

# Reducing Maternal Mortality in India

Maternal Health Division  
MoHFW

# Goals for Tenth Plan (2002-03 to 2006-07) and NPP 2000

<b>Indicator</b>	<b>Current Level</b>	<b>10<sup>th</sup> Plan 2007</b>	<b>2010 goals as per NPP</b>	<b>MDG Goals 2015</b>
<b>Infant Mortality Rate</b> <i>(per 1000 live births)</i>	<b>66</b> <b>(2001)</b>	<b>45</b>	<b>30</b>	<b>30</b>
<b>Maternal Mortality Rate</b> <i>(per 100,000 live births)</i>	<b>407</b> <b>(1999)</b>	<b>200</b>	<b>100</b>	<b>100</b>
<b>Total Fertility Rate</b>	<b>3.2</b> <b>(1999)</b>	<b>2.3</b>	<b>2.1</b>	<b>--</b>

# Maternal Mortality Ratio over the years

NSS(1957-60)*	1321
NSS(1963-64)*	1195
SRS(1972-76)	853
SRS(1977-81)	810
SRS(1982-86)	580
SRS (98)	407

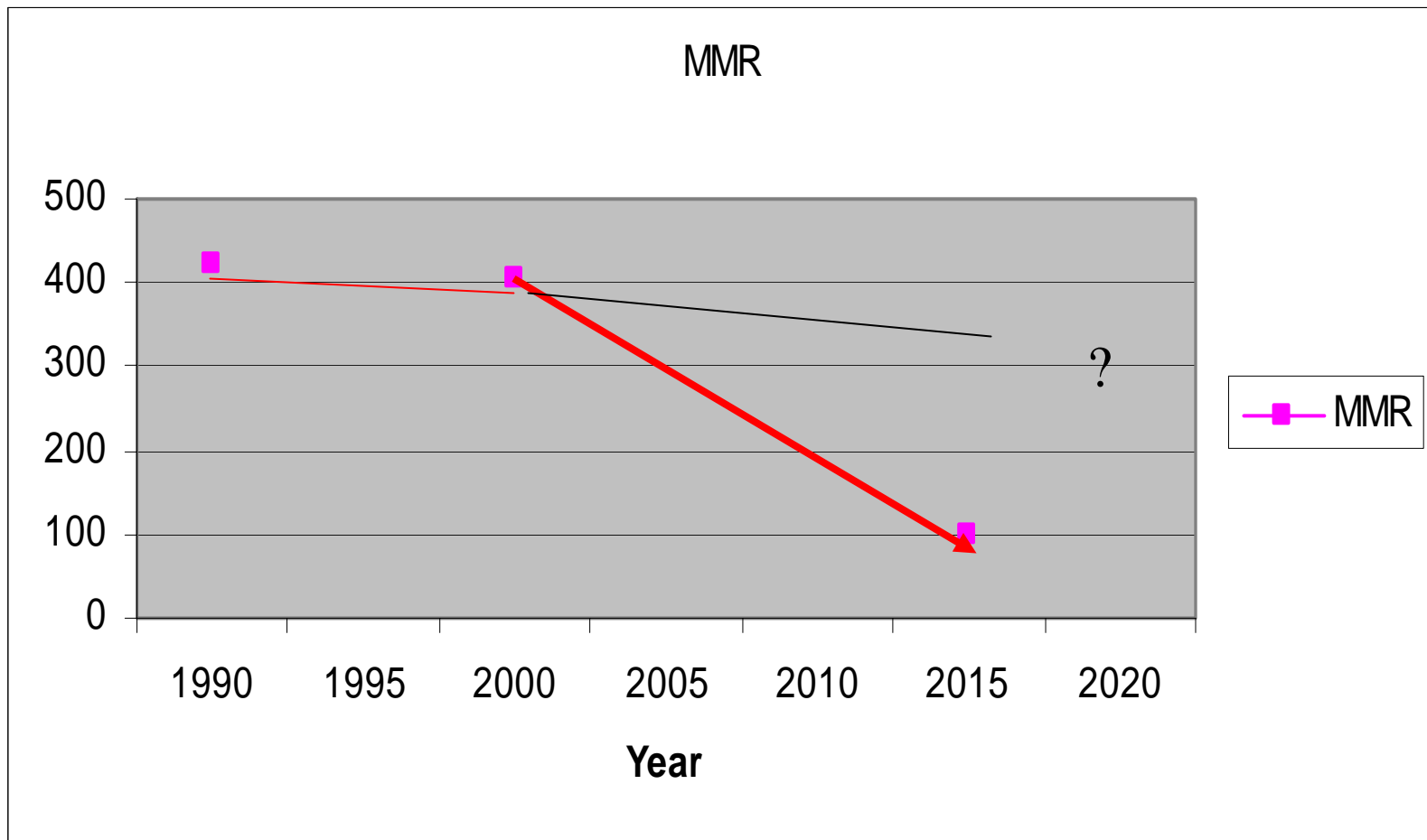


Declining  
trend

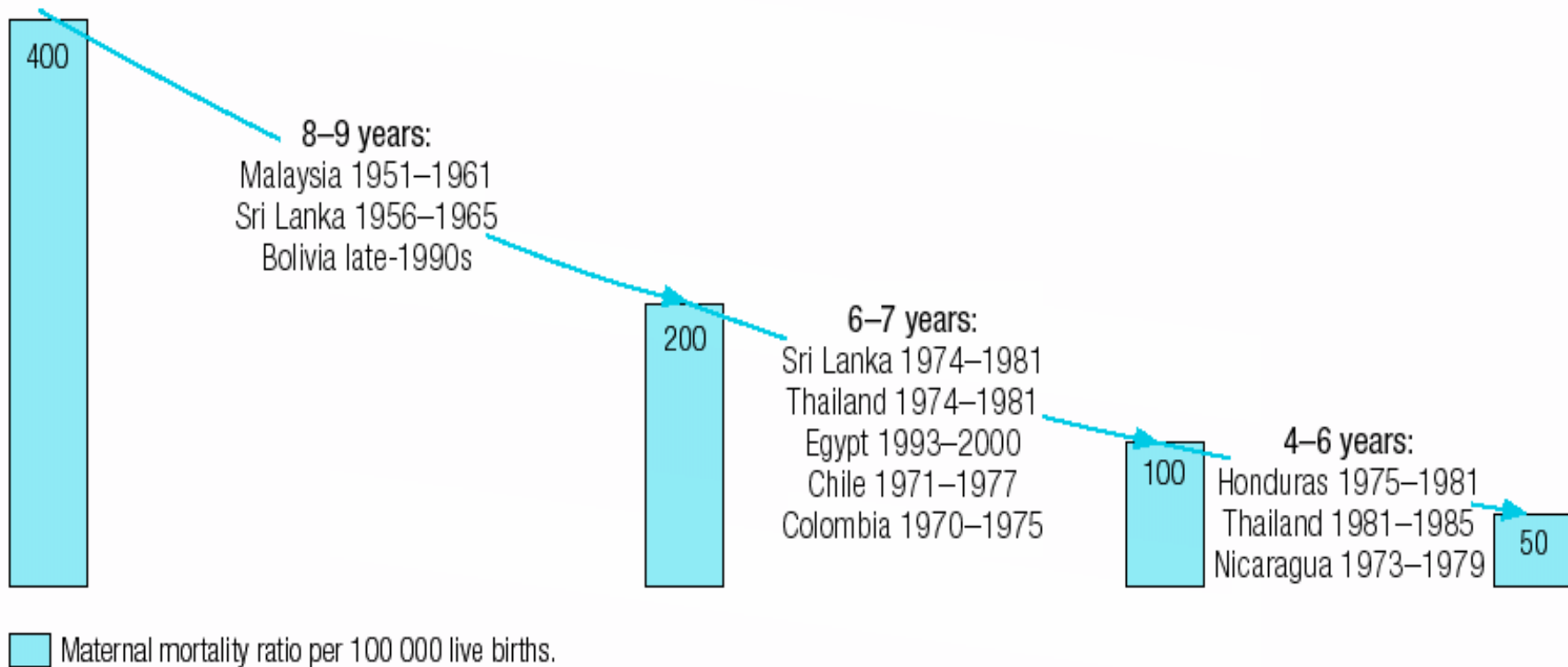
*There has not been any appreciable decline in MMR since 1990*

