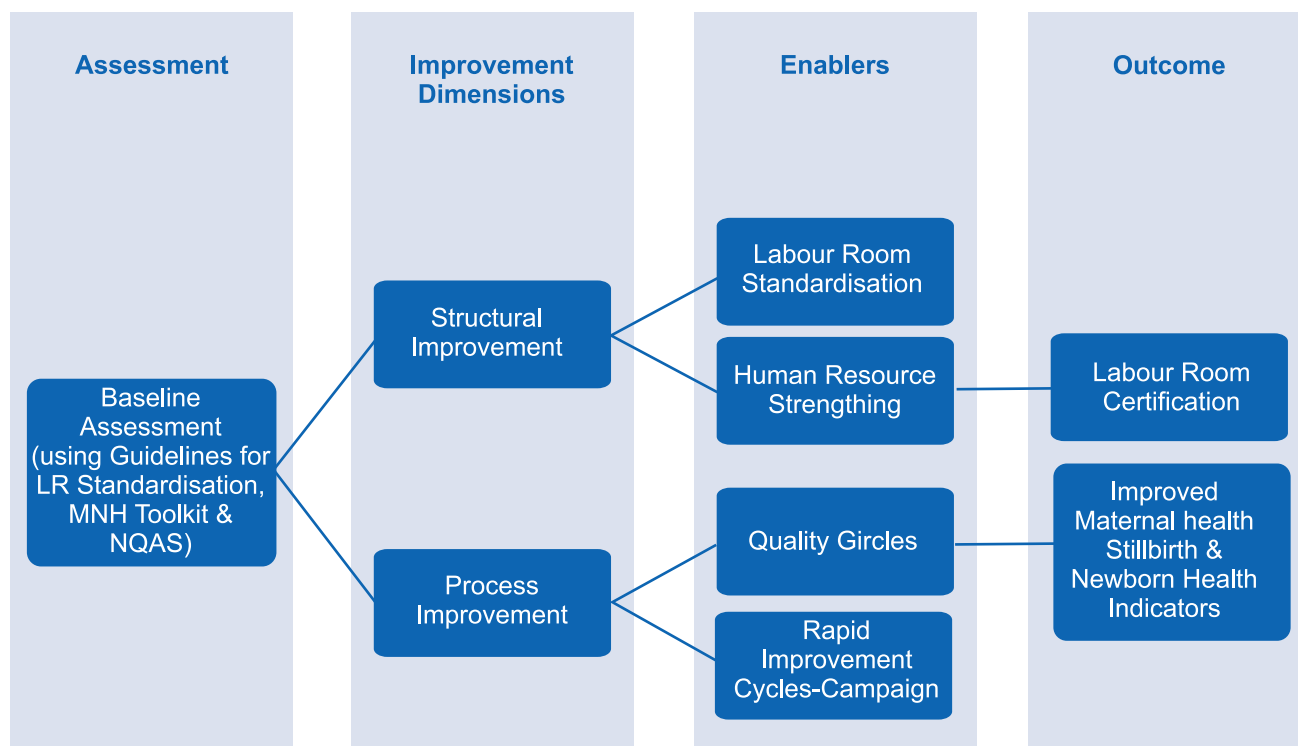
Access to care alone does not guarantee a positive outcome. Care for pregnant women must be of high quality and delivered with respect and dignity. Highly trained doctors, nurses, and other health workers, who adhere to quality standards mandated by the government, are critical to minimizing risk of pregnancy complications and stillbirths.

In view of this Government of India launched “LaQshya program” to improve quality of care in labour room and Maternity OTs in public health facilities.

The LaQshya program is an evidence based approach to improve quality of maternal and newborn care and provide respectful care, particularly during the intrapartum and postpartum periods, which are the most vulnerable periods for a woman and contribute to a significant proportion of maternal deaths.

Its implementation involves improving Infrastructure upgradation, ensuring availability of essential equipment, providing adequate human resources, capacity building of health care workers, adherence to clinical guidelines and improving quality processes in labour room and maternity OT. One of the key interventions in LaQshya program is six focused Quality Improvement cycles of two month each in all LaQshya facilities.

