

Maternal Health



National Health Mission
Deptt. of Health & Family Welfare
Govt. of Odisha.



VHND/UHND- Maternal health

- VHND means Village health and nutrition day
- This is also known as Mamata Diwas
- Held once in a month at AWC level in Tuesdays/Fridays
- Service providers- HW (F), AWW and ASHA
- Beneficiaries:- Pregnant mothers, Post natal mothers, Children within age group of 0- 5yrs

- Services:-
 - Registration and History taking of PW
 - ANC check up
 - PNC check up
 - **Investigations:**
 - Haemoglobin,
 - Blood sugar,
 - Blood Pressure,
 - Urine Sugar and Albumin
 - Identification and Follow up high risk cases

- Referral of high risk cases to facilities using proper referral slip. HW (F) has been provided with special referral slip and register
 - Issue of RED card to all high risk cases to high risk pregnancies / PNC mother
 - Counselling on maternal and child care including Family planning
 - Distribution of IFA and Calcium tablets for ANC and PNC cases. PW will take one IFA and two calcium tabs daily from 14th week if she is not anaemic, if anaemic then two IFA tabs instead of one.
 - De-worming of ANC cases in 2nd trimester
- Documents used for recording of services and counselling :
 - MCP Card and Safe motherhood booklet for each case

Integrated VHND and RI

- Held on Thursdays as per population plan
- Special incentive provided to teams for VHND in hard to reach areas
- Services are same as regular VHND and RI sessions

Maternity Waiting Home (Maa Gruha)

- Waiting home for expected delivery cases from designated hard to reach areas connected to Maa Gruha for ensuring safe institutional delivery
- The beneficiaries are mobilised by ASHA and LHA of Maa Gruha at least 10 days before
- These Maa Gruha are run by NGOs selected at district level
- These Maa Gruhas are situated near to facility of CHC and above.
- Facilities of Maa Gruha:
 - Indoor facility with food and stay
 - One attendant allowed to stay
 - Regular health check up by HW (F) positioned at Maa Gruha
 - Periodic check up by medical officer
 - Free transportation from Home to Maa gruha and Maa Gruha to facility
 - Regular counselling to beneficiary and attendant by service providers

Other transportation facilities to mother in Hard to reach areas

A) Provision of stretcher :-

Provision of stretcher at GKS level for transportation of pregnant women (from conception till delivery)/ Complicated Post Natal Care cases (Delivery to 42 days after delivery) & Sick children up to 5 years of age, from identified difficult villages to motorable point from where she/he can be transported to the appropriate facility or Maternity Waiting Home or vehicle pick up point

B) Reimbursement of Transportation cost to Pregnant Women :-

Rs. 1000/- is being paid to pregnant women as transportation cost belonging to identified difficult villages , where 102/108 ambulances or four wheeler can not reach to shift the mother.

Maternal Death Surveillance and Response (MDSR)

What is a maternal death?

Death of a woman while **pregnant or within 42 days of termination of pregnancy**

- irrespective of the duration and the site of the pregnancy
- from any cause related to or aggravated by the pregnancy or its management
- but not from accidental or incidental causes.

Places of death

- Facility death (Govt/ Private facilities)
- Community/ Home death
- Transit Death

Levels of review

- Facility level
 - Review done for all facility level cases occurred in the same facility
 - Frequency- Once in a month (If death occurred)
 - For finding facility level gap
 - For identifying delays
 - For taking action for indentified facility gaps in treatment, provisioning & supplies etc.
 - Review is held under the chairmanship of Facility Nodal Officer (FNO)

Levels of review

- Community level
 - Review done for all reported maternal death cases
 - Frequency- Within 21 days of reported death
 - For finding the causes leading to death from family and community members
 - For identifying delays at family and community
 - For taking action for indentified field functioning gaps.
 - Community investigation by three members team facilitated by Block MO I/c
 - Review is held under the chairmanship of Block Medical officer

Levels of review

- Transit level
 - Review done for all reported transit maternal death cases
 - Frequency- If reported under facility then as per facility norm and If reported under community as per community norm

Levels of review

- District level under chairmanship of CDM & PHO
 - Monthly for all reported cases
 - To analyse cause of death and delays responsible
 - To make action plan to the identified gaps for each reported death and suggest recommendations

Levels of review

- District level under chairmanship of Collector & DM
 - Quarterly for sample of reported cases
 - Cases will be reviewed in the presence of the family members who are present during the death of with the deceased in the family
 - Helps in cross verifying the audit in community and facility by interacting with family members
 - Facilitation of action plan prepared in CDM & PHO Meeting
 - Addressing interdepartmental convergence issues associated with cause of death
 - To make action plan to the identified gaps for each reviewed death and suggest recommendations

Levels of review

- At State level under chairmanship of MD NHM
 - Quarterly for sample cases
 - To analyse cause of death and action taken
 - Review the action taken status from the district
 - Discuss on the bottlenecks and issues

Levels of review

- At State level under chairmanship of Principal Secretary
 - Once annually as State Task Force
 - Review the overall status

Thank you