\* Based on indirect time series estimates

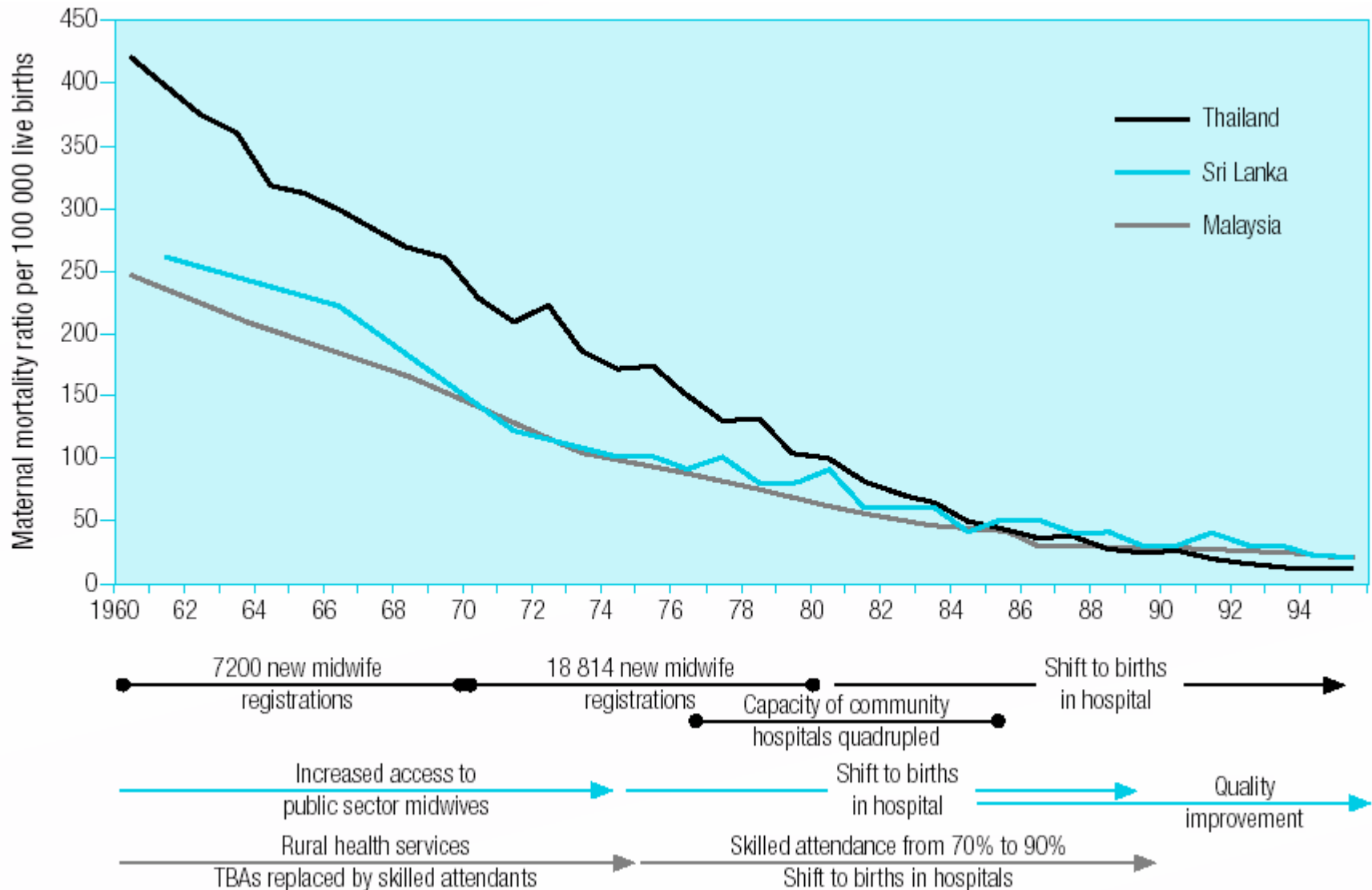
# MMR reduction – We need to accelerate



# Number of years to **halve MMR**, in selected countries



# MMR since 1960s in Malaysia, Sri Lanka & Thailand



# Strategies ... over the years

Strategies	Pre-CSSM	CSSM 1992	RCH -I	RCH-II
<b>Care of Preg women (Antenatal Care, Identify Comp. Refer, Safe/Inst Dely, PP Care)</b>	High risk approach	Essn OC	Essn OC	Essn OC
<b>Deliveries / Institutional deliveries</b>	TBAs	TBAs / Clean delivery	Instt / Safe delivery TBAs	Instt/ Safe delivery Skilled attendance at birth
<b>Emergency Obstetric Care</b>	-	Delay model FRUs	Operationalisa tion of FRUs	Operationali sation of FRUs