The Quality Improvement in labour room and maternity OT will be assessed through NQAS (National Quality Assurance Standards). Every facility achieving 70% score on NQAS will be certified as LaQshya certified facility. Furthermore, branding of LaQshya certified facilities will be done as per the NQAS score. Facilities scoring more than 90%, 80% and 70% will be given Platinum, Gold and Silver badge accordingly. Facilities achieving NQAS certification and defined quality indicators and 80% satisfied beneficiaries will be provided incentive of Rs 6 lakh, Rs 3 lakh and Rs 2 lakh for Medical College Hospital, District Hospital and FRUs respectively.



Interventions under LaQshya

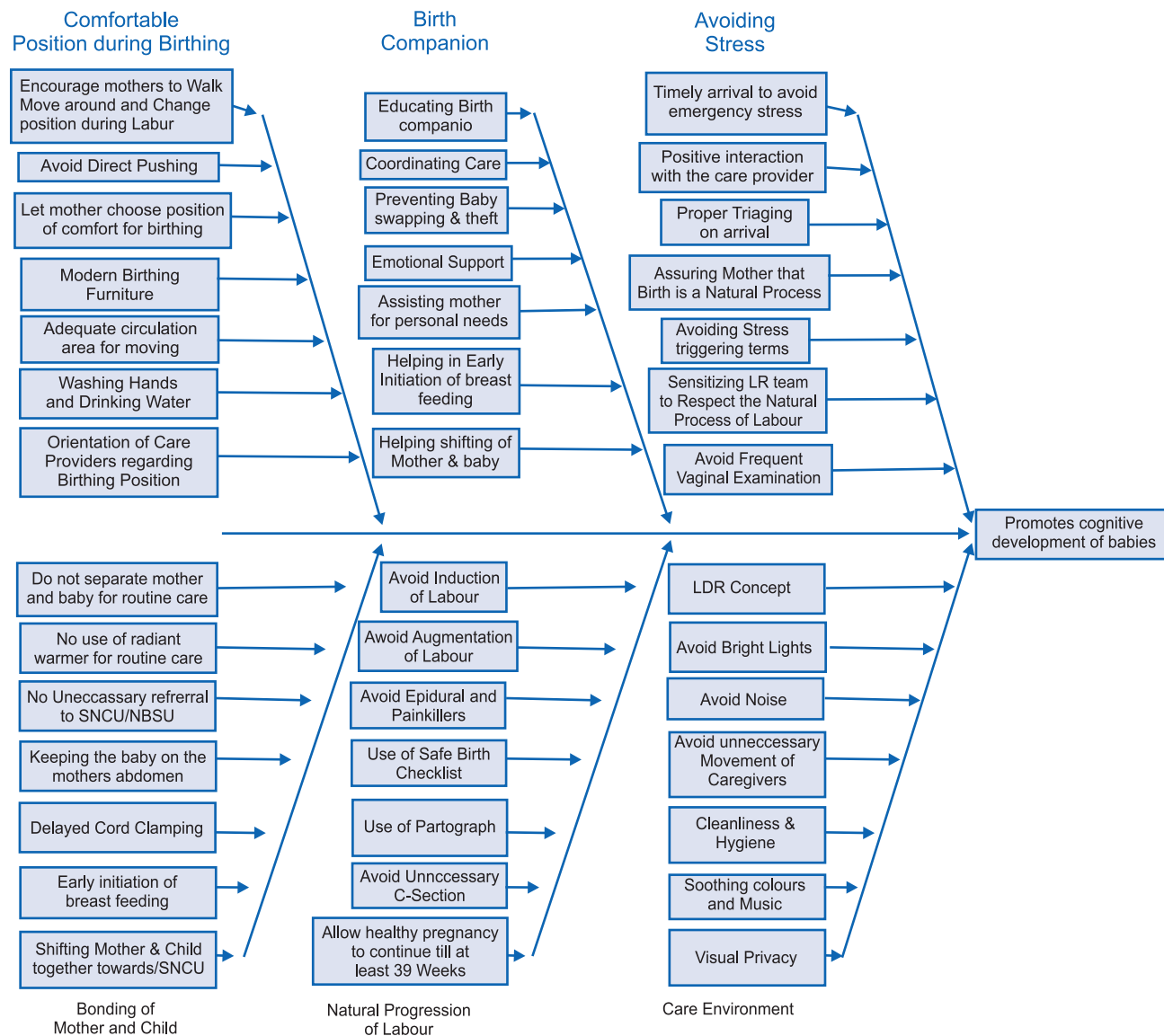
- Ensuring availability of optimal and skilled human resources as per case-load and prevalent norms through rational deployment and skill upgradation.
- Ensuring skill assessment of all staff of LR & Maternal OT through OSCE.



- Sensitizing care-providers for delivery of respectful maternity care and close monitoring of language, behaviour and conduct of the labour room, OT & HDU Staff.
- Creating an enabling environment for natural birthing process.
- Implementation of Clinical Guidelines, Labour Room Clinical Pathways, Referral Protocols, safe birth checklist (in labour room and Obstetric OT) and surgical safety check-list.
- Ensuring round the clock availability of Blood transfusion services, diagnostic services, drugs & consumables.
- Ensuring availability of triage area and functional newborn care area.
- Ensuring systematic facility-level review of all cases of maternal/neonatal deaths, stillbirth, and maternal near miss etc. including with their mentor teams through clinical discussions, peer reviews in teaching institutes, Videoconference, or other distance mode mechanisms for continuous improvement and learning.
- Operationalisation of 'C' Section audit and corrective & preventive actions for ensuring that 'C' Sections are undertaken judiciously in those cases having robust clinical indications.
- Instituting an ongoing system of capturing of beneficiaries' independent feedback through mechanism '**Mera- Aspataal**' or manual recording, or **Grievance Redressal Help Desk** and take action to address concerns, for continual enhancement in their satisfaction.
- Ensuring availability of essential support services such as 24x7 running water, electricity, housekeeping, linen and laundry, security, equipment maintenance, laboratory services, dietary services, BMW management, etc.
- Use of digital technology for record keeping & monitoring for maternity wing (MIS), including use of E partograph.
- Use aggressive IEC, user friendly training material and IT-enabled tools.
- Rapid Improvement Events - Six cycles of two months each as defined below will need to be rigorously supervised and ensured.

Determinants impacting health and well-being of mothers & newborns during the intrapartum & immediate post-partum period.

Promoting Respectful Maternity Care & Cognitive Development of Baby



Pradhan Mantri Matritva Vandana Yojna (PMMVY)

Malnourishment is highest among poor pregnant women and newborn babies. In a bid to do away with this gravethreat, PMMVY has been launched in 2017. This is a financial assistance scheme from central government for expecting and lactating mothers. PMMVY offers Rs. 5,000 to all eligible applicants. This financial assistance will help candidates to procure nutritious food and obtain medical help as and when needed. The cash shall be transferred directly to the beneficiary's account amounting to Rs. 1,000/- on registration, Rs. 2,000/- on first ANC, and Rs. 2,000/- after delivery and 1st round of vaccination.

Under this program, it will be the responsibility of AWW and ICDS supervisors at district and block level to create awareness and help the entitled beneficiaries in getting the amount transferred to their account.



Provisions under Operationalization of FRUs

Under NHM, states have been given flexibility to ensure availability of blood banks/blood storage centres, hiring of HR on differential salary/incentives, placing requisite equipment and infrastructure, so that all the designated first referral units are functional round the clock.

Under this program, it will be the responsibility of the district RCH (Reproductive and Child Health) officers and program managers to operationalize all the FRUs in their district, and clearly defined onward and upward linkages of health facilities below the FRU. The ambulance network operational in the district should have knowledge about operational FRUs to avoid any high risk cases (pregnant women and infants) from being hunted from one facility to another.

National Ambulance Services (NAS)

In the country, more than 26,000 ambulances are running with a state level centralized call center. Besides this, additional ambulances are running under JSSK exclusively for pregnant women and infants. This vast network of ambulances transports both normal and complicated cases for delivery, and serves as a medium in case of emergency complication management.

Under this program, the state and district program officer is responsible for adequate sensitization training of call center executives, EMTs (emergency medical technicians) and pilots regarding the importance of timely transportation to an appropriate health facility, which is functional as FRU.

Other Maternal and Infant Health Care Guidelines

Guidelines pertaining to MNH Toolkit, labour room, Obstetric HDU, OT, IPHS, MCH, SBA, Dakshata, Skill Labs, NSSK, FBNC (Operational guidelines & training package), ETAT, IMNCI, F-IMNCI, HBNC/HBYC, MAA etc. will help the program officers at all levels in utilizing the provisions and norms for creating infrastructure, recruiting qualified and experienced Human resource, logistics including procurement processes for equipment and capacity building of service providers, so that good quality care can be given.

Midwifery-led Care

Skilled and motivated nurse midwives play a key role in achieving positive health outcomes for mothers and children.