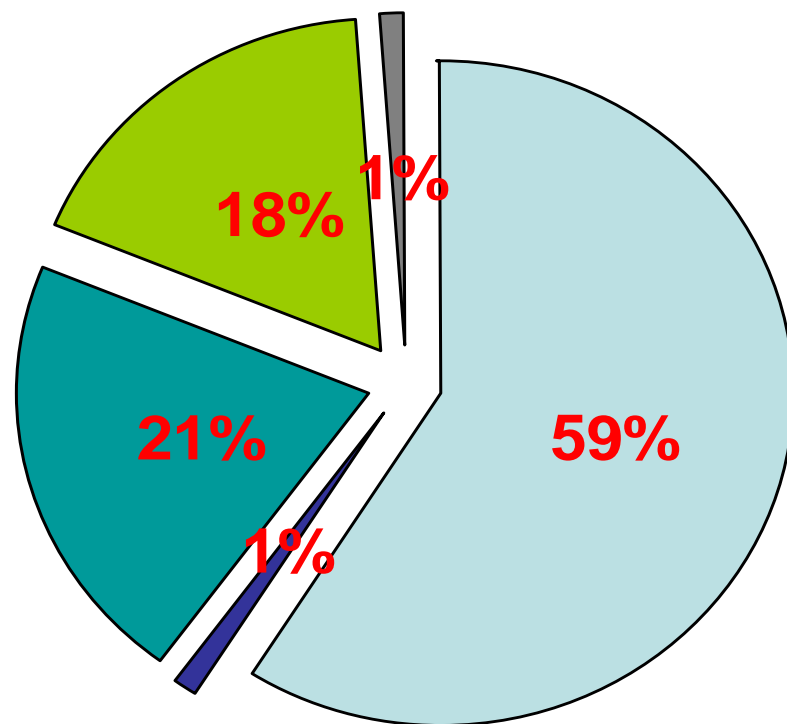
# Key Strategies in RCH-II

- Skilled Attendance at delivery - community and institutions
- Promote Institutional Deliveries-Janani Suraksha Yojana
- Operationalise Emergency Obstetric care;
- Strengthen Referral Systems
- Expand early Safe Abortion Services-introduce MVA at PHC level

# How to achieve the key results- Operational Targets for RH-II

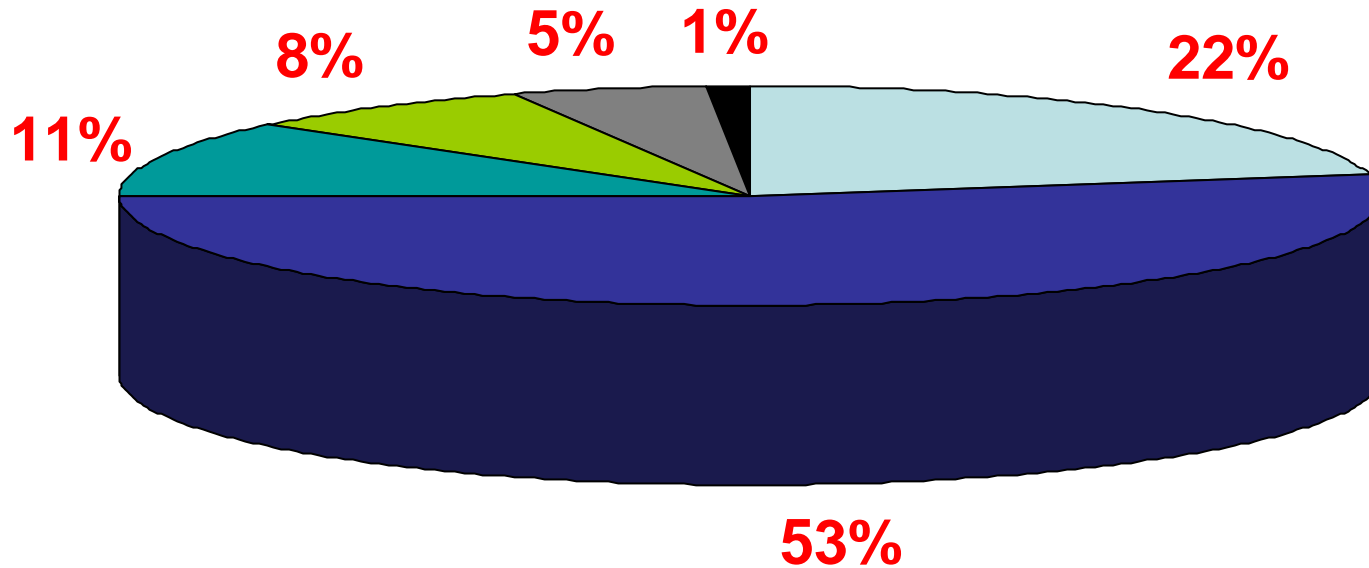
- Operationalise 2000+ FRUs in the country;
- Make at least 50% PHC operational for 24 hours for
  - Management of common obst complications;
  - Management of sick children;
  - Early and safe abortion; and
  - RTI/STI services
- Train and empower MOs/ANMs/LHVs as Skilled birth attendants;
- Develop referral linkages