According to the Lancet series on midwifery, safe and effective midwifery care (which includes family planning) can avert 83% of all maternal deaths, stillbirths and newborn deaths. 24% of pre-term births can be prevented through a model of midwife-led continuity of care, where there is a well-functioning midwifery program.

The 'Midwifery Services Initiative' aims to create a cadre of Nurse Practitioners in Midwifery who are skilled in accordance to competencies prescribed by the International Confederation of Midwives (ICM) and are knowledgeable and capable of providing compassionate women-centered, reproductive, maternal and newborn health care services.

Bringing midwifery practices at central stage will further improve the quality of care around birth and decongest higher levels of facilities. A strong midwifery cadre will not only provide quality childbirth care to mothers and newborns, it will also ensure care with dignity and compassion and promote a positive child birthing experience.

Qualified and certified Nurse Practitioners in Midwifery would be posted at Midwifery Led Care Units that would be established at all high caseload public health facilities. Under this Midwifery Led Care Unit Model, normal deliveries are expected to be handled by professional midwives and complicated deliveries are expected to be handled by specialists.

Approximately 85% of pregnancies and births do not require specialized obstetric interventions. Midwifery led care can play a critical role in promoting physiological births, and reducing over medicalization.

Recognizing the critical role of skilled midwives, the Government of India developed the Guideline on Midwifery Services (2018) and aims to strengthen the midwifery services of the country to ensure quality care for every mother and newborn. . Introduction of midwifery led care will promote the following objectives-

- To provide access to quality maternal and newborn health services and promote natural birthing by promoting positive child birthing experience.
- To promote respectful maternity care throughout pregnancy and child birth
- To identify, manage, stabilize and/or refer as needed, women and their newborns experiencing complications
- To decongest higher level of healthcare facilities
- To expand access to quality maternal and neonatal services in remote areas including pockets of high home delivery rates and urban slums

**ANNEXURE - E**

SOME OF THE SUGGESTED INDICATORS FOR MEASURING QUALITY MATERNAL CARE SERVICES.

ANTENATAL INDICATORS

1. % of ANC registered within first trimester against the total ANC registrations.
2. % of pregnant women receiving four or more antenatal care check-ups against total ANC registrations.
3. % of Pregnant women having severe anemia treated against total number of PW having severe anemia tested cases.
4. % of Institutional Deliveries out of total estimated deliveries

LABOR ROOM INDICATORS

1. % of deliveries attended by birth companion.
2. % of deliveries conducted at night.
3. % of obstetric complication cases managed.
4. % of deliveries conducted using real time Partograph.
5. % of deliveries conducted using safe birth checklist.
6. Proportion of episiotomies done against all deliveries.
7. Proportion of elective caesarean section.
8. % of cases referred to OT.
9. % of newborn required resuscitation out of total live births.
10. % of newborn breastfeed within 1 hour of birth.
11. No of cases of neonatal asphyxia and neonatal sepsis.
12. No of cases of maternal death related to eclampsia/PIH.
13. No of cases of maternal death related to APH/PPH.
14. % of newborn referred out of those detected with danger signs
15. Number of fresh stillbirths
16. Number of cases of neonatal sepsis
17. Number of cases of birth asphyxia
18. Number of neonatal deaths and proportion reported
19. % of LBW babies receiving KMC
20. % of mothers of LBW supported for breast feeding
21. Proportion of newborn received birth dose immunization

POST NATAL INDICATORS

1. % of PPIUCD inserted against total number of normal delivery.
2. Women discharged under 48 hrs of delivery in public institutions to total no. of deliveries in public institutions.
3. Newborns visited within 24 hrs of home delivery to total reported home deliveries.
4. % of mothers received postnatal care from trained health personnel within 7 days of delivery (post-partum sepsis)
5. Percentage of mothers received postnatal care from a trained community worker within 3 days of delivery.
6. % of newborns received post natal care from a trained community worker within 3 days of delivery.
7. % of registered pregnancies for which the mother received mother and child e-card.