# Place of delivery, India 2002-03



**Institutional deliveries 1998-99 34%**

# Assisting home deliveries, India



# Skilled Birth attendant

A **skilled attendant** is an **accredited** health professional – such as midwife, doctor or nurse – *who has been educated and **trained** to proficiency in the skills needed to manage*

- **normal (uncomplicated)** pregnancies,
- normal childbirth
- the immediate postnatal period, and
- identification, management and referral of **complications** in women and newborns.

# SBA – Competencies required

- Skills for management of complications
  - Maternal Haemorrhage
  - Sepsis
  - Pre-eclampsia and Eclampsia
  - Prolonged / Obstructed labour
  - Addressing abortion complications
  - Preventing Neonatal deaths
  - Conditions that can complicate pregnancy or childbirth (anaemia, malaria, HIV/AIDS etc.)

# Skilled Birth Attendant at community level

*Empower Health Worker for undertaking basic interventions of Em.O.C.*

- Permission to use drugs for prevention of PPH.
- Permission to use drugs in emergency situations before referral
- Permitted to undertake basic procedures at community level in emergency situations

# Life saving drugs approved for use by ANM/LHV for EmOC

Complications of Pregnancy	Expert Group Recommendations	Approval of DCGI
Prevention of PPH	<p>Tab Misoprostol S/L or Orally 600 mcg (3 tablets of 200 mcg each) immediately after the delivery of baby;</p> <p><i>Used as prophylaxis against PPH, in all deliveries as part of active management of 3<sup>rd</sup> stage of labour</i></p>	Tablets Misoprostol 600 mcg to be given orally immediately after delivery

# Life saving drugs approved for use by ANM/LHV for EmOC

<b>Management of PPH</b>	<ul style="list-style-type: none"><li>•If the ANM is trained to give I/V infusion, she should administer wherever feasible, even at home;</li><li>•The ANM should start infusion with Ringer Lactate or Dextrose solution</li><li>•If the I/V infusion was being started in cases of PPH, it was recommended that the IV fluids should be augmented with 20 Units of oxytocin for every 500 ml bottle of fluid. This could be continued through out transport</li></ul>	<ul style="list-style-type: none"><li>(i) Give I/M Oxytocin 10 IU in all cases of PPH;</li><li>(ii) Start I/V infusion in all cases of PPH before referral. Add 20 IU Oxytocin in I/V infusion;</li><li>(iii) In case I/V can not be given, patient may be referred immediately, after I/M oxytocin</li></ul>
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# Life saving drugs approved for use by ANM/LHV for EmOC

Complications of Pregnancy	Expert Group Recommendations	Approval of DCGI
Management of Eclampsia	<ul style="list-style-type: none"> <li>•Inj Magsulf is the drug of choice;</li> <li>•First dose given by ANM/Staff nurse/MO at the PHC;</li> <li>•Immediate referral to CHC/FRU and not PHC;</li> <li>•First dose of Inj Magsulf 10 ml of 5 Gms deep I/M in each buttock (A total of 10 Gms/20 ml of 50% solution injection Magsulf and refer</li> <li>•(other details as in document)</li> </ul>	<ul style="list-style-type: none"> <li>•First dose of Inj Magsulf 10 ml of 5 Gms deep I/M in each buttock (A total of 10 Gms/20 ml of 50% solution injection Magsulf and refer</li> </ul>