ANNEXURE - F

PROGRAM OFFICER'S RESPONSIBILITIES AT DIFFERENT LEVELS

State Level

- i. To be taken up as a citizen guarantee under Public Service Guarantee Act for providing timely and hassle-free delivery of services to the citizens.
- ii. The state program officer should have an update on implementation status from all the districts.
- iii. Awareness generation and encouraging community participation.
- iv. Sensitization and orientation of state and district service providers and program officers on the existing initiatives.
- v. Ensuring all identified EmOC and BEmOC delivery points are fully functional as per GOI guidelines.
- vi. The facilities are geared up to provide care to the low birth weight and sick infant.
- vii. Provision of adequate resources to ensure strengthening of various public health facilities and also cashless care to the beneficiaries.
- viii. Monitoring implementation of the initiative and timely redressal of grievances.
- ix. Organizing meetings of the state level committees and implementing the decisions taken.
- x. Prioritizing implementation of 'Mera Aspatal' initiative at all DHs.
- xi. Reviewing 100% reporting and implementation of MDSR in all districts.
- xii. To work towards ensuring that there are adequate number of CEmONC facilities/ First Referral Units that are so geographically distributed that they can be accessed within an hour from all health care facilities in line with the time to care approach.
- xiii. To ensure 100% registration of all maternal deaths and ensuring systematic maternal death review (facility and community based) are undertaken as per the Guidelines for Maternal Death Surveillance and Response and corrective measures undertaken to address the systemic gaps.
- xiv. To ensure that all delivery points above CHCs have Laqshya Certification, preferably by 2021-22
- xv. In collaboration with the State Committee and CoE, prepare a road map for operationalization of designated health facilities including medical colleges.
- xvi. Adequate funding support to medical colleges for effective implementation of this initiative.
- xvii. Timely recruitment and provision of necessary HR, other logistics and financial support for implementing this activity at facilities identified to provide the services under this initiative as a guarantee to the beneficiary.

District Level

- i. The district program officer will have a line listing of all HRPs and their expected place of delivery. Expected newborn services should also be ensured and team should be well informed and well prepped.
- ii. A comprehensive referral plan should be in position.

- iii. Sensitization and orientation of service providers on the existing initiatives.
- iv. Ensuring all identified EmOC and BEmOC delivery points are fully functional as per GOI guidelines.
- v. To ensure 100% registration of all maternal and child deaths and ensuring systematic maternal death review (facility and community based) are undertaken as per the Guidelines for Maternal Death Surveillance and Response and corrective measures undertaken to address the systemic gaps.
- vi. To ensure that all delivery points above CHCs have Laqshya Certification, preferably by 2021-22
- vii. District hospitals to be strengthened as per the GOI guidelines for strengthening pediatric care at DH and regularly report as per the reporting format.
- viii. Provision of adequate resources to ensure cashless care.
- ix. Monitoring implementation of the initiative and timely redressal of grievances.
- x. Organizing meetings of district level committees and implementing the decisions taken.

Block Level

- i. Ensuring all concerned staff are oriented about this scheme.
- ii. Capacity building of doctors/nurses providing maternity care.
- iii. Preparing line listing of beneficiaries as per the JSY/JSSK/PMSMA list.
- iv. Similar line listing to be done in urban areas under the supervision of Public Health Manager.
- v. Ensuring availability of drugs and diagnostics as per the PMSMA list.
- vi. Ensuring all relevant IEC/BCC material is printed in the local language and prominently displayed at vantage points at the facilities.
- vii. Organizing regular meetings with Women's group and PRI Leaders to engage and sensitize them about this initiative.
- viii. Ensuring all maternal and infant deaths are reported and reviewed and all pregnancies are registered.
- ix. Ensuring none of the identified HRP are without proper plan for delivery and follow up.
- x. Assisting State team or CoE for notification as well as investigation of maternal deaths.
- xi. Ensuring mother and child -friendly environment at facility and receiving regular feedback.
- xii. Assisting in timely treatment at facilities as well as timely referral of clients at higher centres by making transportation arrangement.
- xiii. Ensuring and coordinating with relevant stakeholders so that all HRPs, small and sick newborn will get free treatment and transportation at all facilities.
- xiv. Raising a flag to the District, State committee or CoE for meeting any challenges and extending necessary support which may be required for safe delivery and respectful maternity care.
- xv. Incase home delivery is imminent, even then the nodal officer will be responsible for ensuring that the delivery is conducted by SBA/midwives and referral is ensured in case it is required.

The MO in-charge of the block PHC/UPHC will identify the nurse/ANM/ASHA/volunteer who will be nodal to coordinate and ensure safe and cashless delivery at the public health facilities.



Ministry of Health and Family Welfare
Government of India