# Life saving drugs approved for use by ANM/LHV for EmOC

Complications of Pregnancy	Expert Group Recommendations	Approval of DCGI
<p><b>Prevention and management of Infection</b></p>	<ul style="list-style-type: none"> <li>•Antibiotic therapy is recommended for:</li> <li>•Premature rupture of membranes;</li> <li>•Prolonged labour;</li> <li>•Anything requiring manual interventions</li> <li>•UTI</li> <li>•Puerperal sepsis</li> </ul>	<ul style="list-style-type: none"> <li>•Before referral, ANM should give first dose of antibiotic</li> <li>(80 mg of Inj Gentamycin I/M stat, 1 Gm of Ampicillin, and 400 mg Metronidazole orally and refer immediately</li> </ul>

# Interventions ANM/LHV/MO can perform for obstetric care after training

Removal of retained products of conception	<ul style="list-style-type: none"><li>•For incomplete abortion, if bleeding continues, the ANM and staff nurse can perform only digital evacuation of products of conception.</li></ul>
Manual Removal of Placenta (MRP)	<ul style="list-style-type: none"><li>•MRP should be carried out only by the MO in a health facility (CHC/PHC)</li></ul>
Active management of 3 <sup>rd</sup> stage of labour	<ul style="list-style-type: none"><li>•The ANM should be trained in the active management of 3<sup>rd</sup> stage of labour</li></ul>

# **Interventions ANM/LHV can perform for obstetric care after training**

<p><b>Assisted Vaginal Delivery (forceps and vacuum extraction)</b></p> <p><b>Use of partograph</b></p>	<ul style="list-style-type: none"><li>• <b>Only by MO</b></li><li>• <b>The ANMs and staff nurse need to be trained in the use of partograph, for a diagnostic purposes only. This will help her in taking decision for referral in a case of prolonged labour</b></li></ul>
<p><b>Repair of vaginal and perineal tears</b></p>	<ul style="list-style-type: none"><li>• <b>Superficial tears do not require any repair;</b></li><li>• <b>ANM to be provided with skills for being able to differentiate between superficial and deep tears. Apply pad and pressure;</b></li><li>• <b>For 2<sup>nd</sup> and 3<sup>rd</sup> degree tears, ANM should refer to higher facility;</b></li><li>• <b>The staff nurses should be allowed to repair a second degree tear at the PHC setting, under the supervision of MO.</b></li><li>• <b>Refer third degree</b></li></ul>

# Maternal Health Interventions

<b>Areas</b>	<b>Status</b>
<b>Guidelines for operationalisation of FRUs</b>	<b>Completed and available</b>
<b>Guidelines for establishing blood storage at FRU</b>	<b>Completed and available</b>
<b>Guidelines for operationalising 24 hours functioning PHCs</b>	<b>Completed; To be Printed</b>

# Maternal Health Interventions

<b>Area (For Medical Officers/ANM)</b>	<b>Guidelines</b>
<b>MVA as safe abortion method up to 8 weeks</b>	<b>Guidelines Printed &amp; Available</b>
<b>Life saving anaesthetic skills for EmOC</b>	<b>Course curriculum and modules ready and available Administrative approval pending</b>
<b>Caesarean section by MBBS doctors</b>	<b>Prepared by FOGSI; Training Material ready and Master training already done</b>

# Maternal Health Interventions

<b>Area (For Medical Officers/ANM)</b>	<b>Status</b>
<b>Normal Delivery and management of obstetric complications at PHCs/CHC</b>	<b>Guidelines under print</b>
<i>Guidelines for ANC and skilled birth attendance at birth for ANM/LHVs</i>	<i>Guidelines ready</i>

# Issues

## **Related to Drugs**

- Storage**
- Distribution**
- Requirement assessment for kits at different institutions**
- Replenishment**
- Record keeping/monitoring**

# Issues

## Related to Skills enhancement

- **Training module/s including list of skills and competencies, facilitators guide, required duration etc. (?)**
- **Skills for starting I/V line**
- **Sites for training**
- **Numbers and actual training of master trainers and trainee**
- **Need and process for translation**
- **Pre-service (need for inclusion in curriculum) and in service**
- **Pilot in few districts or go on scale?**

# Issues

- **Fund**
- **Personnel**
- **Empower program management**
- **Numbers of trainee/master trainers per district (sizing the task)**
- **At least 15 states and in all districts**
- **Embedded in NRHM**
- **Resources shall not be constraint**
- **(Involve ANMs and review the material through their eyes)**
- **Circulate the guidelines/manuals to nursing schools/ANMTC in selected states**

THANK YOU

